Senator ..... moves to amend S.F. No. 3322 as follows:

Delete everything after the enacting clause and insert:

"ARTICLE 1

CHILD PROTECTION AND OUT-OF-HOME PLACEMENT

Section 1. **[120A.21] ENROLLMENT OF A STUDENT IN FOSTER CARE.**

A student placed in foster care must remain enrolled in the student's prior school unless it is determined that remaining enrolled in the prior school is not in the student's best interests. If the student does not remain enrolled in the prior school, the student must be enrolled in a new school within seven school days.

Sec. 2. Minnesota Statutes 2018, section 257.0725, is amended to read:

257.0725 ANNUAL REPORT.

The commissioner of human services shall publish an annual report on child maltreatment and on children in out-of-home placement. The commissioner shall confer with counties, child welfare organizations, child advocacy organizations, the courts, and other groups on how to improve the content and utility of the department's annual report. In regard to child maltreatment, the report shall include the number and kinds of maltreatment reports received and any other data that the commissioner determines is appropriate to include in a report on child maltreatment. In regard to children in out-of-home placement, the report shall include, by county and statewide, information on legal status, living arrangement, age, sex, race, accumulated length of time in placement, reason for most recent placement, race of family with whom placed, school enrollments within seven days of placement pursuant to section 120A.21, and other information deemed appropriate on all children in out-of-home placement. Out-of-home placement includes placement in any facility by an authorized child-placing agency.

Sec. 3. Minnesota Statutes 2018, section 260C.219, is amended to read:

260C.219 AGENCY RESPONSIBILITIES FOR PARENTS AND CHILDREN IN PLACEMENT.

Subdivision 1. **Responsibilities for parents; noncustodial parents.** (a) When a child is in foster care, the responsible social services agency shall make diligent efforts to identify, locate, and, where appropriate, offer services to both parents of the child.

~~(1)~~ (b) The responsible social services agency shall assess whether a noncustodial or nonadjudicated parent is willing and capable of providing for the day-to-day care of the child temporarily or permanently. An assessment under this ~~clause~~ paragraph may include, but is not limited to, obtaining information under section 260C.209. If after assessment, the responsible social services agency determines that a noncustodial or nonadjudicated parent is willing and capable of providing day-to-day care of the child, the responsible social services agency may seek authority from the custodial parent or the court to have that parent assume day-to-day care of the child. If a parent is not an adjudicated parent, the responsible social services agency shall require the nonadjudicated parent to cooperate with paternity establishment procedures as part of the case plan.

~~(2)~~ (c) If, after assessment, the responsible social services agency determines that the child cannot be in the day-to-day care of either parent, the agency shall:

~~(i)~~ (1) prepare an out-of-home placement plan addressing the conditions that each parent must meet before the child can be in that parent's day-to-day care; and

~~(ii)~~ (2) provide a parent who is the subject of a background study under section 260C.209 15 days' notice that it intends to use the study to recommend against putting the child with that parent, and the court shall afford the parent an opportunity to be heard concerning the study.

The results of a background study of a noncustodial parent shall not be used by the agency to determine that the parent is incapable of providing day-to-day care of the child unless the agency reasonably believes that placement of the child into the home of that parent would endanger the child's health, safety, or welfare.

~~(3)~~ (d) If, after the provision of services following an out-of-home placement plan under this ~~section~~ subdivision, the child cannot return to the care of the parent from whom the child was removed or who had legal custody at the time the child was placed in foster care, the agency may petition on behalf of a noncustodial parent to establish legal custody with that parent under section 260C.515, subdivision 4. If paternity has not already been established, it may be established in the same proceeding in the manner provided for under chapter 257.

~~(4)~~ (e) The responsible social services agency may be relieved of the requirement to locate and offer services to both parents by the juvenile court upon a finding of good cause after the filing of a petition under section 260C.141.

Subd. 2. **Notice to parent or guardian.** ~~(b)~~ The responsible social services agency shall give notice to the parent or guardian of each child in foster care, other than a child in voluntary foster care for treatment under chapter 260D, of the following information:

(1) that the child's placement in foster care may result in termination of parental rights or an order permanently placing the child out of the custody of the parent, but only after notice and a hearing as required under this chapter and the juvenile court rules;

(2) time limits on the length of placement and of reunification services, including the date on which the child is expected to be returned to and safely maintained in the home of the parent or parents or placed for adoption or otherwise permanently removed from the care of the parent by court order;

(3) the nature of the services available to the parent;

(4) the consequences to the parent and the child if the parent fails or is unable to use services to correct the circumstances that led to the child's placement;

(5) the first consideration for placement with relatives;

(6) the benefit to the child in getting the child out of foster care as soon as possible, preferably by returning the child home, but if that is not possible, through a permanent legal placement of the child away from the parent;

(7) when safe for the child, the benefits to the child and the parent of maintaining visitation with the child as soon as possible in the course of the case and, in any event, according to the visitation plan under this section; and

(8) the financial responsibilities and obligations, if any, of the parent or parents for the support of the child during the period the child is in foster care.

Subd. 3. **Information for a parent considering voluntary placement.** ~~(c)~~ The responsible social services agency shall inform a parent considering voluntary placement of a child under section 260C.227 of the following information:

(1) the parent and the child each has a right to separate legal counsel before signing a voluntary placement agreement, but not to counsel appointed at public expense;

(2) the parent is not required to agree to the voluntary placement, and a parent who enters a voluntary placement agreement may at any time request that the agency return the child. If the parent so requests, the child must be returned within 24 hours of the receipt of the request;

(3) evidence gathered during the time the child is voluntarily placed may be used at a later time as the basis for a petition alleging that the child is in need of protection or services or as the basis for a petition seeking termination of parental rights or other permanent placement of the child away from the parent;

(4) if the responsible social services agency files a petition alleging that the child is in need of protection or services or a petition seeking the termination of parental rights or other permanent placement of the child away from the parent, the parent would have the right to appointment of separate legal counsel and the child would have a right to the appointment of counsel and a guardian ad litem as provided by law, and that counsel will be appointed at public expense if they are unable to afford counsel; and

(5) the timelines and procedures for review of voluntary placements under section 260C.212, subdivision 3, and the effect the time spent in voluntary placement on the scheduling of a permanent placement determination hearing under sections 260C.503 to 260C.521.

Subd. 4. **Medical examinations.** ~~(d)~~ When an agency accepts a child for placement, the agency shall determine whether the child has had a physical examination by or under the direction of a licensed physician within the 12 months immediately preceding the date when the child came into the agency's care. If there is documentation that the child has had an examination within the last 12 months, the agency is responsible for seeing that the child has another physical examination within one year of the documented examination and annually in subsequent years. If the agency determines that the child has not had a physical examination within the 12 months immediately preceding placement, the agency shall ensure that the child has an examination within 30 days of coming into the agency's care and once a year in subsequent years.

Subd. 5. **Children reaching age of majority; copies of records.** ~~(e)~~ Whether under state guardianship or not, if a child leaves foster care by reason of having attained the age of majority under state law, the child must be given at no cost a copy of the child's social and medical history, as defined in section 259.43, and education report.

Subd. 6. **Prenatal alcohol exposure screening.** The responsible social services agency shall coordinate a prenatal alcohol exposure screening for any child who enters foster care as soon as practicable but no later than 45 days after the removal of the child from the child's home, if the agency has determined that the child has not previously been screened or identified as being prenatally exposed to alcohol. The responsible social services agency shall ensure that the screening is conducted in accordance with existing prenatal alcohol

exposure screening best practice guidelines and criteria developed and provided to the responsible social services agencies by the statewide organization that focuses solely on prevention of and intervention with fetal alcohol spectrum disorder and receives funding under the appropriation for fetal alcohol spectrum disorder in Laws 2007, chapter 147, article 19, section 4, subdivision 2.

Subd. 7. **Initial foster care phone call.** (a) When a child enters foster care or moves to a new foster care placement, the responsible social services agency shall coordinate a phone call between the foster parent or facility and the child's parent or legal guardian to establish a connection and encourage ongoing information sharing between the child's parent or legal guardian and the foster parent or facility; and to provide an opportunity to share any information regarding the child, the child's needs, or the child's care that would facilitate the child's adjustment to the foster home, promote stability, reduce the risk of trauma, or otherwise improve the quality of the child's care.

(b) The responsible social services agency shall coordinate the phone call in paragraph (a) as soon as practicable after the child arrives at the placement but no later than 48 hours after the child's placement. If the responsible social services agency determines that the phone call is not in the child's best interests, or if the agency is unable to identify, locate, or contact the child's parent or legal guardian despite reasonable efforts, or despite active efforts if the child is an American Indian child, the agency may delay the phone call until up to 48 hours after the agency determines that the phone call is in the child's best interests, or up to 48 hours after the child's parent or legal guardian is located or becomes available for the phone call.

(c) The responsible social services agency shall document the date and time of the phone call in paragraph (a), its efforts to coordinate the phone call, its efforts to identify, locate, or find availability for the child's parent or legal guardian, any determination of whether the phone call is in the child's best interests, and any reasons that the phone call did not occur.

EFFECTIVE DATE. This section is effective for children who enter foster care on or after August 1, 2020, except subdivision 7 is effective for children entering out-of-home placement or moving between placements on or after November 1, 2020.

Sec. 4. **DIRECTION TO COMMISSIONER; INITIAL FOSTER CARE PHONE CALL TRAINING.**

By August 1, 2020, the commissioner of human services shall issue written guidance to county social services agencies, foster parents, and facilities to fully implement the initial foster care phone call procedures in Minnesota Statutes, section 260C.219, subdivision 6.

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

ARTICLE 2
COMMUNITY SUPPORTS ADMINISTRATION

Section 1. Minnesota Statutes 2018, section 245.4682, subdivision 2, is amended to read:

Subd. 2. **General provisions.** (a) In the design and implementation of reforms to the mental health system, the commissioner shall:

(1) consult with consumers, families, counties, tribes, advocates, providers, and other stakeholders;

(2) bring to the legislature, and the State Advisory Council on Mental Health, by January 15, 2008, recommendations for legislation to update the role of counties and to clarify the case management roles, functions, and decision-making authority of health plans and counties, and to clarify county retention of the responsibility for the delivery of social services as required under subdivision 3, paragraph (a);

(3) withhold implementation of any recommended changes in case management roles, functions, and decision-making authority until after the release of the report due January 15, 2008;

(4) ensure continuity of care for persons affected by these reforms including ensuring client choice of provider by requiring broad provider networks and developing mechanisms to facilitate a smooth transition of service responsibilities;

(5) provide accountability for the efficient and effective use of public and private resources in achieving positive outcomes for consumers;

(6) ensure client access to applicable protections and appeals; and

(7) make budget transfers necessary to implement the reallocation of services and client responsibilities between counties and health care programs that do not increase the state and county costs and efficiently allocate state funds.

(b) When making transfers under paragraph (a) necessary to implement movement of responsibility for clients and services between counties and health care programs, the commissioner, in consultation with counties, shall ensure that any transfer of state grants to health care programs, including the value of case management transfer grants under section 256B.0625, subdivision 20, does not exceed the value of the services being transferred for the latest 12-month period for which data is available. The commissioner may make quarterly adjustments based on the availability of additional data during the first four quarters after the transfers first occur. If case management transfer grants under section 256B.0625, subdivision 20, are repealed and the value, based on the last year prior to repeal, exceeds the value of the services being transferred, the difference becomes an ongoing part of each county's adult mental health grants under sections 245.4661 and 256E.12.

(c) This appropriation is not authorized to be expended after December 31, 2010, unless approved by the legislature.

(d) Beginning July 1, 2020, the commissioner of human services shall not impose new or additional state reporting requirements to those existing in law as of July 1, 2020, for community-based mental health service providers as a condition for reimbursement for mental health services provided through medical assistance or MinnesotaCare, unless the corresponding service reimbursement rates are first increased. This provision does not apply to any new services offered by community-based mental health service providers after July 1, 2020.

Sec. 2. Minnesota Statutes 2018, section 245A.11, subdivision 2a, is amended to read:

Subd. 2a. **Adult foster care and community residential setting license capacity.** (a) The commissioner shall issue adult foster care and community residential setting licenses with a maximum licensed capacity of four beds, including nonstaff roomers and boarders, except that the commissioner may issue a license with a capacity of five beds, including roomers and boarders, according to paragraphs (b) to (g).

(b) The license holder may have a maximum license capacity of five if all persons in care are age 55 or over and do not have a serious and persistent mental illness or a developmental disability.

(c) The commissioner may grant variances to paragraph (b) to allow a facility with a licensed capacity of up to five persons to admit an individual under the age of 55 if the variance complies with section 245A.04, subdivision 9, and approval of the variance is recommended by the county in which the licensed facility is located.

(d) The commissioner may grant variances to paragraph (a) to allow the use of an additional bed, up to five, for emergency crisis services for a person with serious and persistent mental illness or a developmental disability, regardless of age, if the variance complies with section 245A.04, subdivision 9, and approval of the variance is recommended by the county in which the licensed facility is located.

(e) The commissioner may grant a variance to paragraph (b) to allow for the use of an additional bed, up to five, for respite services, as defined in section 245A.02, for persons with disabilities, regardless of age, if the variance complies with sections 245A.03, subdivision 7, and 245A.04, subdivision 9, and approval of the variance is recommended by the county in which the licensed facility is located. Respite care may be provided under the following conditions:

(1) staffing ratios cannot be reduced below the approved level for the individuals being served in the home on a permanent basis;

(2) no more than two different individuals can be accepted for respite services in any calendar month and the total respite days may not exceed 120 days per program in any calendar year;

(3) the person receiving respite services must have his or her own bedroom, which could be used for alternative purposes when not used as a respite bedroom, and cannot be the room of another person who lives in the facility; and

(4) individuals living in the facility must be notified when the variance is approved. The provider must give 60 days' notice in writing to the residents and their legal representatives prior to accepting the first respite placement. Notice must be given to residents at least two days prior to service initiation, or as soon as the license holder is able if they receive notice of the need for respite less than two days prior to initiation, each time a respite client will be served, unless the requirement for this notice is waived by the resident or legal guardian.

(f) The commissioner may issue an adult foster care or community residential setting license with a capacity of five adults if the fifth bed does not increase the overall statewide capacity of licensed adult foster care or community residential setting beds in homes that are not the primary residence of the license holder, as identified in a plan submitted to the commissioner by the county, when the capacity is recommended by the county licensing agency of the county in which the facility is located and if the recommendation verifies that:

(1) the facility meets the physical environment requirements in the adult foster care licensing rule;

(2) the five-bed living arrangement is specified for each resident in the resident's:

(i) individualized plan of care;

(ii) individual service plan under section 256B.092, subdivision 1b, if required; or

(iii) individual resident placement agreement under Minnesota Rules, part 9555.5105, subpart 19, if required;

(3) the license holder obtains written and signed informed consent from each resident or resident's legal representative documenting the resident's informed choice to remain living in the home and that the resident's refusal to consent would not have resulted in service termination; and

(4) the facility was licensed for adult foster care before March 1, ~~2011~~ 2016.

(g) The commissioner shall not issue a new adult foster care license under paragraph (f) after June 30, ~~2019~~ 2024. The commissioner shall allow a facility with an adult foster care license issued under paragraph (f) before June 30, ~~2019~~ 2024, to continue with a capacity of five adults if the license holder continues to comply with the requirements in paragraph (f).

Sec. 3. Minnesota Statutes 2018, section 245D.02, is amended by adding a subdivision to read:

Subd. 32a. **Sexual violence.** "Sexual violence" means the use of sexual actions or words that are unwanted or harmful to another person.

Sec. 4. Minnesota Statutes 2018, section 245D.071, subdivision 3, is amended to read:

Subd. 3. **Assessment and initial service planning.** (a) Within 15 days of service initiation the license holder must complete a preliminary coordinated service and support plan addendum based on the coordinated service and support plan.

(b) Within the scope of services, the license holder must, at a minimum, complete assessments in the following areas before the 45-day planning meeting:

(1) the person's ability to self-manage health and medical needs to maintain or improve physical, mental, and emotional well-being, including, when applicable, allergies, seizures, choking, special dietary needs, chronic medical conditions, self-administration of medication or treatment orders, preventative screening, and medical and dental appointments;

(2) the person's ability to self-manage personal safety to avoid injury or accident in the service setting, including, when applicable, risk of falling, mobility, regulating water temperature, community survival skills, water safety skills, and sensory disabilities; and

(3) the person's ability to self-manage symptoms or behavior that may otherwise result in an incident as defined in section 245D.02, subdivision 11, clauses (4) to (7), suspension or termination of services by the license holder, or other symptoms or behaviors that may jeopardize the health and welfare of the person or others.

Assessments must produce information about the person that describes the person's overall strengths, functional skills and abilities, and behaviors or symptoms. Assessments must be based on the person's status within the last 12 months at the time of service initiation. Assessments based on older information must be documented and justified. Assessments must be conducted annually at a minimum or within 30 days of a written request from the person or the person's legal representative or case manager. The results must be reviewed by the support team or expanded support team as part of a service plan review.

(c) ~~Within~~ Before providing 45 days of service ~~initiation~~ or within 60 calendar days of the first day of service, whichever is shorter, the license holder must meet with the person, the person's legal representative, the case manager, and other members of the support team or expanded support team, and other people as identified y the person or the person's legal representative to determine the following based on information obtained from the assessments identified in paragraph (b), the person's identified needs in the coordinated service and support plan, and the requirements in subdivision 4 and section 245D.07, subdivision 1a:

(1) the scope of the services to be provided to support the person's daily needs and activities;

(2) the person's desired outcomes and the supports necessary to accomplish the person's desired outcomes;

(3) the person's preferences for how services and supports are provided, including how the provider will support the person to have control of the person's schedule;

(4) whether the current service setting is the most integrated setting available and appropriate for the person; ~~and~~

(5) opportunities to develop and maintain essential and life-enriching skills, abilities, strengths, interests, and preferences;

(6) opportunities for community access, participation, and inclusion in preferred community activities;

(7) opportunities to develop and strengthen personal relationships with other persons of the person's choice in the community;

(8) opportunities to seek competitive employment and work at competitively paying jobs in the community; and

~~(5)~~ (9) how services must be coordinated across other providers licensed under this chapter serving the person and members of the support team or expanded support team to ensure continuity of care and coordination of services for the person.

(d) A discussion of how technology might be used to meet the person's desired outcomes must be included in the 45-day planning meeting. The coordinated service and support plan or support plan addendum must include a summary of this discussion. The summary must include a statement regarding any decision that is made regarding the use of technology and a description of any further research that needs to be completed before a decision regarding the use of technology can be made. Nothing in this paragraph requires that the coordinated service and support plan include the use of technology for the provision of services.

Sec. 5. Minnesota Statutes 2018, section 245D.081, subdivision 2, is amended to read:

Subd. 2. **Coordination and evaluation of individual service delivery.** (a) Delivery and evaluation of services provided by the license holder must be coordinated by a designated staff person. Except as provided in clause (3), the designated coordinator must provide supervision, support, and evaluation of activities that include:

(1) oversight of the license holder's responsibilities assigned in the person's coordinated service and support plan and the coordinated service and support plan addendum;

(2) taking the action necessary to facilitate the accomplishment of the outcomes according to the requirements in section 245D.07;

(3) instruction and assistance to direct support staff implementing the coordinated service and support plan and the service outcomes, including direct observation of service delivery sufficient to assess staff competency. The designated coordinator may delegate the direct observation and competency assessment of the service delivery activities of direct support staff to an individual whom the designated coordinator has previously deemed competent in those activities; and

(4) evaluation of the effectiveness of service delivery, methodologies, and progress on the person's outcomes based on the measurable and observable criteria for identifying when the desired outcome has been achieved according to the requirements in section 245D.07.

(b) The license holder must ensure that the designated coordinator is competent to perform the required duties identified in paragraph (a) through education, training, and work experience relevant to the primary disability of persons served by the license holder and the individual persons for whom the designated coordinator is responsible. The designated coordinator must have the skills and ability necessary to develop effective plans and to design and use data systems to measure effectiveness of services and supports. The license holder must verify and document competence according to the requirements in section 245D.09, subdivision 3. The designated coordinator must minimally have:

(1) a baccalaureate degree in a field related to human services, and one year of full-time work experience providing direct care services to persons with disabilities or persons age 65 and older;

(2) an associate degree in a field related to human services, and two years of full-time work experience providing direct care services to persons with disabilities or persons age 65 and older;

(3) a diploma in a field related to human services from an accredited postsecondary institution and three years of full-time work experience providing direct care services to persons with disabilities or persons age 65 and older; or

(4) a minimum of 50 hours of education and training related to human services and disabilities; and

(5) four years of full-time work experience providing direct care services to persons with disabilities or persons age 65 and older under the supervision of a staff person who meets the qualifications identified in clauses (1) to (3).

Sec. 6. Minnesota Statutes 2018, section 245D.09, subdivision 4, is amended to read:

Subd. 4. **Orientation to program requirements.** Except for a license holder who does not supervise any direct support staff, within 60 calendar days of hire, unless stated otherwise, the license holder must provide and ensure completion of orientation sufficient to create staff competency for direct support staff that combines supervised on-the-job training with review of and instruction in the following areas:

(1) the job description and how to complete specific job functions, including:

(i) responding to and reporting incidents as required under section 245D.06, subdivision 1; and

(ii) following safety practices established by the license holder and as required in section 245D.06, subdivision 2;

(2) the license holder's current policies and procedures required under this chapter, including their location and access, and staff responsibilities related to implementation of those policies and procedures;

(3) data privacy requirements according to sections 13.01 to 13.10 and 13.46, the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA), and staff responsibilities related to complying with data privacy practices;

(4) the service recipient rights and staff responsibilities related to ensuring the exercise and protection of those rights according to the requirements in section 245D.04;

(5) sections 245A.65, 245A.66, 626.556, and 626.557, governing maltreatment reporting and service planning for children and vulnerable adults, and staff responsibilities related to protecting persons from maltreatment and reporting maltreatment. This orientation must be provided within 72 hours of first providing direct contact services and annually thereafter according to section 245A.65, subdivision 3;

(6) the principles of person-centered service planning and delivery as identified in section 245D.07, subdivision 1a, and how they apply to direct support service provided by the staff person;

(7) the safe and correct use of manual restraint on an emergency basis according to the requirements in section 245D.061 or successor provisions, and what constitutes the use of restraints, time out, and seclusion, including chemical restraint;

(8) staff responsibilities related to prohibited procedures under section 245D.06, subdivision 5, or successor provisions, why such procedures are not effective for reducing or eliminating symptoms or undesired behavior, and why such procedures are not safe;

(9) basic first aid; ~~and~~

(10) strategies to minimize the risk of sexual violence, including concepts of healthy relationships, consent, and bodily autonomy of people with disabilities; and

(11) other topics as determined necessary in the person's coordinated service and support plan by the case manager or other areas identified by the license holder.

Sec. 7. Minnesota Statutes 2018, section 245D.09, subdivision 4a, is amended to read:

Subd. 4a. **Orientation to individual service recipient needs.** (a) Before having unsupervised direct contact with a person served by the program, or for whom the staff

person has not previously provided direct support, or any time the plans or procedures identified in paragraphs (b) to (f) are revised, the staff person must review and receive instruction on the requirements in paragraphs (b) to (f) as they relate to the staff person's job functions for that person.

(b) For community residential services, training and competency evaluations must include the following, if identified in the coordinated service and support plan:

(1) appropriate and safe techniques in personal hygiene and grooming, including hair care; bathing; care of teeth, gums, and oral prosthetic devices; and other activities of daily living (ADLs) as defined under section 256B.0659, subdivision 1;

(2) an understanding of what constitutes a healthy diet according to data from the Centers for Disease Control and Prevention and the skills necessary to prepare that diet; and

(3) skills necessary to provide appropriate support in instrumental activities of daily living (IADLs) as defined under section 256B.0659, subdivision 1.

(c) The staff person must review and receive instruction on the person's coordinated service and support plan or coordinated service and support plan addendum as it relates to the responsibilities assigned to the license holder, and when applicable, the person's individual abuse prevention plan, to achieve and demonstrate an understanding of the person as a unique individual, and how to implement those plans.

(d) The staff person must review and receive instruction on medication setup, assistance, or administration procedures established for the person when assigned to the license holder according to section 245D.05, subdivision 1, paragraph (b). Unlicensed staff may perform medication setup or medication administration only after successful completion of a medication setup or medication administration training, from a training curriculum developed by a registered nurse or appropriate licensed health professional. The training curriculum must incorporate an observed skill assessment conducted by the trainer to ensure unlicensed staff demonstrate the ability to safely and correctly follow medication procedures.

Medication administration must be taught by a registered nurse, clinical nurse specialist, certified nurse practitioner, physician assistant, or physician if, at the time of service initiation or any time thereafter, the person has or develops a health care condition that affects the service options available to the person because the condition requires:

(1) specialized or intensive medical or nursing supervision; and

(2) nonmedical service providers to adapt their services to accommodate the health and safety needs of the person.

(e) The staff person must review and receive instruction on the safe and correct operation of medical equipment used by the person to sustain life or to monitor a medical condition that could become life-threatening without proper use of the medical equipment, including but not limited to ventilators, feeding tubes, or endotracheal tubes. The training must be provided by a licensed health care professional or a manufacturer's representative and incorporate an observed skill assessment to ensure staff demonstrate the ability to safely and correctly operate the equipment according to the treatment orders and the manufacturer's instructions.

(f) The staff person must review and receive instruction on mental health crisis response, de-escalation techniques, and suicide intervention when providing direct support to a person with a serious mental illness.

(g) In the event of an emergency service initiation, the license holder must ensure the training required in this subdivision occurs within 72 hours of the direct support staff person first having unsupervised contact with the person receiving services. The license holder must document the reason for the unplanned or emergency service initiation and maintain the documentation in the person's service recipient record.

(h) License holders who provide direct support services themselves must complete the orientation required in subdivision 4, clauses (3) to ~~(10)~~ (11).

Sec. 8. Minnesota Statutes 2019 Supplement, section 245D.09, subdivision 5, is amended to read:

Subd. 5. **Annual training.** A license holder must provide annual training to direct support staff on the topics identified in subdivision 4, clauses (3) to ~~(10)~~ (11). If the direct support staff has a first aid certification, annual training under subdivision 4, clause (9), is not required as long as the certification remains current.

Sec. 9. **[254A.21] FETAL ALCOHOL SPECTRUM DISORDERS PREVENTION GRANTS.**

(a) The commissioner of human services shall award a grant to a statewide organization that focuses solely on prevention of and intervention with fetal alcohol spectrum disorders. The grant recipient must make subgrants to eligible regional collaboratives in rural and urban areas of the state for the purposes specified in paragraph (c).

(b) "Eligible regional collaboratives" means a partnership between at least one local government and at least one community-based organization and, where available, a family

home visiting program. For purposes of this paragraph, a local government includes a county or a multicounty organization, a tribal government, a county-based purchasing entity, or a community health board.

(c) Eligible regional collaboratives must use subgrant funds to reduce the incidence of fetal alcohol spectrum disorders and other prenatal drug-related effects in children in Minnesota by identifying and serving pregnant women suspected of or known to use or abuse alcohol or other drugs. Eligible regional collaboratives must provide intensive services to chemically dependent women to increase positive birth outcomes.

(d) An eligible regional collaborative that receives a subgrant under this section must report to the grant recipient by January 15 of each year on the services and programs funded by the subgrant. The report must include measurable outcomes for the previous year, including the number of pregnant women served and the number of toxic-free babies born. The grant recipient must compile the information in the subgrant reports and submit a summary report to the commissioner of human services by February 15 of each year.

Sec. 10. Minnesota Statutes 2019 Supplement, section 256B.056, subdivision 5c, is amended to read:

Subd. 5c. **Excess income standard.** (a) The excess income standard for parents and caretaker relatives, pregnant women, infants, and children ages two through 20 is the standard specified in subdivision 4, paragraph (b).

(b) The excess income standard for a person whose eligibility is based on blindness, disability, or age of 65 or more years shall equal:

(1) 81 percent of the federal poverty guidelines; and

(2) effective July 1, 2022, ~~100 percent of the federal poverty guidelines~~ the standard specified in subdivision 4, paragraph (a).

Sec. 11. Minnesota Statutes 2019 Supplement, section 256B.0711, subdivision 1, is amended to read:

Subdivision 1. **Definitions.** For purposes of this section:

(a) "Commissioner" means the commissioner of human services unless otherwise indicated.

(b) "Covered program" means a program to provide direct support services funded in whole or in part by the state of Minnesota, including the community first services and

supports program under section 256B.85, subdivision 2, paragraph (e); ~~consumer-directed~~ consumer-directed community supports ~~services~~ and extended state plan personal care assistance services available under programs established pursuant to home and community-based service waivers authorized under section 1915(c) of the Social Security Act, and Minnesota Statutes, including, but not limited to, chapter 256S and sections 256B.092 and 256B.49, and under the alternative care program~~, as offered pursuant to~~ under section 256B.0913; the personal care assistance choice program~~, as established pursuant to~~ under section 256B.0659, subdivisions 18 to 20; and any similar program that may provide similar services in the future.

(c) "Direct support services" means personal care assistance services covered by medical assistance under section 256B.0625, subdivisions 19a and 19c; assistance with activities of daily living as defined in section 256B.0659, subdivision 1, paragraph (b), and instrumental activities of daily living as defined in section 256B.0659, subdivision 1, paragraph (i); and other similar, in-home, nonprofessional long-term services and supports provided to an elderly person or person with a disability by the person's employee or the employee of the person's representative to meet such person's daily living needs and ensure that such person may adequately function in the person's home and have safe access to the community.

(d) "Individual provider" means an individual selected by and working under the direction of a participant in a covered program, or a participant's representative, to provide direct support services to the participant, but does not include an employee of a provider agency, subject to the agency's direction and control commensurate with agency employee status.

(e) "Participant" means a person who receives direct support services through a covered program.

(f) "Participant's representative" means a participant's legal guardian or an individual having the authority and responsibility to act on behalf of a participant with respect to the provision of direct support services through a covered program.

Sec. 12. Minnesota Statutes 2018, section 256B.0941, subdivision 1, is amended to read:

Subdivision 1. **Eligibility.** (a) An individual who is eligible for mental health treatment services in a psychiatric residential treatment facility must meet all of the following criteria:

(1) before admission, services are determined to be medically necessary ~~by the state's medical review agent~~ according to Code of Federal Regulations, title 42, section 441.152;

(2) is younger than 21 years of age at the time of admission. Services may continue until the individual meets criteria for discharge or reaches 22 years of age, whichever occurs first;

(3) has a mental health diagnosis as defined in the most recent edition of the Diagnostic and Statistical Manual for Mental Disorders, as well as clinical evidence of severe aggression, or a finding that the individual is a risk to self or others;

(4) has functional impairment and a history of difficulty in functioning safely and successfully in the community, school, home, or job; an inability to adequately care for one's physical needs; or caregivers, guardians, or family members are unable to safely fulfill the individual's needs;

(5) requires psychiatric residential treatment under the direction of a physician to improve the individual's condition or prevent further regression so that services will no longer be needed;

(6) utilized and exhausted other community-based mental health services, or clinical evidence indicates that such services cannot provide the level of care needed; and

(7) was referred for treatment in a psychiatric residential treatment facility by a qualified mental health professional licensed as defined in section 245.4871, subdivision 27, clauses (1) to (6).

(b) ~~A mental health professional making a referral shall submit documentation to the state's medical review agent containing all information necessary to determine medical necessity, including a standard diagnostic assessment completed within 180 days of the individual's admission. Documentation shall include evidence of family participation in the individual's treatment planning and signed consent for services~~ The commissioner shall provide oversight and review the use of referrals for clients admitted to psychiatric residential treatment facilities to ensure that eligibility criteria, clinical services, and treatment planning reflect clinical, state, and federal standards for psychiatric residential treatment facility level of care. The commissioner shall coordinate the production of a statewide list of children and youth who meet the medical necessity criteria for psychiatric residential treatment facility level of care and who are awaiting admission. The commissioner and any recipient of the list shall not use the statewide list to direct admission of children and youth to specific facilities.

EFFECTIVE DATE. This section is effective August 1, 2020, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 13. Minnesota Statutes 2018, section 256B.0941, subdivision 3, is amended to read:

Subd. 3. **Per diem rate.** (a) The commissioner ~~shall~~ must establish ~~a statewide~~ one per diem rate per provider for psychiatric residential treatment facility services for individuals 21 years of age or younger. The rate for a provider must not exceed the rate charged by that provider for the same service to other payers. Payment must not be made to more than one entity for each individual for services provided under this section on a given day. The commissioner ~~shall~~ must set rates prospectively for the annual rate period. The commissioner ~~shall~~ must require providers to submit annual cost reports on a uniform cost reporting form and ~~shall~~ must use submitted cost reports to inform the rate-setting process. The cost reporting ~~shall~~ must be done according to federal requirements for Medicare cost reports.

(b) The following are included in the rate:

(1) costs necessary for licensure and accreditation, meeting all staffing standards for participation, meeting all service standards for participation, meeting all requirements for active treatment, maintaining medical records, conducting utilization review, meeting inspection of care, and discharge planning. The direct services costs must be determined using the actual cost of salaries, benefits, payroll taxes, and training of direct services staff and service-related transportation; and

(2) payment for room and board provided by facilities meeting all accreditation and licensing requirements for participation.

(c) A facility may submit a claim for payment outside of the per diem for professional services arranged by and provided at the facility by an appropriately licensed professional who is enrolled as a provider with Minnesota health care programs. Arranged services ~~must be billed by the facility on a separate claim, and the facility shall be responsible for payment to the provider~~ may be billed by either the facility or the licensed professional. These services must be included in the individual plan of care and are subject to prior authorization ~~by the state's medical review agent~~.

(d) Medicaid ~~shall~~ must reimburse for concurrent services as approved by the commissioner to support continuity of care and successful discharge from the facility. "Concurrent services" means services provided by another entity or provider while the individual is admitted to a psychiatric residential treatment facility. Payment for concurrent services may be limited and these services are subject to prior authorization by the state's medical review agent. Concurrent services may include targeted case management, assertive community treatment, clinical care consultation, team consultation, and treatment planning.

(e) Payment rates under this subdivision ~~shall~~ must not include the costs of providing the following services:

(1) educational services;

(2) acute medical care or specialty services for other medical conditions;

(3) dental services; and

(4) pharmacy drug costs.

(f) For purposes of this section, "actual cost" means costs that are allowable, allocable, reasonable, and consistent with federal reimbursement requirements in Code of Federal Regulations, title 48, chapter 1, part 31, relating to for-profit entities, and the Office of Management and Budget Circular Number A-122, relating to nonprofit entities.

Sec. 14. Minnesota Statutes 2018, section 256B.0944, subdivision 1, is amended to read:

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

(a) "Mental health crisis" means a child's behavioral, emotional, or psychiatric situation that, but for the provision of crisis response services to the child, would likely result in significantly reduced levels of functioning in primary activities of daily living, an emergency situation, or the child's placement in a more restrictive setting, including, but not limited to, inpatient hospitalization.

(b) "Mental health emergency" means a child's behavioral, emotional, or psychiatric situation that causes an immediate need for mental health services and is consistent with section 62Q.55. A physician, mental health professional, or crisis mental health practitioner determines a mental health crisis or emergency for medical assistance reimbursement with input from the client and the client's family, if possible.

(c) "Mental health crisis assessment" means an immediate face-to-face assessment by a physician, mental health professional, or mental health practitioner under the clinical supervision of a mental health professional, following a screening that suggests the child may be experiencing a mental health crisis or mental health emergency situation.

(d) "Mental health mobile crisis intervention services" means face-to-face, short-term intensive mental health services initiated during a mental health crisis or mental health emergency. Mental health mobile crisis services must help the recipient cope with immediate stressors, identify and utilize available resources and strengths, and begin to return to the recipient's baseline level of functioning. Mental health mobile services must be provided

on site by a mobile crisis intervention team outside of ~~an emergency room, urgent care, or~~ an inpatient hospital setting.

(e) "Mental health crisis stabilization services" means individualized mental health services provided to a recipient following crisis intervention services that are designed to restore the recipient to the recipient's prior functional level. The individual treatment plan recommending mental health crisis stabilization must be completed by the intervention team or by staff after an inpatient or urgent care visit. Mental health crisis stabilization services may be provided in the recipient's home, the home of a family member or friend of the recipient, schools, another community setting, or a short-term supervised, licensed residential program if the service is not included in the facility's cost pool or per diem. Mental health crisis stabilization is not reimbursable when provided as part of a partial hospitalization or day treatment program.

Sec. 15. Minnesota Statutes 2018, section 256B.0947, subdivision 2, is amended to read:

Subd. 2. **Definitions.** For purposes of this section, the following terms have the meanings given them.

(a) "Intensive nonresidential rehabilitative mental health services" means child rehabilitative mental health services as defined in section 256B.0943, except that these services are provided by a multidisciplinary staff using a total team approach consistent with assertive community treatment, as adapted for youth, and are directed to recipients ages 16~~, 17, 18, 19, or 20~~ through 25 with a serious mental illness or co-occurring mental illness and substance abuse addiction who require intensive services to prevent admission to an inpatient psychiatric hospital or placement in a residential treatment facility or who require intensive services to step down from inpatient or residential care to community-based care.

(b) "Co-occurring mental illness and substance abuse addiction" means a dual diagnosis of at least one form of mental illness and at least one substance use disorder. Substance use disorders include alcohol or drug abuse or dependence, excluding nicotine use.

(c) "Diagnostic assessment" has the meaning given to it in Minnesota Rules, part 9505.0370, subpart 11. A diagnostic assessment must be provided according to Minnesota Rules, part 9505.0372, subpart 1, and for this section must incorporate a determination of the youth's necessary level of care using a standardized functional assessment instrument approved and periodically updated by the commissioner.

(d) "Education specialist" means an individual with knowledge and experience working with youth regarding special education requirements and goals, special education plans, and coordination of educational activities with health care activities.

(e) "Housing access support" means an ancillary activity to help an individual find, obtain, retain, and move to safe and adequate housing. Housing access support does not provide monetary assistance for rent, damage deposits, or application fees.

(f) "Integrated dual disorders treatment" means the integrated treatment of co-occurring mental illness and substance use disorders by a team of cross-trained clinicians within the same program, and is characterized by assertive outreach, stage-wise comprehensive treatment, treatment goal setting, and flexibility to work within each stage of treatment.

(g) "Medication education services" means services provided individually or in groups, which focus on:

(1) educating the client and client's family or significant nonfamilial supporters about mental illness and symptoms;

(2) the role and effects of medications in treating symptoms of mental illness; and

(3) the side effects of medications.

Medication education is coordinated with medication management services and does not duplicate it. Medication education services are provided by physicians, pharmacists, or registered nurses with certification in psychiatric and mental health care.

(h) "Peer specialist" means an employed team member who is a mental health certified peer specialist according to section 256B.0615 and also a former children's mental health consumer who:

(1) provides direct services to clients including social, emotional, and instrumental support and outreach;

(2) assists younger peers to identify and achieve specific life goals;

(3) works directly with clients to promote the client's self-determination, personal responsibility, and empowerment;

(4) assists youth with mental illness to regain control over their lives and their developmental process in order to move effectively into adulthood;

(5) provides training and education to other team members, consumer advocacy organizations, and clients on resiliency and peer support; and

(6) meets the following criteria:

(i) is at least 22 years of age;

(ii) has had a diagnosis of mental illness, as defined in Minnesota Rules, part 9505.0370, subpart 20, or co-occurring mental illness and substance abuse addiction;

(iii) is a former consumer of child and adolescent mental health services, or a former or current consumer of adult mental health services for a period of at least two years;

(iv) has at least a high school diploma or equivalent;

(v) has successfully completed training requirements determined and periodically updated by the commissioner;

(vi) is willing to disclose the individual's own mental health history to team members and clients; and

(vii) must be free of substance use problems for at least one year.

(i) "Provider agency" means a for-profit or nonprofit organization established to administer an assertive community treatment for youth team.

(j) "Substance use disorders" means one or more of the disorders defined in the diagnostic and statistical manual of mental disorders, current edition.

(k) "Transition services" means:

(1) activities, materials, consultation, and coordination that ensures continuity of the client's care in advance of and in preparation for the client's move from one stage of care or life to another by maintaining contact with the client and assisting the client to establish provider relationships;

(2) providing the client with knowledge and skills needed posttransition;

(3) establishing communication between sending and receiving entities;

(4) supporting a client's request for service authorization and enrollment; and

(5) establishing and enforcing procedures and schedules.

A youth's transition from the children's mental health system and services to the adult mental health system and services and return to the client's home and entry or re-entry into community-based mental health services following discharge from an out-of-home placement or inpatient hospital stay.

(l) "Treatment team" means all staff who provide services to recipients under this section.

(m) "Family peer specialist" means a staff person qualified under section 256B.0616.

Sec. 16. Minnesota Statutes 2018, section 256B.0947, subdivision 3, is amended to read:

Subd. 3. **Client eligibility.** An eligible recipient is an individual who:

(1) is age 16~~, 17, 18, 19, or 20~~ through 25; ~~and~~

(2) is diagnosed with a serious mental illness or co-occurring mental illness and substance abuse addiction, for which intensive nonresidential rehabilitative mental health services are needed;

(3) has received a level-of-care determination, using an instrument approved by the commissioner, that indicates a need for intensive integrated intervention without 24-hour medical monitoring and a need for extensive collaboration among multiple providers;

(4) has a functional impairment and a history of difficulty in functioning safely and successfully in the community, school, home, or job; or who is likely to need services from the adult mental health system ~~within the next two years~~ in adulthood; and

(5) has had a recent diagnostic assessment, as provided in Minnesota Rules, part 9505.0372, subpart 1, by a mental health professional who is qualified under Minnesota Rules, part 9505.0371, subpart 5, item A, that documents that intensive nonresidential rehabilitative mental health services are medically necessary to ameliorate identified symptoms and functional impairments and to achieve individual transition goals.

Sec. 17. Minnesota Statutes 2018, section 256B.0947, subdivision 4, is amended to read:

Subd. 4. **Provider contract requirements.** (a) The intensive nonresidential rehabilitative mental health services provider agency shall have a contract with the commissioner to provide intensive transition youth rehabilitative mental health services.

(b) The commissioner shall develop ~~administrative and clinical contract standards and~~ performance evaluation criteria for providers, including county providers, and may require applicants and providers to submit documentation as needed to allow the commissioner to determine whether the ~~standards~~ criteria are met.

Sec. 18. Minnesota Statutes 2018, section 256B.0947, subdivision 5, is amended to read:

Subd. 5. **Standards for intensive nonresidential rehabilitative providers.** (a) Services must be provided by a provider entity as provided in subdivision 4.

(b) The treatment team must have specialized training in the specific age group they serve. An individual treatment team must either serve youth ages 16 through 20 or youth ages 18 through 25.

~~(b)~~ (c) The treatment team for intensive nonresidential rehabilitative mental health services comprises both permanently employed core team members and client-specific team members as follows:

(1) The core treatment team is an entity that operates under the direction of an independently licensed mental health professional, who is qualified under Minnesota Rules, part 9505.0371, subpart 5, item A, and that assumes comprehensive clinical responsibility for clients. Based on professional qualifications and client needs, clinically qualified core team members are assigned on a rotating basis as the client's lead worker to coordinate a client's care. The core team must comprise at least four full-time equivalent direct care staff and must include, but is not limited to:

(i) an independently licensed mental health professional, qualified under Minnesota Rules, part 9505.0371, subpart 5, item A, who serves as team leader to provide administrative direction and clinical supervision to the team;

(ii) an advanced-practice registered nurse with certification in psychiatric or mental health care or a board-certified child and adolescent psychiatrist, either of which must be credentialed to prescribe medications;

(iii) a licensed alcohol and drug counselor who is also trained in mental health interventions; and

(iv) a peer specialist as defined in subdivision 2, paragraph (h).

(2) The core team may also include any of the following:

(i) additional mental health professionals;

(ii) a vocational specialist;

(iii) an educational specialist;

(iv) a child and adolescent psychiatrist who may be retained on a consultant basis;

(v) a mental health practitioner, as defined in section 245.4871, subdivision 26;

(vi) a ~~mental health manager~~ case management service provider, as defined in section 245.4871, subdivision 4; ~~and~~

(vii) a housing access specialist; and

(viii) a family peer specialist as defined in subdivision 2, paragraph (m).

(3) A treatment team may include, in addition to those in clause (1) or (2), ad hoc members not employed by the team who consult on a specific client and who must accept overall clinical direction from the treatment team for the duration of the client's placement with the treatment team and must be paid by the provider agency at the rate for a typical session by that provider with that client or at a rate negotiated with the client-specific member. Client-specific treatment team members may include:

(i) the mental health professional treating the client prior to placement with the treatment team;

(ii) the client's current substance abuse counselor, if applicable;

(iii) a lead member of the client's individualized education program team or school-based mental health provider, if applicable;

(iv) a representative from the client's health care home or primary care clinic, as needed to ensure integration of medical and behavioral health care;

(v) the client's probation officer or other juvenile justice representative, if applicable; and

(vi) the client's current vocational or employment counselor, if applicable.

~~(c)~~ (d) The clinical supervisor shall be an active member of the treatment team and shall function as a practicing clinician at least on a part-time basis. The treatment team shall meet with the clinical supervisor at least weekly to discuss recipients' progress and make rapid adjustments to meet recipients' needs. The team meeting must include client-specific case reviews and general treatment discussions among team members. Client-specific case reviews and planning must be documented in the individual client's treatment record.

~~(d)~~ (e) The staffing ratio must not exceed ten clients to one full-time equivalent treatment team position.

~~(e)~~ (f) The treatment team shall serve no more than 80 clients at any one time. Should local demand exceed the team's capacity, an additional team must be established rather than exceed this limit.

~~(f)~~ (g) Nonclinical staff shall have prompt access in person or by telephone to a mental health practitioner or mental health professional. The provider shall have the capacity to promptly and appropriately respond to emergent needs and make any necessary staffing adjustments to ~~assure~~ ensure the health and safety of clients.

~~(g)~~ (h) The intensive nonresidential rehabilitative mental health services provider shall participate in evaluation of the assertive community treatment for youth (Youth ACT) model as conducted by the commissioner, including the collection and reporting of data and the reporting of performance measures as specified by contract with the commissioner.

~~(h)~~ (i) A regional treatment team may serve multiple counties.

Sec. 19. Minnesota Statutes 2018, section 256B.0947, subdivision 6, is amended to read:

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

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

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

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

~~(c)~~ (d) The initial functional assessment must be completed within ten days of intake and updated at least every ~~three~~ six months or prior to discharge from the service, whichever comes first.

~~(d)~~ (e) An individual treatment plan must ~~be completed for each client, according to criteria specified in section 256B.0943, subdivision 6, paragraph (b), clause (2), and, additionally, must~~:

(1) be based on the information in the client's diagnostic assessment and baselines;

(2) identify goals and objectives of treatment, a treatment strategy, a schedule for accomplishing treatment goals and objectives, and the individuals responsible for providing treatment services and supports;

(3) be developed after completion of the client's diagnostic assessment by a mental health professional or clinical trainee and before the provision of children's therapeutic services and supports;

(4) be developed through a child-centered, family-driven, culturally appropriate planning process, including allowing parents and guardians to observe or participate in individual and family treatment services, assessments, and treatment planning;

(5) be reviewed at least once every six months and revised to document treatment progress on each treatment objective and next goals or, if progress is not documented, to document changes in treatment;

(6) be signed by the clinical supervisor and by the client or by the client's parent or other person authorized by statute to consent to mental health services for the client. A client's parent may approve the client's individual treatment plan by secure electronic signature or by documented oral approval that is later verified by written signature;

~~(1)~~ (7) be completed in consultation with the client's current therapist and key providers and provide for ongoing consultation with the client's current therapist to ensure therapeutic continuity and to facilitate the client's return to the community. For clients under the age of 18, the treatment team must consult with parents and guardians in developing the treatment plan;

~~(2)~~ (8) if a need for substance use disorder treatment is indicated by validated assessment:

(i) identify goals, objectives, and strategies of substance use disorder treatment; develop a schedule for accomplishing treatment goals and objectives; and identify the individuals responsible for providing treatment services and supports;

(ii) be reviewed at least once every 90 days and revised, if necessary;

~~(3)~~ (9) be signed by the clinical supervisor and by the client and, if the client is a minor, by the client's parent or other person authorized by statute to consent to mental health treatment and substance use disorder treatment for the client; and

~~(4)~~ (10) provide for the client's transition out of intensive nonresidential rehabilitative mental health services by defining the team's actions to assist the client and subsequent providers in the transition to less intensive or "stepped down" services.

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

~~(f)~~ (g) For a client age 18 or older, the treatment team may disclose to a family member, other relative, or a close personal friend of the client, or other person identified by the client, the protected health information directly relevant to such person's involvement with the client's care, as provided in Code of Federal Regulations, title 45, part 164.502(b). If the client is present, the treatment team shall obtain the client's agreement, provide the client with an opportunity to object, or reasonably infer from the circumstances, based on the exercise of professional judgment, that the client does not object. If the client is not present

or is unable, by incapacity or emergency circumstances, to agree or object, the treatment team may, in the exercise of professional judgment, determine whether the disclosure is in the best interests of the client and, if so, disclose only the protected health information that is directly relevant to the family member's, relative's, friend's, or client-identified person's involvement with the client's health care. The client may orally agree or object to the disclosure and may prohibit or restrict disclosure to specific individuals.

~~(g)~~ (h) The treatment team shall provide interventions to promote positive interpersonal relationships.

Sec. 20. Minnesota Statutes 2018, section 256B.49, subdivision 16, is amended to read:

Subd. 16. **Services and supports.** (a) Services and supports included in the home and community-based waivers for persons with disabilities ~~shall~~ must meet the requirements set out in United States Code, title 42, section 1396n. The services and supports, which are offered as alternatives to institutional care, ~~shall~~ must promote consumer choice, community inclusion, self-sufficiency, and self-determination.

(b) ~~Beginning January 1, 2003,~~ The commissioner ~~shall~~ must simplify and improve access to home and community-based waivered services, to the extent possible, through the establishment of a common service menu that is available to eligible recipients regardless of age, disability type, or waiver program.

(c) ~~Consumer directed community support services shall~~ Consumer-directed community supports must be offered as an option to all persons eligible for services under subdivision 11~~, by January 1, 2002~~.

(d) Services and supports ~~shall~~ must be arranged and provided consistent with individualized written plans of care for eligible waiver recipients.

(e) A transitional supports allowance ~~shall~~ must be available to all persons under a home and community-based waiver who are moving from a licensed setting to a community setting. "Transitional supports allowance" means a onetime payment of up to $3,000, to cover the costs, not covered by other sources, associated with moving from a licensed setting to a community setting. Covered costs include:

(1) lease or rent deposits;

(2) security deposits;

(3) utilities setup costs, including telephone;

(4) essential furnishings and supplies; and

(5) personal supports and transports needed to locate and transition to community settings.

(f) The state of Minnesota and county agencies that administer home and community-based waivered services for persons with disabilities, ~~shall~~ must not be liable for damages, injuries, or liabilities sustained through the purchase of supports by the individual, the individual's family, legal representative, or the authorized representative with funds received through ~~the~~ consumer-directed community ~~support service~~ supports under this section. Liabilities include but are not limited to~~:~~ workers' compensation liability, the Federal Insurance Contributions Act (FICA), or the Federal Unemployment Tax Act (FUTA).

Sec. 21. **[256B.4911] CONSUMER-DIRECTED COMMUNITY SUPPORTS.**

Subdivision 1. **Federal authority.** Consumer-directed community supports, as referenced in sections 256B.0913, subdivision 5, clause (17); 256B.092, subdivision 1b, clause (4); 256B.49, subdivision 16, paragraph (c); and chapter 256S are governed, in whole, by the federally-approved waiver plans for home and community-based services.

Subd. 2. **Costs associated with physical activities.** The expenses allowed for adults under the consumer-directed community supports option must include the costs at the lowest rate available considering daily, monthly, semiannual, annual, or membership rates, including transportation, associated with physical exercise or other physical activities to maintain or improve the person's health and functioning.

Subd. 3. **Expansion and increase of budget exceptions.** (a) The commissioner of human services must provide up to 30 percent more funds for either:

(1) consumer-directed community supports participants under sections 256B.092 and 256B.49 who have a coordinated service and support plan which identifies the need for more services or supports under consumer-directed community supports than the amount the participants are currently receiving under the consumer-directed community supports budget methodology to:

(i) increase the amount of time a person works or otherwise improves employment opportunities;

(ii) plan a transition to, move to, or live in a setting described in section 256D.44, subdivision 5, paragraph (g), clause (1), item (iii); or

(iii) develop and implement a positive behavior support plan; or

(2) home and community-based waiver participants under sections 256B.092 and 256B.49 who are currently using licensed providers for: (i) employment supports or services during the day; or (ii) residential services, either of which cost more annually than the person would spend under a consumer-directed community supports plan for any or all of the supports needed to meet a goal identified in clause (1), item (i), (ii), or (iii).

(b) The exception under paragraph (a), clause (1), is limited to persons who can demonstrate that they will have to discontinue using consumer-directed community supports and accept other non-self-directed waiver services because their supports needed for a goal described in paragraph (a), clause (1), item (i), (ii), or (iii), cannot be met within the consumer-directed community supports budget limits.

(c) The exception under paragraph (a), clause (2), is limited to persons who can demonstrate that, upon choosing to become a consumer-directed community supports participant, the total cost of services, including the exception, will be less than the cost of current waiver services.

Subd. 4. **Budget exception for persons leaving institutions and crisis residential settings.** (a) The commissioner must establish an institutional and crisis bed consumer-directed community supports budget exception process in the home and community-based services waivers under sections 256B.092 and 256B.49. This budget exception process must be available for any individual who:

(1) is not offered available and appropriate services within 60 days since approval for discharge from the individual's current institutional setting; and

(2) requires services that are more expensive than appropriate services provided in a noninstitutional setting using the consumer-directed community supports option.

(b) Institutional settings for purposes of this exception include intermediate care facilities for persons with developmental disabilities; nursing facilities; acute care hospitals; Anoka Metro Regional Treatment Center; Minnesota Security Hospital; and crisis beds.

(c) The budget exception must be limited to no more than the amount of appropriate services provided in a noninstitutional setting as determined by the lead agency managing the individual's home and community-based services waiver. The lead agency must notify the Department of Human Services of the budget exception.

Subd. 5. **Shared services.** (a) Medical assistance payments for shared services under consumer-directed community supports are limited to this subdivision.

(b) For purposes of this subdivision, "shared services" means services provided at the same time by the same direct care worker for individuals who have entered into an agreement to share consumer-directed community support services.

(c) Shared services may include services in the personal assistance category as outlined in the consumer-directed community supports community support plan and shared services agreement, except:

(1) services for more than three individuals provided by one worker at one time;

(2) use of more than one worker for the shared services; and

(3) a child care program licensed under chapter 245A or operated by a local school district or private school.

(d) The individuals, or as needed the individuals' representatives, must develop the plan for shared services when developing or amending the consumer-directed community supports plan, and must follow the consumer-directed community supports process for approval of the plan by the lead agency. The plan for shared services in an individual's consumer-directed community supports plan must include the intention to utilize shared services based on individuals' needs and preferences.

(e) Individuals sharing services must use the same financial management services provider.

(f) Individuals whose consumer-directed community supports community support plans include an intent to utilize shared services must jointly develop, with the support of the individuals' representatives as needed, a shared services agreement. This agreement must include:

(1) the names of the individuals receiving shared services;

(2) the individuals' representative, if identified in their consumer-directed community supports plans, and their duties;

(3) the names of the case managers;

(4) the financial management services provider;

(5) the shared services that must be provided;

(6) the schedule for shared services;

(7) the location where shared services must be provided;

(8) the training specific to each individual served;

(9) the training specific to providing shared services to the individuals identified in the agreement;

(10) instructions to follow all required documentation for time and services provided;

(11) a contingency plan for each individual that accounts for service provision and billing in the absence of one of the individuals in a shared services setting due to illness or other circumstances;

(12) signatures of all parties involved in the shared services; and

(13) agreement by each individual who is sharing services on the number of shared hours for services provided.

(g) Any individual or any individual's representative may withdraw from participating in a shared services agreement at any time.

(h) The lead agency for each individual must authorize the use of the shared services option based on the criteria that the shared service is appropriate to meet the needs, health, and safety of each individual for whom they provide case management or care coordination.

(i) This subdivision must not be construed to reduce the total authorized consumer-directed community supports budget for an individual.

(j) No later than September 30, 2019, the commissioner of human services must:

(1) submit an amendment to the Centers for Medicare and Medicaid Services for the home and community-based services waivers authorized under sections 256B.0913, 256B.092, and 256B.49, and chapter 256S, to allow for a shared services option under consumer-directed community supports; and

(2) with stakeholder input, develop guidance for shared services in consumer-directed community-supports within the community-based services manual. Guidance must include:

(i) recommendations for negotiating payment for one-to-two and one-to-three services; and

(ii) a template of the shared services agreement.

EFFECTIVE DATE. This section is effective the day following final enactment, except for subdivision 5, paragraphs (a) to (i), which are effective the day following final enactment or upon federal approval, whichever occurs later. The commissioner of human services must notify the revisor of statutes when federal approval is obtained.

Sec. 22. Minnesota Statutes 2019 Supplement, section 256B.4914, subdivision 10a, is amended to read:

Subd. 10a. **Reporting and analysis of cost data.** (a) The commissioner must ensure that wage values and component values in subdivisions 5 to 9 reflect the cost to provide the service. As determined by the commissioner, in consultation with stakeholders identified in subdivision 17, a provider enrolled to provide services with rates determined under this section must submit requested cost data to the commissioner to support research on the cost of providing services that have rates determined by the disability waiver rates system. Requested cost data may include, but is not limited to:

(1) worker wage costs;

(2) benefits paid;

(3) supervisor wage costs;

(4) executive wage costs;

(5) vacation, sick, and training time paid;

(6) taxes, workers' compensation, and unemployment insurance costs paid;

(7) administrative costs paid;

(8) program costs paid;

(9) transportation costs paid;

(10) staff vacancy rates; ~~and~~

(11) recipient absence rates; and

(12) other data relating to costs required to provide services requested by the commissioner.

(b) At least once in any five-year period, a provider must submit cost data for a fiscal year that ended not more than 18 months prior to the submission date. The commissioner shall provide each provider a 90-day notice prior to its submission due date. If a provider fails to submit required reporting data, the commissioner shall provide notice to providers that have not provided required data 30 days after the required submission date, and a second notice for providers who have not provided required data 60 days after the required submission date. The commissioner shall temporarily suspend payments to the provider if cost data is not received 90 days after the required submission date. Withheld payments shall be made once data is received by the commissioner.

(c) The commissioner shall conduct a random validation of data submitted under paragraph (a) to ensure data accuracy. The commissioner shall analyze cost documentation in paragraph (a) and provide recommendations for adjustments to cost components.

(d) The commissioner shall analyze cost documentation in paragraph (a) and, in consultation with stakeholders identified in subdivision 17, may submit recommendations on component values and inflationary factor adjustments to the chairs and ranking minority members of the legislative committees with jurisdiction over human services every four years beginning January 1, 2021. When analyzing the costs associated with absences from day programs, unit-based services with programming, and unit-based services without programming except respite, and when recommending adjustments to the absence and utilization ratios for these services, the commissioner must use at least 24 consecutive months of cost reporting data, claims data, or other available data. The commissioner must not include in the commissioner's analysis or recommendations factors unsupported by the cost or claims data, including but not limited to assumptions regarding variable expenses. The commissioner shall make recommendations in conjunction with reports submitted to the legislature according to subdivision 10, paragraph (c). The commissioner shall release cost data in an aggregate form, and cost data from individual providers shall not be released except as provided for in current law.

(e) The commissioner, in consultation with stakeholders identified in subdivision 17, shall develop and implement a process for providing training and technical assistance necessary to support provider submission of cost documentation required under paragraph (a).

(f) By December 31, 2020, providers paid with rates calculated under subdivision 5, paragraph (b), shall identify additional revenues from the competitive workforce factor and prepare a written distribution plan for the revenues. A provider shall make the provider's distribution plan available and accessible to all direct care staff for a minimum of one calendar year. Upon request, a provider shall submit the written distribution plan to the commissioner.

(g) Providers enrolled to provide services with rates determined under section 256B.4914, subdivision 3, shall submit labor market data to the commissioner annually on or before November 1, including but not limited to:

(1) number of direct care staff;

(2) wages of direct care staff;

(3) overtime wages of direct care staff;

(4) hours worked by direct care staff;

(5) overtime hours worked by direct care staff;

(6) benefits provided to direct care staff;

(7) direct care staff job vacancies; and

(8) direct care staff retention rates.

(h) The commissioner shall publish annual reports on provider and state-level labor market data, including but not limited to the data obtained under paragraph (g).

(i) The commissioner may temporarily suspend payments to the provider if data requested under paragraph (g) is not received 90 days after the required submission date. Withheld payments shall be made once data is received by the commissioner.

(j) Providers who receive payment under this section for less than 25 percent of their clients in the year prior to the report may attest to the commissioner in a manner determined by the commissioner that they are declining to provide the data required under paragraph (g) and will not be subject to the payment suspension in paragraph (i).

Sec. 23. Minnesota Statutes 2019 Supplement, section 256S.01, subdivision 6, is amended to read:

Subd. 6. **Immunity; consumer-directed community supports.** The state of Minnesota, or a county, managed care plan, county-based purchasing plan, or tribal government under contract to administer the elderly waiver, is not liable for damages, injuries, or liabilities sustained as a result of the participant, the participant's family, or the participant's authorized representatives purchasing direct supports or goods with funds received through consumer-directed community ~~support services~~ supports under the elderly waiver. Liabilities include, but are not limited to, workers' compensation liability, Federal Insurance Contributions Act under United States Code, title 26, subtitle c, chapter 21, or Federal Unemployment Tax Act under Internal Revenue Code, chapter 23.

Sec. 24. Minnesota Statutes 2019 Supplement, section 256S.19, subdivision 4, is amended to read:

Subd. 4. **Calculation of monthly conversion budget cap with consumer-directed community supports.** For the elderly waiver monthly conversion budget cap for the cost of elderly waiver services with consumer-directed community ~~support services~~ supports, the nursing facility case mix adjusted total payment rate used under subdivision 3 to calculate

the monthly conversion budget cap for elderly waiver services without consumer-directed community supports must be reduced by a percentage equal to the percentage difference between the consumer-directed ~~services~~ community supports budget limit that would be assigned according to the elderly waiver plan and the corresponding monthly case mix budget cap under this chapter, but not to exceed 50 percent.

Sec. 25. Laws 2017, First Special Session chapter 6, article 7, section 33, subdivision 2, is amended to read:

Subd. 2. **Pilot design and goals.** The pilot will establish ~~five~~ key developmental milestone markers from birth to age eight. ~~Enrollees in the~~ Pilot program participants will be developmentally assessed and tracked by a technology solution that tracks developmental milestones along the established developmental continuum. If a ~~child's~~ pilot program participant's progress falls below established milestones ~~and the weighted scoring~~, the coordinated service system will focus on identified areas of concern~~, mobilize appropriate supportive services,~~ and offer referrals or services to ~~identified children and their families~~ pilot program participants.

Sec. 26. Laws 2017, First Special Session chapter 6, article 7, section 33, subdivision 3, is amended to read:

Subd. 3. **Program participants in ~~phase 1~~ target population.** Pilot program participants must opt in and provide parental or guardian consent to participate and be enrolled or engaged in one or more of the following:

(1) ~~be enrolled in a~~ Women's Infant & Children (WIC) program;

(2) ~~be participating in a~~ family home visiting program~~,~~ or ~~nurse family practice, or Healthy Families America (HFA)~~ Follow Along Program;

~~(3) be children and families qualifying for and participating in early language learners (ELL) in the school district in which they reside; and~~

~~(4) opt in and provide parental consent to participate in the pilot project.~~

(3) school's early childhood screening; or

(4) any other Dakota County or school program that is determined as useful for identifying children at risk of falling below established guidelines.

Sec. 27. Laws 2019, First Special Session chapter 9, article 14, section 2, subdivision 33, is amended to read:

Subd. 33. **Grant Programs; Chemical Dependency Treatment Support Grants**

	Appropriations by Fund	
General	2,636,000	2,636,000
Lottery Prize	1,733,000	1,733,000

(a) **Problem Gambling.** $225,000 in fiscal year 2020 and $225,000 in fiscal year 2021 are from the lottery prize fund for a grant to the state affiliate recognized by the National Council on Problem Gambling. The affiliate must provide services to increase public awareness of problem gambling, education, and training for individuals and organizations providing effective treatment services to problem gamblers and their families, and research related to problem gambling.

(b) **Fetal Alcohol Spectrum Disorders Grants for Fiscal Year 2020.** (1) $500,000 in fiscal year 2020 ~~and $500,000 in fiscal year 2021 are from~~ is from the general fund for a grant to Proof Alliance. Of this appropriation, Proof Alliance shall make grants to eligible regional collaboratives for the purposes specified in clause (3).

(2) "Eligible regional collaboratives" means a partnership between at least one local government and at least one community-based organization and, where available, a family home visiting program. For purposes of this clause, a local government includes a county or multicounty organization, a tribal government, a county-based purchasing entity, or a community health board.

(3) Eligible regional collaboratives must use grant funds to reduce the incidence of fetal alcohol spectrum disorders and other prenatal drug-related effects in children in Minnesota by identifying and serving pregnant women suspected of or known to use or abuse alcohol or other drugs. Eligible regional collaboratives must provide intensive services to chemically dependent women to increase positive birth outcomes.

(4) Proof Alliance must make grants to eligible regional collaboratives from both rural and urban areas of the state.

(5) An eligible regional collaborative that receives a grant under this paragraph must report to Proof Alliance by January 15 of each year on the services and programs funded by the grant. The report must include measurable outcomes for the previous year, including the number of pregnant women served and the number of toxic-free babies born. Proof Alliance must compile the information in these reports and report that information to the commissioner of human services by February 15 of each year.

(c) **Fetal Alcohol Spectrum Disorders Grants for Fiscal Year 2021.** $500,000 in fiscal year 2021 is from the general fund for a grant under Minnesota Statutes, section 254A.21, to a statewide organization that focuses solely on prevention of and intervention with fetal alcohol spectrum disorders.

Sec. 28. **ADULT FOSTER CARE MORATORIUM EXEMPTION.**

A family foster care home located in Elk River, Sherburne County, and initially licensed in 2003 to serve four people that seeks to transition to a corporate foster care home or community residential setting is exempt form the moratorium under Minnesota Statutes, section 245A.03, subdivision 7, until July 1, 2021.

EFFECTIVE DATE. This section is effective July 1, 2020.

Sec. 29. **TREATMENT OF PREVIOUSLY OBTAINED FEDERAL APPROVALS.**

This act must not be construed to require the commissioner to seek federal approval for provisions in Minnesota Statutes, section 256B.4911, for which the commissioner has already received federal approval. Federal approvals the commissioner previously obtained for provisions repealed in section 30 survive and apply to the corresponding subdivisions in Minnesota Statutes, section 256B.4911.

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

Sec. 30. **REPEALER.**

(a) Laws 2005, First Special Session chapter 4, article 7, section 50, is repealed.

(b) Laws 2005, First Special Session chapter 4, article 7, section 51, is repealed.

(c) Laws 2012, chapter 247, article 4, section 47, as amended by Laws 2014, chapter 312, article 27, section 72, Laws 2015, chapter 71, article 7, section 58, Laws 2016, chapter 144, section 1, Laws 2017, First Special Session chapter 6, article 1, section 43, Laws 2017, First Special Session chapter 6, article 1, section 54, is repealed.

(d) Laws 2015, chapter 71, article 7, section 54, as amended by Laws 2017, First Special Session chapter 6, article 1, section 54, is repealed.

(e) Laws 2017, First Special Session chapter 6, article 1, section 44, as amended by Laws 2019, First Special Session chapter 9, article 5, section 80, is repealed.

(f) Laws 2017, First Special Session chapter 6, article 1, section 45, as amended by Laws 2019, First Special Session chapter 9, article 5, section 81, is repealed.

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

ARTICLE 3

EMPLOYMENT FIRST, INDEPENDENT LIVING FIRST, AND SELF-DIRECTION FIRST

Section 1. **[256B.4905] HOME AND COMMUNITY-BASED SERVICES POLICY STATEMENT.**

Subdivision 1. **Employment first policy.** It is the policy of this state that all working-age Minnesotans with disabilities can work, want to work, and can achieve competitive integrated employment, and that each working-age Minnesotan with a disability be offered the opportunity to work and earn a competitive wage before being offered other supports and services.

Subd. 2. **Employment first implementation for disability waiver services.** The commissioner of human services shall ensure that:

(1) the disability waivers under sections 256B.092 and 256B.49 support the presumption that all working-age Minnesotans with disabilities can work, want to work, and can achieve competitive integrated employment; and

(2) each waiver recipient of working age be offered, after an informed decision-making process and during a person-centered planning process, the opportunity to work and earn a competitive wage before being offered exclusively day services as defined in section 245D.03, subdivision 1, paragraph (c), clause (4), or successor provisions.

Subd. 3. **Independent living first policy.** It is the policy of this state that all adult Minnesotans with disabilities can and want to live independently with proper supports and services; and that each adult Minnesotan with a disability be offered the opportunity to live as independently as possible before being offered supports and services in provider-controlled settings.

Subd. 4. **Independent living first implementation for disability waiver services.** The commissioner of human services shall ensure that:

(1) the disability waivers under sections 256B.092 and 256B.49 support the presumption that all adult Minnesotans with disabilities can and want to live independently with proper services and supports as needed; and

(2) each adult waiver recipient be offered, after an informed decision-making process and during a person-centered planning process, the opportunity to live as independently as possible before being offered customized living services provided in a single family home or residential supports and services as defined in section 245D.03, subdivision 1, paragraph

(c), clause (3), or successor provisions, unless the residential supports and services are provided in a family adult foster care residence under a shared living option as described in Laws 2013, chapter 108, article 7, section 62.

Subd. 5. **Self-direction first policy.** It is the policy of this state that adult Minnesotans with disabilities and families of children with disabilities can and want to use self-directed services and supports; and that each adult Minnesotan with a disability and each family of the child with a disability be offered the opportunity to choose self-directed services and supports before being offered services and supports that are not self-directed.

Subd. 6. **Self-directed first implementation for disability waiver services.** The commissioner of human services shall ensure that:

(1) the disability waivers under sections 256B.092 and 256B.49 support the presumption that adult Minnesotans with disabilities and families of children with disabilities can and want to use self-directed services and supports, including self-directed funding options; and

(2) each waiver recipient be offered, after an informed decision-making process and during a person-centered planning process, the opportunity to choose self-directed services and supports, including self-directed funding options, before being offered services and supports that are not self-directed.

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

Sec. 2. Laws 2019, First Special Session chapter 9, article 5, section 86, is amended to read:

Sec. 86. **DISABILITY WAIVER RECONFIGURATION.**

Subdivision 1. **Intent.** It is the intent of the legislature to reform the medical assistance waiver programs for people with disabilities to simplify administration of the programs~~,~~. Disability waiver reconfiguration must incentivize inclusive, person-centered, individualized supports~~,~~ and services; enhance each person's self-determination and personal authority over the person's service choice~~,~~; align benefits across waivers~~, encourage~~; ensure equity across programs and populations~~, and~~; promote long-term sustainability of ~~needed~~ waiver services~~. To the maximum extent possible, the Disability waiver reconfiguration must~~; and maintain service stability and continuity of care~~,~~ while prioritizing, promoting ~~the most~~, and creating incentives for independent ~~and~~, integrated, and individualized supports ~~of each person's choosing in both short- and long-term~~ and services chosen by each person through an informed decision-making process and person-centered planning.

Subd. 2. **Report.** By January 15, 2021, the commissioner of human services shall submit a report to the members of the legislative committees with jurisdiction over human services on any necessary waivers, state plan amendments, requests for new funding or realignment of existing funds, any changes to state statute or rule, and any other federal authority necessary to implement this section. The report must include information about the commissioner's work to collect feedback and input from providers, persons accessing home and community-based services waivers and their families, and client advocacy organizations.

Subd. 3. **Proposal.** By January 15, 2021, the commissioner shall develop a proposal to reconfigure the medical assistance waivers provided in sections 256B.092 and 256B.49. The proposal shall include all necessary plans for implementing two home and community-based services waiver programs, as authorized under section 1915(c) of the Social Security Act that serve persons who are determined to require the levels of care provided in a nursing home, a hospital, a neurobehavioral hospital, or an intermediate care facility for persons with developmental disabilities. The proposal must include in each home and community-based waiver program options to self-direct services. Before submitting the final report to the legislature, the commissioner shall publish a draft report with sufficient time for interested persons to offer additional feedback.

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

ARTICLE 4

ASSESSMENT, CASE MANAGEMENT, AND SERVICE PLANNING MODIFICATIONS

Section 1. Minnesota Statutes 2019 Supplement, section 245D.071, subdivision 5, is amended to read:

Subd. 5. **Service plan review and evaluation.** (a) The license holder must give the person or the person's legal representative and case manager an opportunity to participate in the ongoing review and development of the service plan and the methods used to support the person and accomplish outcomes identified in subdivisions 3 and 4. At least once per year, or within 30 days of a written request by the person, the person's legal representative, or the case manager, the license holder, in coordination with the person's support team or expanded support team, must meet with the person, the person's legal representative, and the case manager, and participate in service plan review meetings following stated timelines established in the person's coordinated service and support plan or coordinated service and support plan addendum. The purpose of the service plan review is to determine whether changes are needed to the service plan based on the assessment information, the license

holder's evaluation of progress ~~towards~~ toward accomplishing outcomes, or other information provided by the support team or expanded support team.

(b) At least once per year, the license holder, in coordination with the person's support team or expanded support team, must meet with the person, the person's legal representative, and the case manager to discuss how technology might be used to meet the person's desired outcomes. The coordinated service and support plan addendum must include a summary of this discussion. The summary must include a statement regarding any decision made related to the use of technology and a description of any further research that must be completed before a decision regarding the use of technology can be made. Nothing in this paragraph requires the coordinated service and support plan addendum to include the use of technology for the provision of services.

(c) At least once per year, the license holder, in coordination with the person's support team or expanded support team, must meet with a person receiving residential supports and services, the person's legal representative, and the case manager to discuss options for transitioning out of a community setting controlled by a provider and into a setting not controlled by a provider.

(d) The coordinated service and support plan addendum must include a summary of the discussion required in paragraph (c). The summary must include a statement about any decision made regarding transitioning out of a provider-controlled setting and a description of any further research or education that must be completed before a decision regarding transitioning out of a provider-controlled setting can be made.

(e) At least once per year, the license holder, in coordination with the person's support team or expanded support team, must meet with a person receiving day services, the person's legal representative, and the case manager to discuss options for transitioning to an employment service described in section 245D.03, subdivision 1, paragraph (c), clauses (5) to (7).

(f) The coordinated service and support plan addendum must include a summary of the discussion required in paragraph (e). The summary must include a statement about any decision made concerning transition to an employment service and a description of any further research or education that must be completed before a decision regarding transitioning to an employment service can be made.

(g) The license holder must summarize the person's status and progress toward achieving the identified outcomes and make recommendations and identify the rationale for changing, continuing, or discontinuing implementation of supports and methods identified in

subdivision 4 in a report available at the time of the progress review meeting. The report must be sent at least five working days prior to the progress review meeting if requested by the team in the coordinated service and support plan or coordinated service and support plan addendum.

~~(d)~~ (h) The license holder must send the coordinated service and support plan addendum to the person, the person's legal representative, and the case manager by mail within ten working days of the progress review meeting. Within ten working days of the mailing of the coordinated service and support plan addendum, the license holder must obtain dated signatures from the person or the person's legal representative and the case manager to document approval of any changes to the coordinated service and support plan addendum.

~~(e)~~ (i) If, within ten working days of submitting changes to the coordinated service and support plan and coordinated service and support plan addendum, the person or the person's legal representative or case manager has not signed and returned to the license holder the coordinated service and support plan or coordinated service and support plan addendum or has not proposed written modifications to the license holder's submission, the submission is deemed approved and the coordinated service and support plan addendum becomes effective and remains in effect until the legal representative or case manager submits a written request to revise the coordinated service and support plan addendum.

Sec. 2. Minnesota Statutes 2018, section 256B.0911, subdivision 1, is amended to read:

Subdivision 1. **Purpose and goal.** (a) The purpose of long-term care consultation services is to assist persons with long-term or chronic care needs in making care decisions and selecting support and service options that meet their needs and reflect their preferences. The availability of, and access to, information and other types of assistance, including long-term care consultation assessment and community support planning, is also intended to prevent or delay institutional placements and to provide access to transition assistance after ~~admission~~ placement. Further, the goal of ~~these~~ long-term care consultation services is to contain costs associated with unnecessary institutional admissions. ~~Long-term consultation services must be available to any person regardless of public program eligibility.~~

(b) The commissioner of human services shall seek to maximize use of available federal and state funds ~~and establish the broadest program possible within the funding available~~.

~~(b) These~~ (c) Long-term care consultation services must be coordinated with long-term care options counseling provided under subdivision 4d, section 256.975, subdivisions 7 to 7c, and section 256.01, subdivision 24.

(d) The lead agency providing long-term care consultation services shall encourage the use of volunteers from families, religious organizations, social clubs, and similar civic and service organizations to provide community-based services.

Sec. 3. Minnesota Statutes 2019 Supplement, section 256B.0911, subdivision 1a, is amended to read:

Subd. 1a. **Definitions.** For purposes of this section, the following definitions apply:

(a) Until additional requirements apply under paragraph (b), "long-term care consultation services" means:

(1) intake for and access to assistance in identifying services needed to maintain an individual in the most inclusive environment;

(2) providing recommendations for and referrals to cost-effective community services that are available to the individual;

(3) development of an individual's person-centered community support plan;

(4) providing information regarding eligibility for Minnesota health care programs;

(5) face-to-face long-term care consultation assessments, which may be completed in a hospital, nursing facility, intermediate care facility for persons with developmental disabilities (ICF/DDs), regional treatment centers, or the person's current or planned residence;

(6) determination of home and community-based waiver and other service eligibility as required under chapter 256S and sections 256B.0913, 256B.092, and 256B.49, including level of care determination for individuals who need an institutional level of care as determined under subdivision 4e, based on a long-term care consultation assessment and community support plan development, appropriate referrals to obtain necessary diagnostic information, and including an eligibility determination for consumer-directed community supports;

(7) providing recommendations for institutional placement when there are no cost-effective community services available;

(8) providing access to assistance to transition people back to community settings after institutional admission; ~~and~~

(9) providing information about competitive employment, with or without supports, for school-age youth and working-age adults and referrals to the Disability Linkage Line and Disability Benefits 101 to ensure that an informed choice about competitive employment can be made. For the purposes of this subdivision, "competitive employment" means work

in the competitive labor market that is performed on a full-time or part-time basis in an integrated setting, and for which an individual is compensated at or above the minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities;

(10) providing information about independent living to ensure that a fully informed choice about independent living can be made; and

(11) providing information about self-directed services and supports, including self-directed funding options, to ensure that a fully informed choice about self-directed options can be made.

(b) Upon statewide implementation of lead agency requirements in subdivisions 2b, 2c, and 3a, "long-term care consultation services" also means:

(1) service eligibility determination for the following state plan services ~~identified in~~:

(i) personal care assistance services under section 256B.0625, subdivisions 19a and 19c;

(ii) consumer support grants under section 256.476; or

(iii) community first services and supports under section 256B.85;

(2) notwithstanding provisions in Minnesota Rules, parts 9525.0004 to 9525.0024, gaining access to:

(i) relocation-targeted case management services available under ~~sections~~ section 256B.0621, subdivision 2, clause (4)~~,~~;

(ii) case management services targeted to vulnerable adults or developmental disabilities under section 256B.0924~~,~~; and

(iii) case management services targeted to people with developmental disabilities under Minnesota Rules, part 9525.0016;

(3) determination of eligibility for semi-independent living services under section 252.275; and

(4) obtaining necessary diagnostic information to determine eligibility under clauses (2) and (3).

(c) "Long-term care options counseling" means the services provided by the linkage lines as mandated by sections 256.01, subdivision 24, and 256.975, subdivision 7, and also includes telephone assistance and follow up once a long-term care consultation assessment has been completed.

(d) "Minnesota health care programs" means the medical assistance program under this chapter and the alternative care program under section 256B.0913.

(e) "Lead agencies" means counties administering or tribes and health plans under contract with the commissioner to administer long-term care consultation ~~assessment and support planning~~ services.

(f) "Person-centered planning" is a process that includes the active participation of a person in the planning of the person's services, including in making meaningful and informed choices about the person's own goals, talents, and objectives, as well as making meaningful and informed choices about the services the person receives~~. For the purposes of this section~~, the settings in which the person receives them, and the setting in which the person lives.

(g) "Informed choice" means a voluntary choice of services, settings, and living arrangement by a person from all available service and setting options based on accurate and complete information concerning all available service and setting options and concerning the person's own preferences, abilities, goals, and objectives. In order for a person to make an informed choice, all available options must be developed and presented to the person in a way the person can understand to empower the person to make ~~decisions~~ fully informed choices.

(h) "Available service and setting options" or "available options," with respect to the home and community-based waivers under chapter 256S and sections 256B.092 and 256B.49, means all services and settings defined under the relevant waiver plan.

(i) "Independent living" means living in a setting that is not controlled by a provider.

Sec. 4. Minnesota Statutes 2018, section 256B.0911, is amended by adding a subdivision to read:

Subd. 1b. **Eligibility.** (a) To be eligible for long-term care consultation services, a person must be:

(1) enrolled in medical assistance;

(2) determined financially eligible for the alternative care program;

(3) determined to have a developmental disability or related condition as defined in Minnesota Rules, part 9525.0016, subpart 2, items A to E; or

(4) referred to a lead agency under section 256.975, subdivision 7c, paragraph (a), clause (2), following a nursing facility preadmission screening.

(b) To be eligible for long-term care consultation services, a person enrolled in medical assistance must also have utilized state plan services for at least six months and be either:

(1) age 65 or older;

(2) blind; or

(3) determined to have a disability by the commissioner's state medical review team as identified in section 256B.055, subdivision 7, or by the Social Security Administration.

Sec. 5. Minnesota Statutes 2018, section 256B.0911, is amended by adding a subdivision to read:

Subd. 1c. **Assessments for personal care assistance services.** Notwithstanding subdivision 1b, paragraph (b), a lead agency may assess a recipient's need for personal care assistance services under this section.

Sec. 6. Minnesota Statutes 2018, section 256B.0911, subdivision 3, is amended to read:

Subd. 3. **Long-term care consultation team.** (a) A long-term care consultation team shall be established by the county board of commissioners. Two or more counties may collaborate to establish a joint local consultation team or teams.

(b) Each lead agency shall establish and maintain a team of certified assessors qualified under subdivision 2b, paragraph (b). Each team member is responsible for providing consultation with other team members upon request. The team is responsible for providing long-term care consultation services to all eligible persons located in the county who request the services~~, regardless of eligibility for Minnesota health care programs~~. The team of certified assessors must include, at a minimum:

(1) a social worker; and

(2) a public health nurse or registered nurse.

(c) The commissioner shall allow arrangements and make recommendations that encourage counties and tribes to collaborate to establish joint local long-term care consultation teams to ensure that long-term care consultations are done within the timelines and parameters of the service. This includes integrated service models as required in subdivision 1, paragraph (b).

(d) Tribes and health plans under contract with the commissioner must provide long-term care consultation services as specified in the contract.

(e) The lead agency must provide the commissioner with an administrative contact for communication purposes.

Sec. 7. Minnesota Statutes 2019 Supplement, section 256B.0911, subdivision 3a, is amended to read:

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

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

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

(d) The assessment must be conducted by a certified assessor in a face-to-face conversational interview with the person being assessed. The person's legal representative must provide input during the assessment process and may do so remotely if requested. At the request of the person, other individuals may participate in the assessment to provide information on the needs, strengths, and preferences of the person necessary to develop a community support plan that ensures the person's health and safety. Except for legal representatives or family members invited by the person, persons participating in the assessment may not be a provider of service or have any financial interest in the provision of services. For persons who are to be assessed for elderly waiver customized living or adult day services under chapter 256S, with the permission of the person being assessed or the person's designated or legal representative, the client's current or proposed provider of services may submit a copy of the provider's nursing assessment or written report outlining its recommendations regarding the client's care needs. The person conducting the assessment

must notify the provider of the date by which this information is to be submitted. This information shall be provided to the person conducting the assessment prior to the assessment. For a person who is to be assessed for waiver services under section 256B.092 or 256B.49, with the permission of the person being assessed or the person's designated legal representative, the person's current provider of services may submit a written report outlining recommendations regarding the person's care needs the person completed in consultation with someone who is known to the person and has interaction with the person on a regular basis. The provider must submit the report at least 60 days before the end of the person's current service agreement. The certified assessor must consider the content of the submitted report prior to finalizing the person's assessment or reassessment.

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

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

(g) The written community support plan must include:

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

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

(i) all available options for case management services and providers~~, including~~;

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

(iii) all available options for living arrangements;

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

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

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

(4) referral information; and

(5) informal caregiver supports, if applicable.

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

(h) ~~A person may request assistance in identifying community supports without participating in a complete assessment.~~ Upon a request for assistance identifying community support, ~~the~~ a person who is not eligible for long-term care consultations services must be transferred or referred to long-term care options counseling services available under sections 256.975, subdivision 7, and 256.01, subdivision 24, for telephone assistance and follow up.

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

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

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

(3) between day services and employment services; and

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

(j) The lead agency must give the person receiving assessment ~~or support planning,~~ or the person's legal representative, materials, and forms supplied by the commissioner containing the following information:

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

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

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

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

(5) information about Minnesota health care programs;

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

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

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

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

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

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

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

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

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

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

(p) At the time of reassessment, the certified assessor shall assess each person receiving nonself-directed waiver services to determine if that person would prefer an available service and setting option that would permit self-directed services and supports. The certified assessor shall offer the person through a person-centered planning process the option to receive self-directed services and supports.

Sec. 8. Minnesota Statutes 2018, section 256B.0911, subdivision 3b, is amended to read:

Subd. 3b. **Transition assistance.** (a) Notwithstanding subdivision 1b, lead agency certified assessors shall provide assistance to all persons residing in a nursing facility, hospital, regional treatment center, or intermediate care facility for persons with developmental disabilities who request or are referred for assistance. Transition assistance must include assessment, community support plan development, referrals to long-term care options counseling under section 256.975, subdivision 7, for community support plan implementation and to Minnesota health care programs, including home and community-based waiver services and consumer-directed options through the waivers, and referrals to programs that provide assistance with housing. Transition assistance must also

include information about the Centers for Independent Living, Disability Linkage Line, and about other organizations that can provide assistance with relocation efforts, and information about contacting these organizations to obtain their assistance and support.

(b) The lead agency shall ensure that:

(1) referrals for in-person assessments are taken from long-term care options counselors as provided for in section 256.975, subdivision 7, paragraph (b), clause (11);

(2) persons assessed in institutions receive information about transition assistance that is available;

(3) the assessment is completed for persons within 20 calendar days of the date of request or recommendation for assessment;

(4) there is a plan for transition and follow-up for the individual's return to the community, including notification of other local agencies when a person may require assistance from agencies located in another county; and

(5) ~~relocation targeted~~ relocation-targeted case management as defined in section 256B.0621, subdivision 2, clause (4), is authorized for an eligible medical assistance recipient.

Sec. 9. Minnesota Statutes 2019 Supplement, section 256B.0911, subdivision 3f, is amended to read:

Subd. 3f. **Long-term care reassessments and community support plan updates.** (a) Prior to a face-to-face reassessment, the certified assessor must review the person's most recent assessment. Reassessments must be tailored using the professional judgment of the assessor to the person's known needs, strengths, preferences, and circumstances. Reassessments provide information to support the person's informed choice and opportunities to express choice regarding activities that contribute to quality of life, as well as information and opportunity to identify goals related to desired employment, community activities, and preferred living environment. Reassessments require a review of the most recent assessment, review of the current coordinated service and support plan's effectiveness, monitoring of services, and the development of an updated person-centered community support plan. Reassessments must verify continued service eligibility ~~or~~, offer alternatives as warranted, and provide an opportunity for quality assurance of service delivery. Face-to-face reassessments must be conducted annually or as required by federal and state laws and rules. For reassessments, the certified assessor and the individual responsible for developing the coordinated service and support plan must ensure the continuity of care for the person

receiving services and complete the updated community support plan and the updated coordinated service and support plan no more than 60 days from the reassessment visit.

(b) The commissioner shall develop mechanisms for providers and case managers to share information with the assessor to facilitate a reassessment and support planning process tailored to the person's current needs and preferences.

(c) An individual or an individual's legal representative may indicate, in writing, at the conclusion of an annual reassessment that a complete annual long-term care consultation reassessment is not desired for up to two years. Before granting an individual's request to decline one or two complete annual reassessments, the certified assessor must provide the individual sufficient information to make a fully informed choice to decline complete annual reassessments. An eligible individual may request a reassessment at any time. In lieu of an annual complete long-term care consultation assessment for individuals who decline the assessment, certified assessors shall annually perform only those activities required by federal law to maintain the individual's service eligibility.

Sec. 10. Minnesota Statutes 2018, section 256B.0911, subdivision 4d, is amended to read:

Subd. 4d. **Preadmission screening of individuals under 65 years of age.** (a) It is the policy of the state of Minnesota to ensure that individuals with disabilities or chronic illness are served in the most integrated setting appropriate to their needs and have the necessary information to make informed choices about home and community-based service options.

(b) Individuals under 65 years of age who are admitted to a Medicaid-certified nursing facility must be screened prior to admission according to the requirements outlined in section 256.975, subdivisions 7a to 7c. This shall be provided by the Senior LinkAge Line as required under section 256.975, subdivision 7.

(c) Notwithstanding subdivision 1b, individuals under 65 years of age who are admitted to nursing facilities with only a telephone screening must receive a face-to-face assessment from the long-term care consultation team member of the county in which the facility is located or from the recipient's county case manager within the timeline established by the commissioner, based on review of data.

(d) At the face-to-face assessment, the long-term care consultation team member or county case manager must perform the activities required under subdivision 3b.

(e) For individuals under 21 years of age, a screening interview which recommends nursing facility admission must be face-to-face and approved by the commissioner before the individual is admitted to the nursing facility.

(f) In the event that an individual under 65 years of age is admitted to a nursing facility on an emergency basis, the Senior LinkAge Line must be notified of the admission on the next working day, and a face-to-face assessment as described in paragraph (c) must be conducted within the timeline established by the commissioner, based on review of data.

(g) At the face-to-face assessment, the long-term care consultation team member or the case manager must present information about home and community-based options, including consumer-directed options, so the individual can make informed choices. If the individual chooses home and community-based services, the long-term care consultation team member or case manager must complete a written relocation plan within 20 working days of the visit. The plan shall describe the services needed to move out of the facility and a time line for the move which is designed to ensure a smooth transition to the individual's home and community.

(h) Notwithstanding subdivision 1b, an individual under 65 years of age residing in a nursing facility shall receive a face-to-face assessment at least every 12 months to review the person's service choices and available alternatives unless the individual indicates, in writing, that annual visits are not desired. In this case, the individual must receive a face-to-face assessment at least once every 36 months for the same purposes.

(i) Notwithstanding the provisions of subdivision 6, the commissioner may pay county agencies directly for face-to-face assessments for individuals under 65 years of age who are being considered for placement or residing in a nursing facility.

(j) Funding for preadmission screening follow-up shall be provided to the Disability Linkage Line for the under-60 population by the Department of Human Services to cover options counseling salaries and expenses to provide the services described in subdivisions 7a to 7c. The Disability Linkage Line shall employ, or contract with other agencies to employ, within the limits of available funding, sufficient personnel to provide preadmission screening follow-up services and shall seek to maximize federal funding for the service as provided under section 256.01, subdivision 2, paragraph (aa).

Sec. 11. Minnesota Statutes 2018, section 256B.092, subdivision 1a, is amended to read:

Subd. 1a. **Case management services.** (a) Each recipient of a home and community-based waiver shall be provided case management services by qualified vendors as described in the federally approved waiver application.

(b) Case management service activities provided to or arranged for a person include:

(1) development of the person-centered coordinated service and support plan under subdivision 1b;

(2) informing the individual or the individual's legal guardian or conservator, or parent if the person is a minor, of service options, including all service options available under the waiver plan;

(3) consulting with relevant medical experts or service providers;

(4) assisting the person in the identification of potential providers, including:

(i) providers of services provided in a ~~non-disability-specific~~ nondisability-specific setting;

(ii) employment service providers;

(iii) providers of services provided in settings that are not controlled by a provider; and

(iv) providers of financial management services;

(5) assisting the person to access services and assisting in appeals under section 256.045;

(6) coordination of services, if coordination is not provided by another service provider;

(7) evaluation and monitoring of the services identified in the coordinated service and support plan, which must incorporate at least one annual face-to-face visit by the case manager with each person; and

(8) reviewing coordinated service and support plans and providing the lead agency with recommendations for service authorization based upon the individual's needs identified in the coordinated service and support plan.

(c) Case management service activities that are provided to the person with a developmental disability shall be provided directly by county agencies or under contract. Case management services must be provided by a public or private agency that is enrolled as a medical assistance provider determined by the commissioner to meet all of the requirements in the approved federal waiver plans. Case management services must not be provided to a recipient by a private agency that has a financial interest in the provision of any other services included in the recipient's coordinated service and support plan. For purposes of this section, "private agency" means any agency that is not identified as a lead agency under section 256B.0911, subdivision 1a, paragraph (e).

(d) Case managers are responsible for service provisions listed in paragraphs (a) and (b). Case managers shall collaborate with consumers, families, legal representatives, and

relevant medical experts and service providers in the development and annual review of the person-centered coordinated service and support plan and habilitation plan.

(e) For persons who need a positive support transition plan as required in chapter 245D, the case manager shall participate in the development and ongoing evaluation of the plan with the expanded support team. At least quarterly, the case manager, in consultation with the expanded support team, shall evaluate the effectiveness of the plan based on progress evaluation data submitted by the licensed provider to the case manager. The evaluation must identify whether the plan has been developed and implemented in a manner to achieve the following within the required timelines:

(1) phasing out the use of prohibited procedures;

(2) acquisition of skills needed to eliminate the prohibited procedures within the plan's timeline; and

(3) accomplishment of identified outcomes.

If adequate progress is not being made, the case manager shall consult with the person's expanded support team to identify needed modifications and whether additional professional support is required to provide consultation.

(f) The Department of Human Services shall offer ongoing education in case management to case managers. Case managers shall receive no less than ten hours of case management education and disability-related training each year. The education and training must include person-centered planning. For the purposes of this section, "person-centered planning" or "person-centered" has the meaning given in section 256B.0911, subdivision 1a, paragraph (f).

Sec. 12. Minnesota Statutes 2019 Supplement, section 256B.092, subdivision 1b, is amended to read:

Subd. 1b. **Coordinated service and support plan.** (a) Each recipient of home and community-based waivered services shall be provided a copy of the written person-centered coordinated service and support plan that:

(1) is developed with and signed by the recipient within the timelines established by the commissioner and section 256B.0911, subdivision 3a, paragraph (e);

(2) includes the person's need for service, including identification of service needs that will be or that are met by the person's relatives, friends, and others, as well as community services used by the general public;

(3) reasonably ensures the health and welfare of the recipient;

(4) identifies the person's preferences for services as stated by the person, the person's legal guardian or conservator, or the parent if the person is a minor, including the person's choices made on self-directed options ~~and on~~, services and supports to achieve employment goals, and living arrangements;

(5) provides for an informed choice, as defined in section 256B.77, subdivision 2, paragraph (o), of service and support providers, and identifies all available options for case management services and providers;

(6) identifies long-range and short-range goals for the person;

(7) identifies specific services and the amount and frequency of the services to be provided to the person based on assessed needs, preferences, and available resources. The person-centered coordinated service and support plan shall also specify other services the person needs that are not available;

(8) identifies the need for an individual program plan to be developed by the provider according to the respective state and federal licensing and certification standards, and additional assessments to be completed or arranged by the provider after service initiation;

(9) identifies provider responsibilities to implement and make recommendations for modification to the coordinated service and support plan;

(10) includes notice of the right to request a conciliation conference or a hearing under section 256.045;

(11) is agreed upon and signed by the person, the person's legal guardian or conservator, or the parent if the person is a minor, and the authorized county representative;

(12) is reviewed by a health professional if the person has overriding medical needs that impact the delivery of services; and

(13) includes the authorized annual and monthly amounts for the services.

(b) In developing the person-centered coordinated service and support plan, the case manager is encouraged to include the use of volunteers, religious organizations, social clubs, and civic and service organizations to support the individual in the community. The lead agency must be held harmless for damages or injuries sustained through the use of volunteers and agencies under this paragraph, including workers' compensation liability.

(c) Approved, written, and signed changes to a consumer's services that meet the criteria in this subdivision shall be an addendum to that consumer's individual service plan.

Sec. 13. Minnesota Statutes 2019 Supplement, section 256B.49, subdivision 13, is amended to read:

Subd. 13. **Case management.** (a) Each recipient of a home and community-based waiver shall be provided case management services by qualified vendors as described in the federally approved waiver application. The case management service activities provided must include:

(1) finalizing the person-centered written coordinated service and support plan within the timelines established by the commissioner and section 256B.0911, subdivision 3a, paragraph (e);

(2) informing the recipient or the recipient's legal guardian or conservator of service options, including all service options available under the waiver plans;

(3) assisting the recipient in the identification of potential service providers ~~and~~, including:

(i) available options for case management service and providers~~, including~~;

(ii) providers of services provided in a ~~non-disability-specific~~ nondisability-specific setting;

(iii) employment service providers;

(iv) providers of services provided in settings that are not community residential settings; and

(v) providers of financial management services;

(4) assisting the recipient to access services and assisting with appeals under section 256.045; and

(5) coordinating, evaluating, and monitoring of the services identified in the service plan.

(b) The case manager may delegate certain aspects of the case management service activities to another individual provided there is oversight by the case manager. The case manager may not delegate those aspects which require professional judgment including:

(1) finalizing the person-centered coordinated service and support plan;

(2) ongoing assessment and monitoring of the person's needs and adequacy of the approved person-centered coordinated service and support plan; and

(3) adjustments to the person-centered coordinated service and support plan.

(c) Case management services must be provided by a public or private agency that is enrolled as a medical assistance provider determined by the commissioner to meet all of

the requirements in the approved federal waiver plans. Case management services must not be provided to a recipient by a private agency that has any financial interest in the provision of any other services included in the recipient's coordinated service and support plan. For purposes of this section, "private agency" means any agency that is not identified as a lead agency under section 256B.0911, subdivision 1a, paragraph (e).

(d) For persons who need a positive support transition plan as required in chapter 245D, the case manager shall participate in the development and ongoing evaluation of the plan with the expanded support team. At least quarterly, the case manager, in consultation with the expanded support team, shall evaluate the effectiveness of the plan based on progress evaluation data submitted by the licensed provider to the case manager. The evaluation must identify whether the plan has been developed and implemented in a manner to achieve the following within the required timelines:

(1) phasing out the use of prohibited procedures;

(2) acquisition of skills needed to eliminate the prohibited procedures within the plan's timeline; and

(3) accomplishment of identified outcomes.

If adequate progress is not being made, the case manager shall consult with the person's expanded support team to identify needed modifications and whether additional professional support is required to provide consultation.

(e) The Department of Human Services shall offer ongoing education in case management to case managers. Case managers shall receive no less than ten hours of case management education and disability-related training each year. The education and training must include person-centered planning. For the purposes of this section, "person-centered planning" or "person-centered" has the meaning given in section 256B.0911, subdivision 1a, paragraph (f).

Sec. 14. Minnesota Statutes 2019 Supplement, section 256B.49, subdivision 14, is amended to read:

Subd. 14. **Assessment and reassessment.** (a) Assessments and reassessments shall be conducted by certified assessors according to section 256B.0911, subdivision 2b. The certified assessor, with the permission of the recipient or the recipient's designated legal representative, may invite other individuals to attend the assessment. With the permission of the recipient or the recipient's designated legal representative, the recipient's current provider of services may submit a written report outlining their recommendations regarding

the recipient's care needs prepared by a direct service employee who is familiar with the person. The provider must submit the report at least 60 days before the end of the person's current service agreement. The certified assessor must consider the content of the submitted report prior to finalizing the person's assessment or reassessment.

(b) There must be a determination that the client requires a hospital level of care or a nursing facility level of care as defined in section 256B.0911, subdivision 4e, at initial and subsequent assessments to initiate and maintain participation in the waiver program.

(c) Regardless of other assessments identified in section 144.0724, subdivision 4, as appropriate to determine nursing facility level of care for purposes of medical assistance payment for nursing facility services, only face-to-face assessments conducted according to section 256B.0911, subdivisions 3a, 3b, and 4d, that result in a hospital level of care determination or a nursing facility level of care determination must be accepted for purposes of initial and ongoing access to waiver services payment.

(d) Recipients who are found eligible for home and community-based services under this section before their 65th birthday may remain eligible for these services after their 65th birthday if they continue to meet all other eligibility factors.

(e) At the time of reassessment, the certified assessor shall assess each person receiving waiver residential supports and services currently residing in a community residential setting, family adult foster care residence, or supervised living facility to determine if that person would prefer to be served in a community-living setting as defined in subdivision 23 or to receive integrated community supports as described in section 245D.03, subdivision 1, paragraph (c), clause (8). The certified assessor shall offer the person through a person-centered planning process the option to receive alternative housing and service options.

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

(g) At the time of reassessment, the certified assessor shall assess each person receiving nonself-directed waiver services to determine if that person would prefer an available service and setting option that would permit self-directed services and supports. The certified assessor shall offer the person through a person-centered planning process the option to receive self-directed services and supports.

ARTICLE 5
CUSTOMIZED LIVING MODIFICATIONS

Section 1. Minnesota Statutes 2019 Supplement, section 144A.484, subdivision 1, is amended to read:

Subdivision 1. **Integrated licensing established.** (a) A home care provider applicant or license holder may apply annually to the commissioner of health for a home and community-based services designation for the provision of basic support services identified under section 245D.03, subdivision 1, paragraph (b). The designation allows the license holder to provide basic support services, except for the provision under section 256B.49 of customized living services as defined in the brain injury or the community access for disability inclusion waivers that would otherwise require licensure under chapter 245D, under the license holder's home care license governed by sections 144A.43 to 144A.4799.

(b) A home care provider applicant or license holder may apply annually to the commissioner of human services under section 245D.35 for a home and community-based services designation for each location in which the applicant or license holder provides under section 256B.49 customized living services as defined in the brain injury or the community access for disability inclusion waivers. The designation allows the license holder to provide customized living services that would otherwise require licensure under chapter 245D, under the license holder's home care license governed by sections 144A.43 to 144A.4799.

EFFECTIVE DATE. This section is effective June 1, 2020, and applies to home care license applications; home care license renewals; home and community-based services designation applications; and home and community-based services designation applications occurring on or after that date.

Sec. 2. Minnesota Statutes 2018, section 144A.484, subdivision 2, is amended to read:

Subd. 2. **Application for home and community-based services designation.** An application for a home and community-based services designation under subdivision 1, paragraph (a), must be made on the forms and in the manner prescribed by the commissioner. The commissioner shall provide the applicant with instruction for completing the application and provide information about the requirements of other state agencies that affect the applicant. Application for the home and community-based services designation under subdivision 1, paragraph (a), is subject to the requirements under section 144A.473.

EFFECTIVE DATE. This section is effective June 1, 2020, and applies to home care license applications; home care license renewals; home and community-based services designation applications; and home and community-based services designation applications occurring on or after that date.

Sec. 3. Minnesota Statutes 2018, section 144A.484, subdivision 4, is amended to read:

Subd. 4. **Applicability of home and community-based services requirements.** A home care provider with a home and community-based services designation under subdivision 1 must comply with the requirements for home care services governed by this chapter. For the provision of basic support services, including customized living services, the home care provider must also comply with the following home and community-based services licensing requirements:

(1) service planning and delivery requirements in section 245D.07;

(2) protection standards in section 245D.06;

(3) emergency use of manual restraints in section 245D.061; and

(4) protection-related rights in section 245D.04, subdivision 3, paragraph (a), clauses (5), (7), (8), (12), and (13), and paragraph (b).

A home care provider with the integrated license-home and community-based services designation under subdivision 1 may utilize a bill of rights which incorporates the service recipient rights in section 245D.04, subdivision 3, paragraph (a), clauses (5), (7), (8), (12), and (13), and paragraph (b) with the home care bill of rights in section 144A.44.

EFFECTIVE DATE. This section is effective June 1, 2020, and applies to home care license applications; home care license renewals; home and community-based services designation applications; and home and community-based services designation applications occurring on or after that date.

Sec. 4. Minnesota Statutes 2018, section 144A.484, subdivision 5, is amended to read:

Subd. 5. **Monitoring and enforcement.** (a) The commissioner shall monitor for compliance with the home and community-based services requirements identified in subdivision 4, in accordance with this section and any agreements by the commissioners of health and human services.

(b) The commissioner shall enforce compliance with applicable home and community-based services licensing requirements as follows:

(1) the commissioner may deny a home and community-based services designation under subdivision 1, paragraph (a), in accordance with section 144A.473 or 144A.475; and

(2) if the commissioner finds that the applicant or license holder has failed to comply with the applicable home and community-based services designation requirements, the commissioner may issue:

(i) a correction order in accordance with section 144A.474;

(ii) an order of conditional license in accordance with section 144A.475;

(iii) a sanction in accordance with section 144A.475; or

(iv) any combination of clauses (i) to (iii).

EFFECTIVE DATE. This section is effective June 1, 2020, and applies to home care license applications; home care license renewals; home and community-based services designation applications; and home and community-based services designation applications occurring on or after that date.

Sec. 5. Minnesota Statutes 2018, section 144A.484, subdivision 6, is amended to read:

Subd. 6. **Appeals.** A home care provider applicant that has been denied a temporary license will also be denied their application for the home and community-based services designation. The applicant may request reconsideration in accordance with section 144A.473, subdivision 3. A licensed home care provider whose application for a home and community-based services designation under subdivision 1, paragraph (a), has been denied or whose designation has been suspended or revoked may appeal the denial, suspension, revocation, or refusal to renew a home and community-based services designation in accordance with section 144A.475. A license holder may request reconsideration of a correction order in accordance with section 144A.474, subdivision 12.

EFFECTIVE DATE. This section is effective June 1, 2020, and applies to home care license applications; home care license renewals; home and community-based services designation applications; and home and community-based services designation applications occurring on or after that date.

Sec. 6. **[245D.35] HOME AND COMMUNITY-BASED SERVICES DESIGNATION.**

Subdivision 1. **Designation for customized living services.** (a) Notwithstanding section 245A.03, subdivision 2, paragraph (a), clause (23), a home care provider applying for licensure under chapter 144A or a home care provider licensed under chapter 144A may

apply annually to the commissioner for a home and community-based services designation for each location in which the applicant or license holder provides under section 256B.49 customized living services as defined in the brain injury or the community access for disability inclusion waivers. The designation allows the license holder to provide customized living services that would otherwise require licensure under this chapter, under the license holder's home care license governed by chapter 144A.

(b) Unless designated by the commissioner under this section, an individual, organization, or government entity must not provide customized living services under section 256B.49 in a setting that is not otherwise licensed by the commissioner.

(c) Licensed home care providers and home care license applicants seeking designation under this section must request this designation for each location in which the provider intends to provide customized living services under section 256B.49. The provider or applicant must request the designation on forms and in the manner prescribed by the commissioner.

Subd. 2. **Designation for customized living services moratorium.** (a) The commissioner shall not issue an initial home and community-based services designation for a location in which customized living services as defined under the brain injury or community access for disability inclusion waiver plans are provided under section 256B.49. The commissioner may renew designations previously issued by the commissioner or the commissioner of health under section 144A.484.

(b) Exceptions to the moratorium include new locations for the provision of customized living services under section 256B.49 the commissioner determines are needed.

(c) When approving an exception under paragraph (b), the commissioner shall consider the availability of beds in registered housing with services establishments, licensed assisted living facilities, and licensed foster care homes in the geographic area in which the home care provider seeks to operate, the results of a person's choices during their annual assessment and service plan review, and the recommendation of the local county board. The determination by the commissioner regarding an exception is final and not subject to appeal.

EFFECTIVE DATE. This section is effective June 1, 2020, and applies to home care license applications; home care license renewals; home and community-based services designation applications; and home and community-based services designation applications occurring on or after that date.

Sec. 7. **DIRECTION TO THE COMMISSIONER; CUSTOMIZED LIVING REPORT.**

By December 1, 2020, the commissioner of human services shall submit a report to the chairs and ranking minority members of the legislative committees with jurisdiction over human services policy and finance. The report must include the commissioner's assessment of the prevalence of customized living services provided under Minnesota Statutes, section 256B.49, supplanting the provision of residential services and supports licensed under Minnesota Statutes, chapter 245D, and provided in settings licensed under Minnesota Statutes, chapter 245A. The commissioner shall include recommendations regarding the continuation of the moratorium on home and community-based services designations under Minnesota Statutes, section 245D.35, and other policy recommendations to ensure that customized living services are being provided in a manner consistent with the policy objectives of the foster care licensing moratorium under Minnesota Statutes, section 245A.03, subdivision 3.

ARTICLE 6
DEPARTMENT OF HUMAN SERVICES POLICY PROPOSALS

Section 1. Minnesota Statutes 2018, section 119B.21, is amended to read:

119B.21 CHILD CARE SERVICES GRANTS.

Subdivision 1. **Distribution of grant funds.** (a) The commissioner shall distribute funds to the child care resource and referral programs designated under ~~section~~ sections 119B.189 and 119B.19, subdivision 1a, for child care services grants to ~~centers under subdivision 5 and family child care programs based upon the following factors~~ improve child care quality, support start-up of new programs, and expand existing programs.

(b) Up to ten percent of funds appropriated for grants under this section may be used by the commissioner for statewide child care development initiatives, training initiatives, collaboration programs, and research and data collection. The commissioner shall develop eligibility guidelines and a process to distribute funds under this paragraph.

(c) At least 90 percent of funds appropriated for grants under this section may be distributed by the commissioner to child care resource and referral programs under ~~section~~ sections 119B.189 and 119B.19, subdivision 1a, ~~for child care center grants and family child care grants~~ based on the following factors:

(1) the number of children under 13 years of age needing child care in the region;

(2) the region served by the program;

(3) the ratio of children under 13 years of age needing child care to the number of licensed spaces in the region;

(4) the number of licensed child care providers and school-age care programs in the region; and

(5) other related factors determined by the commissioner.

(d) Child care resource and referral programs must award child care ~~center grants and family child care~~ services grants based on the recommendation of the child care district proposal review committees under subdivision 3.

(e) The commissioner may distribute funds under this section for a two-year period.

Subd. 1a. **Eligible programs.** A child care resource and referral program designated under section 119B.19, subdivision 1a, may award child care services grants to:

(1) a child care center licensed under Minnesota Rules, chapter 9503, or in the process of becoming licensed;

(2) a family or group family child care home licensed under Minnesota Rules, chapter 9502, or in the process of becoming licensed;

(3) corporations or public agencies that develop or provide child care services;

(4) a school-age care program;

(5) a tribally licensed child care program;

(6) legal nonlicensed or family, friend, and neighbor child care providers; or

(7) other programs as determined by the commissioner.

Subd. 3. **Child care district proposal review committees.** (a) Child care district proposal review committees review applications for ~~family child care grants and~~ child care ~~center~~ services grants under this section and make funding recommendations to the child care resource and referral program designated under ~~section~~ sections 119B.189 and 119B.19, subdivision 1a. Each region within a district must be represented on the review committee. The child care district proposal review committees must complete their reviews and forward their recommendations to the child care resource and referral district programs by the date specified by the commissioner.

(b) A child care resource and referral district program shall establish a process to select members of the child care district proposal review committee. Members must reflect a broad cross-section of the community, and may include the following constituent groups: family

child care providers, child care center providers, school-age care providers, parents who use child care services, health services, social services, public schools, Head Start, employers, representatives of cultural and ethnic communities, and other citizens with demonstrated interest in child care issues. Members of the proposal review committee with a direct financial interest in a pending grant proposal may not provide a recommendation or participate in the ranking of that grant proposal.

(c) The child care resource and referral district program may ~~reimburse committee members for their actual travel, child care, and child care provider substitute expenses for up to two committee meetings per year. The program may also pay~~ offer a stipend to ~~parent representatives~~ proposal review committee members for participating in ~~two meetings per year~~ the grant review process.

Subd. 5. **Child care services grants.** (a) A child care resource and referral program designated under ~~section~~ sections 119B.189 and 119B.19, subdivision 1a, may award child care services grants for:

(1) creating new licensed child care facilities and expanding existing facilities, including, but not limited to, supplies, equipment, facility renovation, and remodeling;

(2) ~~improving licensed child care facility programs~~ facility improvements, including but not limited to improvements to meet licensing requirements;

(3) staff training and development services including, but not limited to, in-service training, curriculum development, accreditation, certification, consulting, resource centers, program and resource materials, supporting effective teacher-child interactions, child-focused teaching, and content-driven classroom instruction;

(4) capacity building through the purchase of appropriate technology to create, enhance, and maintain business management systems;

(5) emergency assistance for child care programs;

(6) new programs or projects for the creation, expansion, or improvement of programs that serve ethnic immigrant and refugee communities; ~~and~~

(7) targeted recruitment initiatives to expand and build the capacity of the child care system and to improve the quality of care provided by legal nonlicensed child care providers~~.~~; and

(8) other uses as approved by the commissioner.

(b) A child care resource and referral organization designated under ~~section~~ sections 119B.189 and 119B.19, subdivision 1a, may award child care services grants ~~of up to $1,000 to family child care providers. These grants may be used~~ for~~:~~ eligible programs in amounts up to a maximum determined by the commissioner for each type of eligible program.

~~(1) facility improvements, including, but not limited to, improvements to meet licensing requirements;~~

~~(2) improvements to expand a child care facility or program;~~

~~(3) toys and equipment;~~

~~(4) technology and software to create, enhance, and maintain business management systems;~~

~~(5) start-up costs;~~

~~(6) staff training and development; and~~

~~(7) other uses approved by the commissioner.~~

~~(c) A child care resource and referral program designated under section 119B.19, subdivision 1a, may award child care services grants to:~~

~~(1) licensed providers;~~

~~(2) providers in the process of being licensed;~~

~~(3) corporations or public agencies that develop or provide child care services;~~

~~(4) school-age care programs;~~

~~(5) legal nonlicensed or family, friend, and neighbor care providers; or~~

~~(6) any combination of clauses (1) to (5).~~

~~(d) A child care center that is a recipient of a child care services grant for facility improvements or staff training and development must provide a 25 percent local match. A local match is not required for grants to family child care providers.~~

~~(e) Beginning July 1, 2009, grants to child care centers under this subdivision shall be increasingly awarded for activities that improve provider quality, including activities under paragraph (a), clauses (1) to (3) and (6). Grants to family child care providers shall be increasingly awarded for activities that improve provider quality, including activities under paragraph (b), clauses (1), (3), and (6).~~

Sec. 2. Minnesota Statutes 2018, section 119B.26, is amended to read:

119B.26 AUTHORITY TO WAIVE REQUIREMENTS DURING DISASTER PERIODS.

The commissioner may waive requirements under this chapter for up to nine months after the disaster in areas where a federal disaster has been declared under United States Code, title 42, section 5121, et seq., or the governor has exercised authority under chapter 12. The commissioner may waive requirements retroactively from the date of the disaster. The commissioner shall notify the chairs of the house of representatives and senate committees with jurisdiction over this chapter and the house of representatives Ways and Means Committee ~~ten days before the effective date of any waiver granted~~ within five business days after the commissioner grants a waiver under this section.

EFFECTIVE DATE. This section is effective July 1, 2020.

Sec. 3. Minnesota Statutes 2019 Supplement, section 245.4889, subdivision 1, is amended to read:

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

(1) counties;

(2) Indian tribes;

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

(4) mental health service providers.

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

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

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

(3) respite care services for children with emotional disturbances or severe emotional disturbances who are at risk of out-of-home placement. A child is not required to have case management services to receive respite care services;

(4) children's mental health crisis services;

(5) mental health services for people from cultural and ethnic minorities;

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

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

(8) school-linked mental health services under section 245.4901;

(9) building evidence-based mental health intervention capacity for children birth to age five;

(10) suicide prevention and counseling services that use text messaging statewide;

(11) mental health first aid training;

(12) training for parents, collaborative partners, and mental health providers on the impact of adverse childhood experiences and trauma and development of an interactive website to share information and strategies to promote resilience and prevent trauma;

(13) transition age services to develop or expand mental health treatment and supports for adolescents and young adults 26 years of age or younger;

(14) early childhood mental health consultation;

(15) evidence-based interventions for youth at risk of developing or experiencing a first episode of psychosis, and a public awareness campaign on the signs and symptoms of psychosis;

(16) psychiatric consultation for primary care practitioners; and

(17) providers to begin operations and meet program requirements when establishing a new children's mental health program. These may be start-up grants.

(c) Services under paragraph (b) must be designed to help each child to function and remain with the child's family in the community and delivered consistent with the child's treatment plan. Transition services to eligible young adults under this paragraph must be designed to foster independent living in the community.

(d) As a condition of receiving grant funds, a grantee shall obtain all available third-party reimbursement sources, if applicable.

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

Sec. 4. Minnesota Statutes 2018, section 245A.02, subdivision 2c, is amended to read:

Subd. 2c. **Annual or annually; family child care training requirements.** For the purposes of ~~section~~ sections 245A.50~~, subdivisions 1 to 9~~ and 245A.53, "annual" or

"annually" means the 12-month period beginning on the license effective date or the annual anniversary of the effective date and ending on the day prior to the annual anniversary of the license effective date.

EFFECTIVE DATE. This section is effective September 30, 2020.

Sec. 5. Minnesota Statutes 2019 Supplement, section 245A.03, subdivision 7, is amended to read:

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

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

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

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

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

(5) ~~new foster care licenses or community residential setting licenses determined to be needed by the commissioner for the transition of people from personal care assistance to the home and community-based services;~~

~~(6) new foster care licenses or community residential setting licenses determined to be needed by the commissioner for the transition of people from the residential care waiver services to foster care services. This exception applies only when:~~

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

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

~~(7)~~ new foster care licenses or community residential setting licenses for people receiving services under chapter 245D and residing in an unlicensed setting before May 1, 2017, and for which a license is required. This exception does not apply to people living in their own home. For purposes of this clause, there is a presumption that a foster care or community residential setting license is required for services provided to three or more people in a dwelling unit when the setting is controlled by the provider. A license holder subject to this exception may rebut the presumption that a license is required by seeking a reconsideration of the commissioner's determination. The commissioner's disposition of a request for reconsideration is final and not subject to appeal under chapter 14. The exception is available until June 30, 2018. This exception is available when:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Sec. 6. Minnesota Statutes 2018, section 245A.041, is amended by adding a subdivision to read:

Subd. 5. **First date of direct contact.** Except for family child care and family foster care for children or adults provided in the license holder's residence, license holders must document the first date a background study subject has direct contact with persons served by the program, as defined in section 245C.02, subdivision 11. Unless otherwise required by this chapter, if this date is not documented in the program's personnel files, the license holder must be able to provide documentation that contains the date for each background study subject to the commissioner upon request.

EFFECTIVE DATE. This section is effective August 1, 2020.

Sec. 7. Minnesota Statutes 2018, section 245A.11, is amended by adding a subdivision to read:

Subd. 13. **License holder qualifications for child foster care.** (a) Child foster care license holders and household members must maintain the ability to care for a foster child. Child foster care license holders and adult household members must continue to be free from substance abuse. License holders must immediately notify the licensing agency of:

(1) any changes to the license holder or household member's health that may affect their ability to care for a foster child or pose a risk to a foster child's health;

(2) a license holder or adult household member's substance abuse; and

(3) the removal of a child for whom the license holder is responsible from the license holder's home.

(b) The licensing agency may request a license holder or adult household member to undergo an evaluation by a specialist in such areas as health, mental health, or substance use disorders to evaluate the license holder's ability to provide a safe environment for a foster child.

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

Sec. 8. Minnesota Statutes 2019 Supplement, section 245A.149, is amended to read:

245A.149 SUPERVISION OF FAMILY CHILD CARE LICENSE HOLDER'S OWN CHILD.

(a) Notwithstanding Minnesota Rules, part 9502.0365, subpart 5, and with the license holder's consent, an individual may be present in the licensed space, may supervise the

family child care license holder's own child both inside and outside of the licensed space, and is exempt from the training and supervision requirements of this chapter and Minnesota Rules, chapter 9502, if the individual:

(1) is related to the license holder or to the license holder's child, as defined in section 245A.02, subdivision 13, or is a household member who the license holder has reported to the county agency;

(2) ~~is not a designated caregiver, helper, or substitute for the licensed program;~~

~~(3)~~ is involved only in the care of the license holder's own child; and

~~(4)~~ (3) does not have direct, unsupervised contact with any nonrelative children receiving services.

(b) If the individual in paragraph (a) is not a household member, the individual is also exempt from background study requirements under chapter 245C.

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

Sec. 9. Minnesota Statutes 2019 Supplement, section 245A.18, subdivision 2, is amended to read:

Subd. 2. **Child passenger restraint systems; training requirement.** (a) Programs licensed by the Department of Human Services under Minnesota Rules, chapter 2960, that serve a child or children under eight years of age must document training that fulfills the requirements in this subdivision.

(b) Before a license holder, staff person, or caregiver transports a child or children under age eight in a motor vehicle, the person transporting the child must satisfactorily complete training on the proper use and installation of child restraint systems in motor vehicles. Training completed under this section may be used to meet initial or ongoing training under Minnesota Rules, part 2960.3070, subparts 1 and 2.

(c) Training required under this section must be completed at orientation or initial training and repeated at least once every five years. At a minimum, the training must address the proper use of child restraint systems based on the child's size, weight, and age, and the proper installation of a car seat or booster seat in the motor vehicle used by the license holder to transport the child or children.

(d) Training under paragraph (c) must be provided by individuals who are certified and approved by the Department of Public Safety, Office of Traffic Safety. License holders may

obtain a list of certified and approved trainers through the Department of Public Safety website or by contacting the agency.

~~(e) Notwithstanding paragraph (a), for an emergency relative placement under section 245A.035, the commissioner may grant a variance to the training required by this subdivision for a relative who completes a child seat safety check up. The child seat safety check up trainer must be approved by the Department of Public Safety, Office of Traffic Safety, and must provide one-on-one instruction on placing a child of a specific age in the exact child passenger restraint in the motor vehicle in which the child will be transported. Once granted a variance, and if all other licensing requirements are met, the relative applicant may receive a license and may transport a relative foster child younger than eight years of age. A child seat safety check up must be completed each time a child requires a different size car seat according to car seat and vehicle manufacturer guidelines. A relative license holder must complete training that meets the other requirements of this subdivision prior to placement of another foster child younger than eight years of age in the home or prior to the renewal of the child foster care license.~~

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

Sec. 10. Minnesota Statutes 2019 Supplement, section 245A.40, subdivision 7, is amended to read:

Subd. 7. **In-service.** (a) A license holder must ensure that the center director, staff persons, substitutes, and unsupervised volunteers complete in-service training each calendar year.

(b) The center director and staff persons who work more than 20 hours per week must complete 24 hours of in-service training each calendar year. Staff persons who work 20 hours or less per week must complete 12 hours of in-service training each calendar year. Substitutes and unsupervised volunteers must complete the requirements of paragraphs ~~(c) to (h)~~ (d) to (g) and do not otherwise have a minimum number of hours of training to complete.

(c) The number of in-service training hours may be prorated for individuals not employed for an entire year.

(d) Each year, in-service training must include:

(1) the center's procedures for maintaining health and safety according to section 245A.41 and Minnesota Rules, part 9503.0140, and handling emergencies and accidents according to Minnesota Rules, part 9503.0110;

(2) the reporting responsibilities under section 626.556 and Minnesota Rules, part 9503.0130;

(3) at least one-half hour of training on the standards under section 245A.1435 and on reducing the risk of sudden unexpected infant death as required under subdivision 5, if applicable; and

(4) at least one-half hour of training on the risk of abusive head trauma from shaking infants and young children as required under subdivision 5a, if applicable.

(e) Each year, or when a change is made, whichever is more frequent, in-service training must be provided on: (1) the center's risk reduction plan under section 245A.66, subdivision 2; and (2) a child's individual child care program plan as required under Minnesota Rules, part 9503.0065, subpart 3.

(f) At least once every two calendar years, the in-service training must include:

(1) child development and learning training under subdivision 2;

(2) pediatric first aid that meets the requirements of subdivision 3;

(3) pediatric cardiopulmonary resuscitation training that meets the requirements of subdivision 4;

(4) cultural dynamics training to increase awareness of cultural differences; and

(5) disabilities training to increase awareness of differing abilities of children.

(g) At least once every five years, in-service training must include child passenger restraint training that meets the requirements of subdivision 6, if applicable.

(h) The remaining hours of the in-service training requirement must be met by completing training in the following content areas of the Minnesota Knowledge and Competency Framework:

(1) Content area I: child development and learning;

(2) Content area II: developmentally appropriate learning experiences;

(3) Content area III: relationships with families;

(4) Content area IV: assessment, evaluation, and individualization;

(5) Content area V: historical and contemporary development of early childhood education;

(6) Content area VI: professionalism;

(7) Content area VII: health, safety, and nutrition; and

(8) Content area VIII: application through clinical experiences.

(i) For purposes of this subdivision, the following terms have the meanings given them.

(1) "Child development and learning training" means training in understanding how children develop physically, cognitively, emotionally, and socially and learn as part of the children's family, culture, and community.

(2) "Developmentally appropriate learning experiences" means creating positive learning experiences, promoting cognitive development, promoting social and emotional development, promoting physical development, and promoting creative development.

(3) "Relationships with families" means training on building a positive, respectful relationship with the child's family.

(4) "Assessment, evaluation, and individualization" means training in observing, recording, and assessing development; assessing and using information to plan; and assessing and using information to enhance and maintain program quality.

(5) "Historical and contemporary development of early childhood education" means training in past and current practices in early childhood education and how current events and issues affect children, families, and programs.

(6) "Professionalism" means training in knowledge, skills, and abilities that promote ongoing professional development.

(7) "Health, safety, and nutrition" means training in establishing health practices, ensuring safety, and providing healthy nutrition.

(8) "Application through clinical experiences" means clinical experiences in which a person applies effective teaching practices using a range of educational programming models.

(j) The license holder must ensure that documentation, as required in subdivision 10, includes the number of total training hours required to be completed, name of the training, the Minnesota Knowledge and Competency Framework content area, number of hours completed, and the director's approval of the training.

(k) In-service training completed by a staff person that is not specific to that child care center is transferable upon a staff person's change in employment to another child care program.

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

Sec. 11. **[245A.70] FAMILY CHILD FOSTER CARE TRAINING REQUIREMENTS.**

Subdivision 1. **Applicability.** This section applies to programs licensed to provide foster care for children in the license holder's residence. For the purposes of this section, "foster parent" means the license holder or license holders.

Subd. 2. **Orientation.** (a) Each foster parent applicant must complete a minimum of six hours of orientation before being licensed. Orientation training hours do not count toward annual training hours. The commissioner may grant a variance regarding the number of orientation hours required under this subdivision.

(b) The foster parent's orientation must include training about the following:

(1) emergency procedures, including evacuation routes, emergency telephone numbers, severe storm and tornado procedures, and location of alarms and equipment;

(2) relevant laws and rules, including but not limited to this chapter; chapters 260 and 260C; section 626.556; Minnesota Rules, chapter 9560; and related legal issues and reporting requirements;

(3) cultural diversity, gender sensitivity, culturally specific services, cultural competence, and information about discrimination and racial bias to ensure that caregivers are culturally competent to care for foster children according to section 260C.212, subdivision 11;

(4) the foster parent's roles and responsibilities in developing and implementing the case plan and in court and administrative reviews of the child's placement;

(5) the licensing agency's requirements;

(6) one hour relating to reasonable and prudent parenting standards for the child's participation in age-appropriate or developmentally appropriate extracurricular, social, or cultural activities according to section 260C.212, subdivision 14;

(7) two hours relating to children's mental health issues according to subdivision 3;

(8) if required by subdivision 4, the proper use and installation of child passenger restraint systems in motor vehicles, if applicable;

(9) if required by subdivision 5, at least one hour about reducing the risk of sudden unexpected infant death and abusive head trauma from shaking infants and young children, if applicable; and

(10) if required by subdivision 6, operating medical equipment, if applicable.

Subd. 3. **Mental health training.** Prior to licensure, each foster parent, staff person, and caregiver must complete two hours of training that addresses the causes, symptoms, and key warning signs of mental health disorders; cultural considerations; and effective approaches to managing a child's behaviors. Prior to caring for a foster child, each caregiver must complete two hours of training that addresses the causes, symptoms, and key warning signs of mental health disorders; cultural considerations; and effective approaches to managing a child's behaviors. Each year, each foster parent, staff person, and caregiver must complete at least one hour of training about children's mental health issues and treatment. A short-term substitute caregiver is exempt from this subdivision. The commissioner of human services shall approve a mental health training curriculum that satisfies the requirements of this subdivision.

Subd. 4. **Child passenger restraint systems.** (a) An applicant must complete the training required by this subdivision prior to licensure if an applicant intends to accept placement of a child younger than eight years of age. Each foster parent, staff person, and caregiver must satisfactorily complete training about the proper use and installation of child passenger restraint systems in motor vehicles before transporting a child younger than eight years of age in a motor vehicle.

(b) Training must be provided by an individual who is certified and approved by the Department of Public Safety, Office of Traffic Safety. At a minimum, the training must address the proper use of child passenger restraint systems based on the child's size, weight, and age, and the proper installation of a car seat or booster seat in the motor vehicle transporting the child. The training required under this subdivision must be repeated at least once every five years.

(c) Notwithstanding paragraph (a), for an emergency relative placement under section 245A.035, the commissioner may grant a variance to the training required by this subdivision for a relative who completes a child seat safety checkup. The child seat safety checkup trainer must be approved by the Department of Public Safety, Office of Traffic Safety, and must provide one-on-one instruction on placing a child of a specific age in the exact child passenger restraint in the motor vehicle in which the child will be transported. Once granted a variance, and if all other licensing requirements are met, the relative applicant may receive a license and may transport a relative foster child younger than eight years of age. A child seat safety checkup must be completed each time a child requires a different size car seat according to car seat and vehicle manufacturer guidelines. A relative license holder must complete training that meets the requirements of this subdivision prior to placement of

another foster child younger than eight years of age in the home or prior to the renewal of the child foster care license.

Subd. 5. **Training about the risk of sudden unexpected infant death and abusive head trauma.** Each foster parent, staff person, and caregiver who cares for an infant or a child five years of age and younger must satisfactorily complete at least one hour of training about reducing the risk of sudden unexpected infant death and abusive head trauma from shaking infants and young children. The county or private licensing agency monitoring the foster care provider under section 245A.16 must approve of the training about reducing the risk of sudden unexpected infant death and abusive head trauma from shaking infants and young children. At a minimum, the training must address the risk factors related to sudden unexpected infant death and abusive head trauma, means of reducing the risk of sudden unexpected infant death and abusive head trauma, and license holder communication with parents regarding reducing the risk of sudden unexpected infant death and abusive head trauma. Each foster parent must complete this training prior to licensure. Each staff person and caregiver must complete this training prior to caring for an infant or a child five years of age and younger. The training required by this subdivision must be completed at least once every five years.

Subd. 6. **Training on use of medical equipment.** (a) If caring for a child who relies on medical equipment to sustain life or monitor a medical condition, each foster parent, staff person, and caregiver must satisfactorily complete training to operate the child's equipment with a health care professional or an individual who provides training on the equipment.

(b) A foster parent, staff person, or caregiver is exempt from this subdivision if:

(1) the foster parent, staff person, or caregiver is currently caring for an individual who is using the same equipment in the foster home; or

(2) the foster parent, staff person, or caregiver has written documentation that the foster parent, staff person, or caregiver has cared for an individual who relied on the same equipment within the past six months.

Subd. 7. **Fetal alcohol spectrum disorders training.** Each foster parent, staff person, and caregiver must complete at least one hour of the annual training requirement about fetal alcohol spectrum disorders. A provider who is also licensed to provide home and community-based services under chapter 245D and the provider's staff are exempt from this subdivision. A short-term substitute caregiver is exempt from this subdivision. The commissioner of human services shall approve a fetal alcohol spectrum disorders training curriculum that satisfies the requirements of this subdivision.

Subd. 8. **Ongoing training requirement.** (a) Each foster parent, staff person, and caregiver must complete a minimum of 12 hours of training per calendar year. If a foster parent fails to complete the required annual training and does not show good cause why the foster parent did not complete the training, the foster parent is prohibited from accepting a new foster child placement until the foster parent completes the training. The commissioner may grant a variance to the required number of annual training hours.

(b) Each year, each foster parent, staff person, and caregiver must complete one hour of training about children's mental health issues according to subdivision 3, and one hour of training about fetal alcohol spectrum disorders, if required by subdivision 7.

(c) At least once every five years, each foster parent, staff person, and caregiver must complete one hour of training about reducing the risk of sudden unexpected infant death and abusive head trauma, if required by subdivision 5.

(d) At least once every five years, each foster parent, staff person, and caregiver must complete training regarding child passenger restraint systems, if required by subdivision 4.

(e) The commissioner may provide a nonexclusive list of training topics eligible to fulfill the remaining hours of required ongoing annual training.

Subd. 9. **Documentation of training.** (a) The licensing agency must document the trainings required by this section on a form that the commissioner has developed.

(b) For training required under subdivision 6, the agency must also retain a training and skills form on file and update the form each year for each foster care provider who completes training about caring for a child who relies on medical equipment to sustain life or monitor a medical condition. The agency placing the child must obtain a copy of the training and skills form from the foster parent or from the agency supervising the foster parent. The agency must retain the form and any updated information on file for the placement's duration. The form must be available to the parent or guardian and the child's social worker for the social worker to make an informed placement decision. The agency must use the training and skills form that the commissioner has developed.

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

Sec. 12. **[245A.75] FOSTER RESIDENCE SETTING STAFF TRAINING REQUIREMENTS.**

Subdivision 1. **Applicability.** For the purposes of this section, "foster residence setting" means foster care that a license holder provides in a home in which the license holder does

not reside. "Foster residence setting" does not include any program licensed or certified under Minnesota Rules, parts 2960.0010 to 2960.0710.

Subd. 2. **Orientation.** The license holder must ensure that all staff attend and successfully complete at least six hours of orientation training before having unsupervised contact with a foster child. Orientation training hours are not counted toward the hours of annual training. Orientation must include training on the following:

(1) emergency procedures, including evacuation routes, emergency telephone numbers, severe storm and tornado procedures, and location of facility alarms and equipment;

(2) relevant laws, rules, and legal issues, including reporting requirements for abuse and neglect specified in sections 626.556 and 626.557 and other reporting requirements based on the children's ages;

(3) cultural diversity, gender sensitivity, culturally specific services, and information about discrimination and racial bias to ensure that caregivers are culturally sensitive and culturally competent to care for foster children according to section 260C.212, subdivision 11;

(4) general and special needs, including disability needs, of children and families served;

(5) operational policies and procedures of the license holder;

(6) data practices requirements and issues;

(7) two hours of training about mental health disorders in accordance with subdivision 3;

(8) if required by subdivision 4, the proper use and installation of child passenger restraint systems in motor vehicles, if applicable;

(9) if required by subdivision 5, at least one hour of training about reducing the risk of sudden unexpected infant death and abusive head trauma from shaking infants and young children, if applicable; and

(10) if required by subdivision 6, caring for a child who relies on medical equipment to sustain life or monitor a medical condition, if applicable.

Subd. 3. **Mental health training.** Prior to caring for a child, staff must complete two hours of training that addresses the causes, symptoms, and key warning signs of mental health disorders; cultural considerations; and effective approaches to address a child's behaviors. Foster residence staff must complete at least one hour of the annual training requirement regarding children's mental health issues and treatment. A short-term substitute

caregiver is exempt from this subdivision. The commissioner of human services shall approve a mental health training curriculum that satisfies the requirements of this subdivision.

Subd. 4. **Child passenger restraint systems.** Prior to transporting a child younger than eight years of age in a motor vehicle, a license holder, staff person, or caregiver must satisfactorily complete training about the proper use and installation of child restraint systems in motor vehicles. Training must be provided by an individual who is certified and approved by the Department of Public Safety, Office of Traffic Safety. At a minimum, the training must address the proper use of child passenger restraint systems based on the child's size, weight, and age and the proper installation of a car seat or booster seat in the motor vehicle transporting the child. The training required under this subdivision must be completed at least once every five years.

Subd. 5. **Training about the risk of sudden unexpected infant death and abusive head trauma.** A license holder, staff person, or caregiver who cares for an infant or a child five years of age and younger must satisfactorily complete at least one hour of training approved by the county or private licensing agency that is responsible for monitoring the child foster care provider under section 245A.16 about reducing the risk of sudden unexpected infant death and abusive head trauma from shaking infants and young children. The county or private licensing agency responsible for monitoring the child foster care provider under section 245A.16 must approve of the training about reducing the risk of sudden unexpected infant death and abusive head trauma from shaking infants and young children. At a minimum, the training must address the risk factors related to sudden unexpected infant death and abusive head trauma, means of reducing the risk of sudden unexpected infant death and abusive head trauma, and license holder communication with parents regarding reducing the risk of sudden unexpected infant death and abusive head trauma. The license holder, staff person, or caregiver must complete this training prior to licensure or, for staff and caregivers, prior to caring for an infant or a child five years of age and younger. The license holder, staff person, or caregiver must complete the training required under this subdivision at least once every five years.

Subd. 6. **Training on use of medical equipment.** (a) If caring for a child who relies on medical equipment to sustain life or monitor a medical condition, the license holder or staff person must complete training to operate the child's equipment. A health care professional or an individual who provides training on the equipment must train the license holder or staff person about how to operate the child's equipment.

(b) A license holder is exempt from this subdivision if:

(1) the license holder is currently caring for an individual who is using the same equipment in the foster home and each staff person has received training to use the equipment; or

(2) the license holder has written documentation that, within the past six months, the license holder has cared for an individual who relied on the same equipment and each current staff person has received training to use the same equipment.

Subd. 7. **Fetal alcohol spectrum disorder training.** (a) Each staff person must complete at least one hour of the annual training requirement about fetal alcohol spectrum disorders. The commissioner of human services shall approve a fetal alcohol spectrum disorder training curriculum that satisfies the requirements of this subdivision.

(b) A provider who is also licensed to provide home and community-based services under chapter 245D and the provider's staff are exempt from this subdivision. A short-term substitute caregiver is exempt from this subdivision.

Subd. 8. **Prudent parenting standards training.** The license holder must have at least one on-site staff person who is trained regarding the standards under section 260C.215, subdivision 4, and authorized to apply the reasonable and prudent parenting standards to decisions involving the approval of a foster child's participation in age-appropriate and developmentally appropriate extracurricular, social, or cultural activities. The trained on-site staff person is not required to be available 24 hours per day.

Subd. 9. **Annual training plan and hours.** (a) The license holder must develop an annual training plan for staff and volunteers. The license holder must modify training for staff and volunteers each year to meet each staff person's current needs and provide sufficient training to accomplish each staff person's duties. To determine the type and amount of training, the license holder must consider the foster care program's target population, the program's services, and outcomes expected from the services, as well as the employee's job description, tasks, and the position's performance indicators.

(b) Full-time staff who have direct contact with a child must complete at least 18 hours of in-service training per calendar year. Nine hours of training must be skill development training.

(c) Part-time direct care staff must complete sufficient training to competently care for children. The amount of training must be at least one hour of training for each 60 hours worked, up to 18 hours of training per part-time employee per year.

(d) Other foster residence staff and volunteers must complete in-service training requirements each year consistent with their duties.

Subd. 10. **Documentation of training.** (a) For each staff person and volunteer, the license holder must document the date, number of training hours, and the entity's name that provided the training.

(b) For training required under subdivision 6, the agency supervising the foster care provider must retain a training and skills form on file and update the form each year for each staff person that completes training about caring for a child who relies on medical equipment to sustain life or monitor a medical condition. The agency placing the child must obtain a copy of the training and skills form from the foster care provider or the agency supervising the foster care provider. The placing agency must retain the form and any updated information on file for the placement's duration. The form must be available to the child's parent or the child's primary caregiver and the child's social worker to make an informed placement decision. The agency must use the training and skills form that the commissioner has developed.

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

Sec. 13. Minnesota Statutes 2018, section 245D.04, subdivision 3, is amended to read:

Subd. 3. **Protection-related rights.** (a) A person's protection-related rights include the right to:

(1) have personal, financial, service, health, and medical information kept private, and be advised of disclosure of this information by the license holder;

(2) access records and recorded information about the person in accordance with applicable state and federal law, regulation, or rule;

(3) be free from maltreatment;

(4) be free from restraint, time out, seclusion, restrictive intervention, or other prohibited procedure identified in section 245D.06, subdivision 5, or successor provisions, except for: (i) emergency use of manual restraint to protect the person from imminent danger to self or others according to the requirements in section 245D.061 or successor provisions; or (ii) the use of safety interventions as part of a positive support transition plan under section 245D.06, subdivision 8, or successor provisions;

(5) receive services in a clean and safe environment when the license holder is the owner, lessor, or tenant of the service site;

(6) be treated with courtesy and respect and receive respectful treatment of the person's property;

(7) reasonable observance of cultural and ethnic practice and religion;

(8) be free from bias and harassment regarding race, gender, age, disability, spirituality, and sexual orientation;

(9) be informed of and use the license holder's grievance policy and procedures, including knowing how to contact persons responsible for addressing problems and to appeal under section 256.045;

(10) know the name, telephone number, and the website, e-mail, and street addresses of protection and advocacy services, including the appropriate state-appointed ombudsman, and a brief description of how to file a complaint with these offices;

(11) assert these rights personally, or have them asserted by the person's family, authorized representative, or legal representative, without retaliation;

(12) give or withhold written informed consent to participate in any research or experimental treatment;

(13) associate with other persons of the person's choice, in the community;

(14) personal privacy, including the right to use the lock on the person's bedroom or unit door;

(15) engage in chosen activities; and

(16) access to the person's personal possessions at any time, including financial resources.

(b) For a person residing in a residential site licensed according to chapter 245A, or where the license holder is the owner, lessor, or tenant of the residential service site, protection-related rights also include the right to:

(1) have daily, private access to and use of a non-coin-operated telephone for local calls and long-distance calls made collect or paid for by the person;

(2) receive and send, without interference, uncensored, unopened mail or electronic correspondence or communication;

(3) have use of and free access to common areas in the residence and the freedom to come and go from the residence at will;

(4) choose the person's visitors and time of visits and have privacy for visits with the person's spouse, next of kin, legal counsel, religious adviser, or others, in accordance with section 363A.09 of the Human Rights Act, including privacy in the person's bedroom;

(5) have access to three nutritionally balanced meals and nutritious snacks between meals each day;

(6) have freedom and support to access food and potable water at any time;

(7) have the freedom to furnish and decorate the person's bedroom or living unit;

(8) a setting that is clean and free from accumulation of dirt, grease, garbage, peeling paint, mold, vermin, and insects;

(9) a setting that is free from hazards that threaten the person's health or safety; and

(10) a setting that meets the definition of a dwelling unit within a residential occupancy as defined in the State Fire Code.

(c) Restriction of a person's rights under paragraph (a), clauses (13) to (16), or paragraph (b) is allowed only if determined necessary to ensure the health, safety, and well-being of the person. Any restriction of those rights must be documented in the person's coordinated service and support plan or coordinated service and support plan addendum. The restriction must be implemented in the least restrictive alternative manner necessary to protect the person and provide support to reduce or eliminate the need for the restriction in the most integrated setting and inclusive manner. The documentation must include the following information:

(1) the justification for the restriction based on an assessment of the person's vulnerability related to exercising the right without restriction;

(2) the objective measures set as conditions for ending the restriction;

(3) a schedule for reviewing the need for the restriction based on the conditions for ending the restriction to occur semiannually from the date of initial approval, at a minimum, or more frequently if requested by the person, the person's legal representative, if any, and case manager; and

(4) signed and dated approval for the restriction from the person, or the person's legal representative, if any. A restriction may be implemented only when the required approval has been obtained. Approval may be withdrawn at any time. If approval is withdrawn, the right must be immediately and fully restored.

Sec. 14. Minnesota Statutes 2018, section 245D.10, subdivision 3a, is amended to read:

Subd. 3a. **Service termination.** (a) The license holder must establish policies and procedures for service termination that promote continuity of care and service coordination with the person and the case manager and with other licensed caregivers, if any, who also provide support to the person. The policy must include the requirements specified in paragraphs (b) to (f).

(b) The license holder must permit each person to remain in the program and must not terminate services unless:

(1) the termination is necessary for the person's welfare and the facility cannot meet the person's needs ~~cannot be met in the facility~~;

(2) the safety of the person or others in the program is endangered and positive support strategies were attempted and have not achieved and effectively maintained safety for the person or others;

(3) the health of the person or others in the program would otherwise be endangered;

(4) the program has not been paid for services;

(5) the program ceases to operate; ~~or~~

(6) the person has been terminated by the lead agency from waiver eligibility~~.~~; or

(7) for state-operated community-based services, the person no longer demonstrates complex behavioral needs that cannot be met by private community-based providers identified in section 252.50, subdivision 5, paragraph (a), clause (1).

(c) Prior to giving notice of service termination, the license holder must document actions taken to minimize or eliminate the need for termination. Action taken by the license holder must include, at a minimum:

(1) consultation with the person's support team or expanded support team to identify and resolve issues leading to issuance of the termination notice; ~~and~~

(2) a request to the case manager for intervention services identified in section 245D.03, subdivision 1, paragraph (c), clause (1), or other professional consultation or intervention services to support the person in the program. This requirement does not apply to notices of service termination issued under paragraph (b), ~~clause (4).~~ clauses (4) and (7); and

(3) consultation with the person's support team or expanded support team to identify that the person no longer demonstrates complex behavioral needs that cannot be met by

private community-based providers identified in section 252.50, subdivision 5, paragraph (a), clause (1).

If, based on the best interests of the person, the circumstances at the time of the notice were such that the license holder was unable to take the action specified in clauses (1) and (2), the license holder must document the specific circumstances and the reason for being unable to do so.

(d) The notice of service termination must meet the following requirements:

(1) the license holder must notify the person or the person's legal representative and the case manager in writing of the intended service termination. If the service termination is from residential supports and services as defined in section 245D.03, subdivision 1, paragraph (c), clause (3), the license holder must also notify the commissioner in writing; and

(2) the notice must include:

(i) the reason for the action;

(ii) except for a service termination under paragraph (b), clause (5), a summary of actions taken to minimize or eliminate the need for service termination or temporary service suspension as required under paragraph (c), and why these measures failed to prevent the termination or suspension;

(iii) the person's right to appeal the termination of services under section 256.045, subdivision 3, paragraph (a); and

(iv) the person's right to seek a temporary order staying the termination of services according to the procedures in section 256.045, subdivision 4a or 6, paragraph (c).

(e) Notice of the proposed termination of service, including those situations that began with a temporary service suspension, must be given at least 60 days prior to termination when a license holder is providing intensive supports and services identified in section 245D.03, subdivision 1, paragraph (c), 90 days prior to termination of services under section 245D.10, subdivision 3a, paragraph (b), clause (7), and 30 days prior to termination for all other services licensed under this chapter. This notice may be given in conjunction with a notice of temporary service suspension under subdivision 3.

(f) During the service termination notice period, the license holder must:

(1) work with the support team or expanded support team to develop reasonable alternatives to protect the person and others and to support continuity of care;

(2) provide information requested by the person or case manager; and

(3) maintain information about the service termination, including the written notice of intended service termination, in the service recipient record.

Sec. 15. Minnesota Statutes 2018, section 245F.02, subdivision 7, is amended to read:

Subd. 7. **Clinically managed program.** "Clinically managed program" means a residential setting with staff comprised of a medical director and a licensed practical nurse. A licensed practical nurse must be on site 24 hours a day, seven days a week. A ~~qualified medical professional~~ licensed practitioner must be available by telephone or in person for consultation 24 hours a day. Patients admitted to this level of service receive medical observation, evaluation, and stabilization services during the detoxification process; access to medications administered by trained, licensed staff to manage withdrawal; and a comprehensive assessment pursuant to section ~~245G.05~~ 245F.06.

Sec. 16. Minnesota Statutes 2018, section 245F.02, subdivision 14, is amended to read:

Subd. 14. **Medically monitored program.** "Medically monitored program" means a residential setting with staff that includes a registered nurse and a medical director. A registered nurse must be on site 24 hours a day. A ~~medical director~~ licensed practitioner must be ~~on site~~ available seven days a week, and patients must have the ability to be seen by a ~~medical director~~ licensed practitioner within 24 hours. Patients admitted to this level of service receive medical observation, evaluation, and stabilization services during the detoxification process; medications administered by trained, licensed staff to manage withdrawal; and a comprehensive assessment pursuant to ~~Minnesota Rules, part 9530.6422~~ section 245F.06.

Sec. 17. Minnesota Statutes 2018, section 245F.06, subdivision 2, is amended to read:

Subd. 2. **Comprehensive assessment and assessment summary.** (a) Prior to a medically stable discharge, but not later than 72 hours following admission, a license holder must provide a comprehensive assessment and assessment summary according to sections 245.4863, paragraph (a), and 245G.05, for each patient who has a positive screening for a substance use disorder. If a patient's medical condition prevents a comprehensive assessment from being completed within 72 hours, the license holder must document why the assessment was not completed. The comprehensive assessment must include documentation of the appropriateness of an involuntary referral through the civil commitment process.

(b) If available to the program, a patient's previous comprehensive assessment may be used in the patient record. If a previously completed comprehensive assessment is used, its

contents must be reviewed to ensure the assessment is accurate and current and complies with the requirements of this chapter. The review must be completed by a staff person qualified according to section 245G.11, subdivision 5. The license holder must document that the review was completed and that the previously completed assessment is accurate and current, or the license holder must complete an updated or new assessment.

Sec. 18. Minnesota Statutes 2018, section 245F.12, subdivision 2, is amended to read:

Subd. 2. **Services provided at clinically managed programs.** In addition to the services listed in subdivision 1, clinically managed programs must:

(1) have a licensed practical nurse on site 24 hours a day and a medical director;

(2) provide an initial health assessment conducted by a nurse upon admission;

(3) provide daily on-site medical evaluation by a nurse;

(4) have a registered nurse available by telephone or in person for consultation 24 hours a day;

(5) have a ~~qualified medical professional~~ licensed practitioner available by telephone or in person for consultation 24 hours a day; and

(6) have appropriately licensed staff available to administer medications according to prescriber-approved orders.

Sec. 19. Minnesota Statutes 2018, section 245F.12, subdivision 3, is amended to read:

Subd. 3. **Services provided at medically monitored programs.** In addition to the services listed in subdivision 1, medically monitored programs must have a registered nurse on site 24 hours a day and a medical director. Medically monitored programs must provide intensive inpatient withdrawal management services which must include:

(1) an initial health assessment conducted by a registered nurse upon admission;

(2) the availability of a medical evaluation and consultation with a registered nurse 24 hours a day;

(3) the availability of a ~~qualified medical professional~~ licensed practitioner by telephone or in person for consultation 24 hours a day;

(4) the ability to be seen within 24 hours or sooner by a ~~qualified medical professional~~ licensed practitioner if the initial health assessment indicates the need to be seen;

(5) the availability of on-site monitoring of patient care seven days a week by a ~~qualified medical professional~~ licensed practitioner; and

(6) appropriately licensed staff available to administer medications according to prescriber-approved orders.

Sec. 20. Minnesota Statutes 2018, section 245G.02, subdivision 2, is amended to read:

Subd. 2. **Exemption from license requirement.** This chapter does not apply to a county or recovery community organization that is providing a service for which the county or recovery community organization is an eligible vendor under section 254B.05. This chapter does not apply to an organization whose primary functions are information, referral, diagnosis, case management, and assessment for the purposes of client placement, education, support group services, or self-help programs. This chapter does not apply to the activities of a licensed professional in private practice. An individual referred to a licensed nonresidential substance use disorder treatment program after a positive screen for alcohol or substance misuse when receiving the initial set of substance use disorder services allowable under section 254A.03, subdivision 3, paragraph (c), is exempt from sections 245G.05; 245G.06, subdivisions 1, 2, and 4; 245G.07, subdivisions 1, paragraph (a), clauses (2) to (4), and 2, clauses (1) to (7); and 245G.17.

Sec. 21. Minnesota Statutes 2018, section 245G.09, subdivision 1, is amended to read:

Subdivision 1. **Client records required.** (a) A license holder must maintain a file of current and accurate client records on the premises where the treatment service is provided or coordinated. For services provided off site, client records must be available at the program and adhere to the same clinical and administrative policies and procedures as services provided on site. The content and format of client records must be uniform and entries in each record must be signed and dated by the staff member making the entry. Client records must be protected against loss, tampering, or unauthorized disclosure according to section 254A.09, chapter 13, and Code of Federal Regulations, title 42, chapter 1, part 2, subpart B, sections 2.1 to 2.67, and title 45, parts 160 to 164.

(b) The program must have a policy and procedure that identifies how the program will track and record client attendance at treatment activities, including the date, duration, and nature of each treatment service provided to the client.

(c) The program must identify in the client record designation of an individual who is receiving services under section 254A.03, subdivision 3, including the start date and end

date of services eligible under section 254A.03, subdivision 3. The requirements of sections 245G.05 and 245G.06 become effective upon the end date identified.

Sec. 22. Minnesota Statutes 2018, section 245H.08, subdivision 4, is amended to read:

Subd. 4. **Maximum group size.** (a) For a child six weeks old through 16 months old, the maximum group size shall be no more than eight children.

(b) For a child 16 months old through 33 months old, the maximum group size shall be no more than 14 children.

(c) For a child 33 months old through prekindergarten, a maximum group size shall be no more than 20 children.

(d) For a child in kindergarten through 13 years old, a maximum group size shall be no more than 30 children.

(e) The maximum group size applies at all times except during group activity coordination time not exceeding 15 minutes, during a meal, outdoor activity, field trip, nap and rest, and special activity including a film, guest speaker, indoor large muscle activity, or holiday program.

(f) Notwithstanding paragraph (d), a certified center may continue to serve a child older than 13 years if one of the following conditions is true:

(1) the child remains eligible for child care assistance under section 119B.09, subdivision 1, paragraph (e); or

(2) the certified center serves children in a middle-school-only program, defined as grades 6 through 8.

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

Sec. 23. Minnesota Statutes 2018, section 245H.08, subdivision 5, is amended to read:

Subd. 5. **Ratios.** (a) The minimally acceptable staff-to-child ratios are:

six weeks old through 16 months old	1:4
16 months old through 33 months old	1:7
33 months old through prekindergarten	1:10
kindergarten through 13 years old	1:15

(b) Kindergarten includes a child of sufficient age to have attended the first day of kindergarten or who is eligible to enter kindergarten within the next four months.

(c) For mixed groups, the ratio for the age group of the youngest child applies.

(d) Notwithstanding paragraph (a), a certified center may continue to serve a child older than 13 years if one of the following conditions is true:

(1) the child remains eligible for child care assistance under section 119B.09, subdivision 1, paragraph (e); or

(2) the certified center serves children in a middle-school-only program, defined as grades 6 through 8.

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

Sec. 24. Minnesota Statutes 2019 Supplement, section 254A.03, subdivision 3, is amended to read:

Subd. 3. **Rules for substance use disorder care.** (a) The commissioner of human services shall establish by rule criteria to be used in determining the appropriate level of chemical dependency care for each recipient of public assistance seeking treatment for substance misuse or substance use disorder. Upon federal approval of a comprehensive assessment as a Medicaid benefit, or on July 1, 2018, whichever is later, and notwithstanding the criteria in Minnesota Rules, parts 9530.6600 to 9530.6655, an eligible vendor of comprehensive assessments under section 254B.05 may determine and approve the appropriate level of substance use disorder treatment for a recipient of public assistance. The process for determining an individual's financial eligibility for the consolidated chemical dependency treatment fund or determining an individual's enrollment in or eligibility for a publicly subsidized health plan is not affected by the individual's choice to access a comprehensive assessment for placement.

(b) The commissioner shall develop and implement a utilization review process for publicly funded treatment placements to monitor and review the clinical appropriateness and timeliness of all publicly funded placements in treatment.

(c) If a screen result is positive for alcohol or substance misuse, a brief screening for alcohol or substance use disorder that is provided to a recipient of public assistance within a primary care clinic, hospital, or other medical setting or school setting establishes medical necessity and approval for an initial set of substance use disorder services identified in section 254B.05, subdivision 5. The initial set of services approved for a recipient whose screen result is positive may include any combination of up to four hours of individual or group substance use disorder treatment, two hours of substance use disorder treatment coordination, or two hours of substance use disorder peer support services provided by a

qualified individual according to chapter 245G. A recipient must obtain an assessment pursuant to paragraph (a) to be approved for additional treatment services. Minnesota Rules, parts 9530.6600 to 9530.6655, and a comprehensive assessment pursuant to section 245G.05 are not applicable to the initial set of services allowed under this subdivision. A positive screen result establishes eligibility for the initial set of services allowed under this subdivision.

Sec. 25. Minnesota Statutes 2019 Supplement, section 254B.05, subdivision 1, is amended to read:

Subdivision 1. **Licensure required.** (a) Programs licensed by the commissioner are eligible vendors. Hospitals may apply for and receive licenses to be eligible vendors, notwithstanding the provisions of section 245A.03. American Indian programs that provide substance use disorder treatment, extended care, transitional residence, or outpatient treatment services, and are licensed by tribal government are eligible vendors.

(b) A licensed professional in private practice as defined in section 245G.01, subdivision 17, who meets the requirements of section 245G.11, subdivisions 1 and 4, is an eligible vendor of a comprehensive assessment and assessment summary provided according to section 245G.05, and treatment services provided according to sections 245G.06 and 245G.07, subdivision 1, paragraphs (a), clauses (1) to (4), and (b); and subdivision 2.

(c) A county is an eligible vendor for a comprehensive assessment and assessment summary when provided by an individual who meets the staffing credentials of section 245G.11, subdivisions 1 and 5, and completed according to the requirements of section 245G.05. A county is an eligible vendor of care coordination services when provided by an individual who meets the staffing credentials of section 245G.11, subdivisions 1 and 7, and provided according to the requirements of section 245G.07, subdivision 1, paragraph (a), clause (5).

(d) A recovery community organization that meets certification requirements identified by the commissioner is an eligible vendor of peer support services.

(e) Detoxification programs licensed under Minnesota Rules, parts 9530.6510 to 9530.6590, are not eligible vendors. Programs that are not licensed as a residential or nonresidential substance use disorder treatment or withdrawal management program by the commissioner or by tribal government or do not meet the requirements of subdivisions 1a and 1b are not eligible vendors.

Sec. 26. Minnesota Statutes 2018, section 256B.0625, subdivision 5l, is amended to read:

Subd. 5l. **Intensive mental health outpatient treatment.** Medical assistance covers intensive mental health outpatient treatment for dialectical behavioral therapy ~~for adults~~. The commissioner shall establish:

(1) certification procedures to ensure that providers of these services are qualified; and

(2) treatment protocols including required service components and criteria for admission, continued treatment, and discharge.

Sec. 27. Minnesota Statutes 2019 Supplement, section 256B.064, subdivision 2, is amended to read:

Subd. 2. **Imposition of monetary recovery and sanctions.** (a) The commissioner shall determine any monetary amounts to be recovered and sanctions to be imposed upon a vendor of medical care under this section. Except as provided in paragraphs (b) and (d), neither a monetary recovery nor a sanction will be imposed by the commissioner without prior notice and an opportunity for a hearing, according to chapter 14, on the commissioner's proposed action, provided that the commissioner may suspend or reduce payment to a vendor of medical care, except a nursing home or convalescent care facility, after notice and prior to the hearing if in the commissioner's opinion that action is necessary to protect the public welfare and the interests of the program.

(b) Except when the commissioner finds good cause not to suspend payments under Code of Federal Regulations, title 42, section 455.23 (e) or (f), the commissioner shall withhold or reduce payments to a vendor of medical care without providing advance notice of such withholding or reduction if either of the following occurs:

(1) the vendor is convicted of a crime involving the conduct described in subdivision 1a; or

(2) the commissioner determines there is a credible allegation of fraud for which an investigation is pending under the program. A credible allegation of fraud is an allegation which has been verified by the state, from any source, including but not limited to:

(i) fraud hotline complaints;

(ii) claims data mining; and

(iii) patterns identified through provider audits, civil false claims cases, and law enforcement investigations.

Allegations are considered to be credible when they have an indicia of reliability and the state agency has reviewed all allegations, facts, and evidence carefully and acts judiciously on a case-by-case basis.

(c) The commissioner must send notice of the withholding or reduction of payments under paragraph (b) within five days of taking such action unless requested in writing by a law enforcement agency to temporarily withhold the notice. The notice must:

(1) state that payments are being withheld according to paragraph (b);

(2) set forth the general allegations as to the nature of the withholding action, but need not disclose any specific information concerning an ongoing investigation;

(3) except in the case of a conviction for conduct described in subdivision 1a, state that the withholding is for a temporary period and cite the circumstances under which withholding will be terminated;

(4) identify the types of claims to which the withholding applies; and

(5) inform the vendor of the right to submit written evidence for consideration by the commissioner.

The withholding or reduction of payments will not continue after the commissioner determines there is insufficient evidence of fraud by the vendor, or after legal proceedings relating to the alleged fraud are completed, unless the commissioner has sent notice of intention to impose monetary recovery or sanctions under paragraph (a). Upon conviction for a crime related to the provision, management, or administration of a health service under medical assistance, a payment held pursuant to this section by the commissioner or a managed care organization that contracts with the commissioner under section 256B.035 is forfeited to the commissioner or managed care organization, regardless of the amount charged in the criminal complaint or the amount of criminal restitution ordered.

(d) The commissioner shall suspend or terminate a vendor's participation in the program without providing advance notice and an opportunity for a hearing when the suspension or termination is required because of the vendor's exclusion from participation in Medicare. Within five days of taking such action, the commissioner must send notice of the suspension or termination. The notice must:

(1) state that suspension or termination is the result of the vendor's exclusion from Medicare;

(2) identify the effective date of the suspension or termination; and

(3) inform the vendor of the need to be reinstated to Medicare before reapplying for participation in the program.

(e) Upon receipt of a notice under paragraph (a) that a monetary recovery or sanction is to be imposed, a vendor may request a contested case, as defined in section 14.02, subdivision 3, by filing with the commissioner a written request of appeal. The appeal request must be received by the commissioner no later than 30 days after the date the notification of monetary recovery or sanction was mailed to the vendor. The appeal request must specify:

(1) each disputed item, the reason for the dispute, and an estimate of the dollar amount involved for each disputed item;

(2) the computation that the vendor believes is correct;

(3) the authority in statute or rule upon which the vendor relies for each disputed item;

(4) the name and address of the person or entity with whom contacts may be made regarding the appeal; and

(5) other information required by the commissioner.

(f) The commissioner may order a vendor to forfeit a fine for failure to fully document services according to standards in this chapter and Minnesota Rules, chapter 9505. The commissioner may assess fines if specific required components of documentation are missing. The fine for incomplete documentation shall equal 20 percent of the amount paid on the claims for reimbursement submitted by the vendor, or up to $5,000, whichever is less. If the commissioner determines that a vendor repeatedly violated this chapter, chapter 254B or 245G, or Minnesota Rules, chapter 9505, related to the provision of services to program recipients and the submission of claims for payment, the commissioner may order a vendor to forfeit a fine based on the nature, severity, and chronicity of the violations, in an amount of up to $5,000 or 20 percent of the value of the claims, whichever is greater.

(g) The vendor shall pay the fine assessed on or before the payment date specified. If the vendor fails to pay the fine, the commissioner may withhold or reduce payments and recover the amount of the fine. A timely appeal shall stay payment of the fine until the commissioner issues a final order.

Sec. 28. Minnesota Statutes 2018, section 256B.0652, subdivision 10, is amended to read:

Subd. 10. **Authorization for foster care setting.** (a) Home care services provided in an adult or child foster care setting must receive authorization by the commissioner according to the limits established in subdivision 11.

(b) The commissioner may not authorize:

(1) home care services that are the responsibility of the foster care provider under the terms of the foster care placement agreement, ~~difficulty of care rate as of January 1, 2010~~ assessment under sections 256N.24 and 260C.4411, and administrative rules;

(2) personal care assistance services when the foster care license holder is also the personal care provider or personal care assistant, unless the foster home is the licensed provider's primary residence as defined in section 256B.0625, subdivision 19a; or

(3) personal care assistant and home care nursing services when the licensed capacity is greater than ~~four~~ six, unless all conditions for a variance under section 245A.04, subdivision 9a, are satisfied for a sibling, as defined in section 260C.007, subdivision 32.

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

Sec. 29. Minnesota Statutes 2018, section 256B.0949, subdivision 2, is amended to read:

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

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

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

(1) is severe and chronic;

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

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

(4) results in substantial functional limitations in three core developmental deficits of ASD: social or interpersonal interaction; functional communication, including nonverbal or social communication; and restrictive~~,~~ or repetitive behaviors or hyperreactivity or

hyporeactivity to sensory input; and may include deficits or a high level of support in one or more of the following domains:

(i) self-regulation;

(ii) self-care;

(iii) behavioral challenges;

(iv) expressive communication;

(v) receptive communication;

(vi) cognitive functioning; or

(vii) safety.

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

(e) "Clinical supervision" means the overall responsibility for the control and direction of EIDBI service delivery, including individual treatment planning, staff supervision, individual treatment plan progress monitoring, and treatment review for each person. Clinical supervision is provided by a qualified supervising professional (QSP) who takes full professional responsibility for the service provided by each supervisee.

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

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

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

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

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

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

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

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

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

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

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

(n) "Mental health professional" has the meaning given in section 245.4871, subdivision 27, clauses (1) to (6).

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

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

Sec. 30. Minnesota Statutes 2018, section 256B.0949, subdivision 5, is amended to read:

Subd. 5. **Comprehensive multidisciplinary evaluation.** (a) A CMDE must be completed to determine medical necessity of EIDBI services. For the commissioner to authorize EIDBI services, the CMDE provider must submit the CMDE to the commissioner and the person or the person's legal representative as determined by the commissioner. Information and assessments must be performed, reviewed, and relied upon for the eligibility determination, treatment and services recommendations, and treatment plan development for the person.

(b) The CMDE must:

(1) include an assessment of the person's developmental skills, functional behavior, needs, and capacities based on direct observation of the person which must be administered by a CMDE provider, include medical or assessment information from the person's physician or advanced practice registered nurse, and may also include input from family members,

school personnel, child care providers, or other caregivers, as well as any medical or assessment information from other licensed professionals such as rehabilitation or habilitation therapists, licensed school personnel, or mental health professionals; and

(2) include and document the person's legal representative's or primary caregiver's preferences for involvement in the person's treatment~~; and~~.

~~(3) provide information about the range of current EIDBI treatment modalities recognized by the commissioner.~~

Sec. 31. Minnesota Statutes 2018, section 256B.0949, subdivision 6, is amended to read:

Subd. 6. **Individual treatment plan.** (a) The QSP, level I treatment provider, or level II treatment provider who integrates and coordinates person and family information from the CMDE and ITP progress monitoring process to develop the ITP must develop and monitor the ITP.

(b) Each person's ITP must be:

(1) culturally and linguistically appropriate, as required under subdivision 3a, individualized, and person-centered; and

(2) based on the diagnosis and CMDE information specified in subdivisions 4 and 5.

(c) The ITP must specify:

(1) the medically necessary treatment and service;

(2) the treatment ~~modality~~ method that ~~shall~~ must be used to meet the goals and objectives, including:

(i) baseline measures and projected dates of accomplishment;

(ii) the frequency, intensity, location, and duration of each service provided;

(iii) the level of legal representative or primary caregiver training and counseling;

(iv) any change or modification to the physical and social environments necessary to provide a service;

(v) significant changes in the person's condition or family circumstance;

~~(vi) any specialized equipment or material required;~~

~~(vii)~~ (vi) techniques that support and are consistent with the person's communication mode and learning style;

~~(viii)~~ (vii) the name of the QSP; and

~~(ix)~~ (viii) progress monitoring results and goal mastery data; and

(3) the discharge criteria that ~~shall~~ must be used and a defined transition plan that meets the requirement of paragraph (g).

(d) Implementation of the ITP must be supervised by a QSP.

(e) The ITP must be submitted to the commissioner and the person or the person's legal representative for approval in a manner determined by the commissioner for this purpose.

(f) A service included in the ITP must meet all applicable requirements for medical necessity and coverage.

(g) To terminate service, the provider must send notice of termination to the person or the person's legal representative. The transition period begins when the person or the person's legal representative receives notice of termination from the EIDBI service and ends when the EIDBI service is terminated. Up to 30 days of continued service is allowed during the transition period. Services during the transition period shall be consistent with the ITP. The transition plan ~~shall~~ must include:

(1) protocols for changing service when medically necessary;

(2) how the transition will occur;

(3) the time allowed to make the transition; and

(4) a description of how the person or the person's legal representative will be informed of and involved in the transition.

Sec. 32. Minnesota Statutes 2018, section 256B.0949, subdivision 9, is amended to read:

Subd. 9. **Revision of treatment options.** ~~(a)~~ The commissioner may revise covered treatment ~~options~~ methods and practices as needed based on outcome data and other evidence. EIDBI treatment modalities approved by the department must:

(1) cause no harm to the person or the person's family;

(2) be individualized and person-centered;

(3) be developmentally appropriate and highly structured, with well-defined goals and objectives that provide a strategic direction for treatment;

(4) be based in recognized principles of developmental and behavioral science;

(5) utilize sound practices that are replicable across providers and maintain the fidelity of the ~~specific modality~~ treatment method;

(6) demonstrate an evidentiary basis;

(7) have goals and objectives that are measurable, achievable, and regularly evaluated and adjusted to ensure that adequate progress is being made;

(8) be provided intensively with a high staff-to-person ratio; and

(9) include participation by the person and the person's legal representative in decision making, knowledge building and capacity building, and developing and implementing the person's ITP.

~~(b) Before revisions in department recognized treatment modalities become effective, the commissioner must provide public notice of the changes, the reasons for the change, and a 30-day public comment period to those who request notice through an electronic list accessible to the public on the department's website.~~

Sec. 33. Minnesota Statutes 2018, section 256B.0949, subdivision 13, is amended to read:

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

(b) EIDBI ~~modalities include, but are not limited to:~~ treatment must be based in developmental and behavioral evidence-based practices or practice-based evidence and meet the requirements outlined in subdivision 9.

~~(1) applied behavior analysis (ABA);~~

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

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

~~(4) PLAY project; or~~

~~(5) relationship development intervention (RDI).~~

~~(c) An EIDBI provider may use one or more of the EIDBI modalities in paragraph (b), clauses (1) to (5), as the primary modality for treatment as a covered service, or several~~

~~EIDBI modalities in combination as the primary modality of treatment, as approved by the commissioner. An EIDBI provider that identifies and provides assurance of qualifications for a single specific treatment modality must document the required qualifications to meet fidelity to the specific model. Additional EIDBI modalities not listed in paragraph (b) may be covered upon approval by the commissioner.~~

(c) A qualified EIDBI provider is a person who identifies and provides assurance of qualifications for professional licensure certification, or training in evidence-based treatment methods, and who must document the required qualifications outlined in subdivision 15 in a manner determined by the commissioner.

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

(e) EIDBI intervention observation and direction is the clinical direction and oversight of EIDBI services by the QSP, level I treatment provider, or level II treatment provider, including developmental and behavioral techniques, progress measurement, data collection, function of behaviors, and generalization of acquired skills for the direct benefit of a person. EIDBI intervention observation and direction ~~informs any~~ requires modification of the ~~methods~~ current treatment protocol to support the outcomes outlined in the ITP. ~~EIDBI intervention observation and direction provides a real-time response to EIDBI interventions to maximize the benefit to the person.~~

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

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

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

~~(f)~~ (g) ITP development and ITP progress monitoring is development of the initial, annual, and progress monitoring of an ITP. ITP development and ITP progress monitoring documents~~, provides~~ provide oversight and ongoing evaluation of a person's treatment and

progress on targeted goals and objectives~~,~~ and ~~integrates~~ integrate and ~~coordinates~~ coordinate the person's and the person's legal representative's information from the CMDE and ITP progress monitoring. This service must be reviewed and completed by the QSP, and may include input from a level I ~~treatment~~ provider or a level II ~~treatment~~ provider.

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

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

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

~~(j)~~ (k) Medical assistance covers medically necessary EIDBI services and consultations delivered by a licensed health care provider via telemedicine, as defined under section 256B.0625, subdivision 3b, in the same manner as if the service or consultation was delivered in person. ~~Medical assistance coverage is limited to three telemedicine services per person per calendar week.~~

Sec. 34. Minnesota Statutes 2018, section 256B.0949, subdivision 14, is amended to read:

Subd. 14. **Person's rights.** A person or the person's legal representative has the right to:

(1) protection as defined under the health care bill of rights under section 144.651;

(2) designate an advocate to be present in all aspects of the person's and person's family's services at the request of the person or the person's legal representative;

(3) be informed of the agency policy on assigning staff to a person;

(4) be informed of the opportunity to observe the person while receiving services;

(5) be informed of services in a manner that respects and takes into consideration the person's and the person's legal representative's culture, values, and preferences in accordance with subdivision 3a;

(6) be free from seclusion and restraint, except for emergency use of manual restraint in emergencies as defined in section 245D.02, subdivision 8a;

(7) be under the supervision of a responsible adult at all times;

(8) be notified by the agency within 24 hours if an incident occurs or the person is injured while receiving services, including what occurred and how agency staff responded to the incident;

(9) request a voluntary coordinated care conference; ~~and~~

(10) request a CMDE provider of the person's or the person's legal representative's choice~~.~~; and

(11) be free of all prohibitions as defined in Minnesota Rules, part 9544.0060.

Sec. 35. Minnesota Statutes 2018, section 256B.0949, subdivision 15, is amended to read:

Subd. 15. **EIDBI provider qualifications.** (a) A QSP must be employed by an agency and be:

(1) a licensed mental health professional who has at least 2,000 hours of supervised clinical experience or training in examining or treating people with ASD or a related condition or equivalent documented coursework at the graduate level by an accredited university in ASD diagnostics, ASD developmental and behavioral treatment strategies, and typical child development; or

(2) a developmental or behavioral pediatrician who has at least 2,000 hours of supervised clinical experience or training in examining or treating people with ASD or a related condition or equivalent documented coursework at the graduate level by an accredited university in the areas of ASD diagnostics, ASD developmental and behavioral treatment strategies, and typical child development.

(b) A level I treatment provider must be employed by an agency and:

(1) have at least 2,000 hours of supervised clinical experience or training in examining or treating people with ASD or a related condition or equivalent documented coursework at the graduate level by an accredited university in ASD diagnostics, ASD developmental and behavioral treatment strategies, and typical child development or an equivalent combination of documented coursework or hours of experience; and

(2) have or be at least one of the following:

(i) a master's degree in behavioral health or child development or related fields including, but not limited to, mental health, special education, social work, psychology, speech pathology, or occupational therapy from an accredited college or university;

(ii) a bachelor's degree in a behavioral health, child development, or related field including, but not limited to, mental health, special education, social work, psychology, speech pathology, or occupational therapy, from an accredited college or university, and advanced certification in a treatment modality recognized by the department;

(iii) a board-certified behavior analyst; or

(iv) a board-certified assistant behavior analyst with 4,000 hours of supervised clinical experience that meets all registration, supervision, and continuing education requirements of the certification.

(c) A level II treatment provider must be employed by an agency and must be:

(1) a person who has a bachelor's degree from an accredited college or university in a behavioral or child development science or related field including, but not limited to, mental health, special education, social work, psychology, speech pathology, or occupational therapy; and ~~meet~~ meets at least one of the following:

(i) has at least 1,000 hours of supervised clinical experience or training in examining or treating people with ASD or a related condition or equivalent documented coursework at the graduate level by an accredited university in ASD diagnostics, ASD developmental and behavioral treatment strategies, and typical child development or a combination of coursework or hours of experience;

(ii) has certification as a board-certified assistant behavior analyst from the Behavior Analyst Certification Board;

(iii) is a registered behavior technician as defined by the Behavior Analyst Certification Board; or

(iv) is certified in one of the other treatment modalities recognized by the department; or

(2) a person who has:

(i) an associate's degree in a behavioral or child development science or related field including, but not limited to, mental health, special education, social work, psychology, speech pathology, or occupational therapy from an accredited college or university; and

(ii) at least 2,000 hours of supervised clinical experience in delivering treatment to people with ASD or a related condition. Hours worked as a mental health behavioral aide or level III treatment provider may be included in the required hours of experience; or

(3) a person who has at least 4,000 hours of supervised clinical experience in delivering treatment to people with ASD or a related condition. Hours worked as a mental health behavioral aide or level III treatment provider may be included in the required hours of experience; or

(4) a person who is a graduate student in a behavioral science, child development science, or related field and is receiving clinical supervision by a QSP affiliated with an agency to meet the clinical training requirements for experience and training with people with ASD or a related condition; or

(5) a person who is at least 18 years of age and who:

(i) is fluent in a non-English language;

(ii) completed the level III EIDBI training requirements; and

(iii) receives observation and direction from a QSP or level I treatment provider at least once a week until the person meets 1,000 hours of supervised clinical experience.

(d) A level III treatment provider must be employed by an agency, have completed the level III training requirement, be at least 18 years of age, and have at least one of the following:

(1) a high school diploma or commissioner of education-selected high school equivalency certification;

(2) fluency in a non-English language; ~~or~~

(3) one year of experience as a primary personal care assistant, community health worker, waiver service provider, or special education assistant to a person with ASD or a related condition within the previous five years~~.~~; or

(4) completion of all required EIDBI training within six months of employment.

Sec. 36. Minnesota Statutes 2018, section 256B.0949, subdivision 16, is amended to read:

Subd. 16. **Agency duties.** (a) An agency delivering an EIDBI service under this section must:

(1) enroll as a medical assistance Minnesota health care program provider according to Minnesota Rules, part 9505.0195, and section 256B.04, subdivision 21, and meet all applicable provider standards and requirements;

(2) demonstrate compliance with federal and state laws for EIDBI service;

(3) verify and maintain records of a service provided to the person or the person's legal representative as required under Minnesota Rules, parts 9505.2175 and 9505.2197;

(4) demonstrate that while enrolled or seeking enrollment as a Minnesota health care program provider the agency did not have a lead agency contract or provider agreement discontinued because of a conviction of fraud; or did not have an owner, board member, or manager fail a state or federal criminal background check or appear on the list of excluded individuals or entities maintained by the federal Department of Human Services Office of Inspector General;

(5) have established business practices including written policies and procedures, internal controls, and a system that demonstrates the organization's ability to deliver quality EIDBI services;

(6) have an office located in Minnesota or a border state;

(7) conduct a criminal background check on an individual who has direct contact with the person or the person's legal representative;

(8) report maltreatment according to sections 626.556 and 626.557;

(9) comply with any data requests consistent with the Minnesota Government Data Practices Act, sections 256B.064 and 256B.27;

(10) provide training for all agency staff on the requirements and responsibilities listed in the Maltreatment of Minors Act, section 626.556, and the Vulnerable Adult Protection Act, section 626.557, including mandated and voluntary reporting, nonretaliation, and the agency's policy for all staff on how to report suspected abuse and neglect;

(11) have a written policy to resolve issues collaboratively with the person and the person's legal representative when possible. The policy must include a timeline for when the person and the person's legal representative will be notified about issues that arise in the provision of services;

(12) provide the person's legal representative with prompt notification if the person is injured while being served by the agency. An incident report must be completed by the

agency staff member in charge of the person. A copy of all incident and injury reports must remain on file at the agency for at least five years from the report of the incident; and

(13) before starting a service, provide the person or the person's legal representative a description of the treatment modality that the person shall receive, including the staffing certification levels and training of the staff who shall provide a treatment.

(b) When delivering the ITP, and annually thereafter, an agency must provide the person or the person's legal representative with:

(1) a written copy and a verbal explanation of the person's or person's legal representative's rights and the agency's responsibilities;

(2) documentation in the person's file the date that the person or the person's legal representative received a copy and explanation of the person's or person's legal representative's rights and the agency's responsibilities; and

(3) reasonable accommodations to provide the information in another format or language as needed to facilitate understanding of the person's or person's legal representative's rights and the agency's responsibilities.

Sec. 37. Minnesota Statutes 2018, section 256D.02, subdivision 17, is amended to read:

Subd. 17. **Professional certification.** "Professional certification" means a statement about a person's illness, injury, or incapacity that is signed by a "qualified professional" as defined in section ~~256J.08, subdivision 73a~~ 256P.01, subdivision 6a.

Sec. 38. Minnesota Statutes 2018, section 256I.03, subdivision 3, is amended to read:

Subd. 3. **Housing support.** "Housing support" means ~~a group living situation~~ assistance that provides at a minimum room and board to ~~unrelated~~ persons who meet the eligibility requirements of section 256I.04. To receive payment for ~~a group residence rate~~ housing support, the residence must meet the requirements under section 256I.04, subdivisions 2a to 2f.

Sec. 39. Minnesota Statutes 2018, section 256I.03, subdivision 14, is amended to read:

Subd. 14. **Qualified professional.** "Qualified professional" means an individual as defined in section ~~256J.08, subdivision 73a, or~~ 245G.11, subdivision 3, 4, or 5, or 256P.01, subdivision 6a; or an individual approved by the director of human services or a designee of the director.

Sec. 40. Minnesota Statutes 2019 Supplement, section 256I.04, subdivision 2b, is amended to read:

Subd. 2b. **Housing support agreements.** (a) Agreements between agencies and providers of housing support must be in writing on a form developed and approved by the commissioner and must specify the name and address under which the establishment subject to the agreement does business and under which the establishment, or service provider, if different from the ~~group residential housing~~ establishment, is licensed by the Department of Health or the Department of Human Services; the specific license or registration from the Department of Health or the Department of Human Services held by the provider and the number of beds subject to that license; the address of the location or locations at which ~~group residential~~ housing support is provided under this agreement; the per diem and monthly rates that are to be paid from housing support funds for each eligible resident at each location; the number of beds at each location which are subject to the agreement; whether the license holder is a not-for-profit corporation under section 501(c)(3) of the Internal Revenue Code; and a statement that the agreement is subject to the provisions of sections 256I.01 to 256I.06 and subject to any changes to those sections.

(b) Providers are required to verify the following minimum requirements in the agreement:

(1) current license or registration, including authorization if managing or monitoring medications;

(2) all staff who have direct contact with recipients meet the staff qualifications;

(3) the provision of housing support;

(4) the provision of supplementary services, if applicable;

(5) reports of adverse events, including recipient death or serious injury;

(6) submission of residency requirements that could result in recipient eviction; and

(7) confirmation that the provider will not limit or restrict the number of hours an applicant or recipient chooses to be employed, as specified in subdivision 5.

(c) Agreements may be terminated with or without cause by the commissioner, the agency, or the provider with two calendar months prior notice. The commissioner may immediately terminate an agreement under subdivision 2d.

Sec. 41. Minnesota Statutes 2018, section 256I.05, subdivision 1c, is amended to read:

Subd. 1c. **Rate increases.** An agency may not increase the rates negotiated for housing support above those in effect on June 30, 1993, except as provided in paragraphs (a) to (f).

(a) An agency may increase the rates for room and board to the MSA equivalent rate for those settings whose current rate is below the MSA equivalent rate.

(b) An agency may increase the rates for residents in adult foster care whose difficulty of care has increased. The total housing support rate for these residents must not exceed the maximum rate specified in subdivisions 1 and 1a. Agencies must not include nor increase difficulty of care rates for adults in foster care whose difficulty of care is eligible for funding by home and community-based waiver programs under title XIX of the Social Security Act.

(c) The room and board rates will be increased each year when the MSA equivalent rate is adjusted for SSI cost-of-living increases by the amount of the annual SSI increase, less the amount of the increase in the medical assistance personal needs allowance under section 256B.35.

(d) When housing support pays for an individual's room and board, or other costs necessary to provide room and board, the rate payable to the residence must continue for up to 18 calendar days per incident that the person is temporarily absent from the residence, not to exceed 60 days in a calendar year, if the absence or absences ~~have received the prior approval of~~ are reported in advance to the county agency's social service staff. ~~Prior approval~~ Advance reporting is not required for emergency absences due to crisis, illness, or injury.

(e) For facilities meeting substantial change criteria within the prior year. Substantial change criteria exists if the establishment experiences a 25 percent increase or decrease in the total number of its beds, if the net cost of capital additions or improvements is in excess of 15 percent of the current market value of the residence, or if the residence physically moves, or changes its licensure, and incurs a resulting increase in operation and property costs.

(f) Until June 30, 1994, an agency may increase by up to five percent the total rate paid for recipients of assistance under sections 256D.01 to 256D.21 or 256D.33 to 256D.54 who reside in residences that are licensed by the commissioner of health as a boarding care home, but are not certified for the purposes of the medical assistance program. However, an increase under this clause must not exceed an amount equivalent to 65 percent of the 1991 medical assistance reimbursement rate for nursing home resident class A, in the geographic grouping in which the facility is located, as established under Minnesota Rules, parts 9549.0051 to 9549.0058.

Sec. 42. Minnesota Statutes 2018, section 256I.05, subdivision 1n, is amended to read:

Subd. 1n. **Supplemental rate; Mahnomen County.** Notwithstanding the provisions of this section, for the rate period July 1, 2010, to June 30, 2011, a county agency shall negotiate a supplemental service rate in addition to the rate specified in subdivision 1, not to exceed $753 per month or the existing rate, including any legislative authorized inflationary adjustments, for a ~~group residential~~ housing support provider located in Mahnomen County that operates a 28-bed facility providing 24-hour care to individuals who are homeless, disabled, chemically dependent, mentally ill, or chronically homeless.

Sec. 43. Minnesota Statutes 2018, section 256I.05, subdivision 8, is amended to read:

Subd. 8. **State participation.** For a ~~resident of a group residence~~ person who is eligible under section 256I.04, subdivision 1, paragraph (b), state participation in the ~~group residential~~ housing support payment is determined according to section 256D.03, subdivision 2. For a ~~resident of a group residence~~ person who is eligible under section 256I.04, subdivision 1, paragraph (a), state participation in the ~~group residential~~ housing support rate is determined according to section 256D.36.

Sec. 44. Minnesota Statutes 2018, section 256I.06, subdivision 2, is amended to read:

Subd. 2. **Time of payment.** A county agency may make payments in advance for an individual whose stay is expected to last beyond the calendar month for which the payment is made. Housing support payments made by a county agency on behalf of an individual who is not expected to remain in the ~~group residence~~ establishment beyond the month for which payment is made must be made subsequent to the individual's departure from the residence.

Sec. 45. Minnesota Statutes 2018, section 256I.06, is amended by adding a subdivision to read:

Subd. 10. **Correction of overpayments and underpayments.** The agency shall make an adjustment to housing support payments issued to individuals consistent with requirements of federal law and regulation and state law and rule and shall issue or recover benefits as appropriate. A recipient or former recipient is not responsible for overpayments due to agency error, unless the amount of the overpayment is large enough that a reasonable person would know it is an error.

Sec. 46. Minnesota Statutes 2018, section 256J.08, subdivision 73a, is amended to read:

Subd. 73a. **Qualified professional.** "Qualified professional" means an individual as defined in section 256P.01, subdivision 6a. ~~(a) For physical illness, injury, or incapacity, a "qualified professional" means a licensed physician, a physician assistant, a nurse practitioner, or a licensed chiropractor.~~

~~(b) For developmental disability and intelligence testing, a "qualified professional" means an individual qualified by training and experience to administer the tests necessary to make determinations, such as tests of intellectual functioning, assessments of adaptive behavior, adaptive skills, and developmental functioning. These professionals include licensed psychologists, certified school psychologists, or certified psychometrists working under the supervision of a licensed psychologist.~~

~~(c) For learning disabilities, a "qualified professional" means a licensed psychologist or school psychologist with experience determining learning disabilities.~~

~~(d) For mental health, a "qualified professional" means a licensed physician or a qualified mental health professional. A "qualified mental health professional" means:~~

~~(1) for children, in psychiatric nursing, a registered nurse who is licensed under sections 148.171 to 148.285, and who is certified as a clinical specialist in child and adolescent psychiatric or mental health nursing by a national nurse certification organization or who has a master's degree in nursing or one of the behavioral sciences or related fields from an accredited college or university or its equivalent, with at least 4,000 hours of post-master's supervised experience in the delivery of clinical services in the treatment of mental illness;~~

~~(2) for adults, in psychiatric nursing, a registered nurse who is licensed under sections 148.171 to 148.285, and who is certified as a clinical specialist in adult psychiatric and mental health nursing by a national nurse certification organization or who has a master's degree in nursing or one of the behavioral sciences or related fields from an accredited college or university or its equivalent, with at least 4,000 hours of post-master's supervised experience in the delivery of clinical services in the treatment of mental illness;~~

~~(3) in clinical social work, a person licensed as an independent clinical social worker under chapter 148D, or a person with a master's degree in social work from an accredited college or university, with at least 4,000 hours of post-master's supervised experience in the delivery of clinical services in the treatment of mental illness;~~

~~(4) in psychology, an individual licensed by the Board of Psychology under sections 148.88 to 148.98, who has stated to the Board of Psychology competencies in the diagnosis and treatment of mental illness;~~

~~(5) in psychiatry, a physician licensed under chapter 147 and certified by the American Board of Psychiatry and Neurology or eligible for board certification in psychiatry;~~

~~(6) in marriage and family therapy, the mental health professional must be a marriage and family therapist licensed under sections 148B.29 to 148B.39, with at least two years of post-master's supervised experience in the delivery of clinical services in the treatment of mental illness; and~~

~~(7) in licensed professional clinical counseling, the mental health professional shall be a licensed professional clinical counselor under section 148B.5301 with at least 4,000 hours of post-master's supervised experience in the delivery of clinical services in the treatment of mental illness.~~

Sec. 47. Minnesota Statutes 2018, section 256P.01, is amended by adding a subdivision to read:

Subd. 6a. **Qualified professional.** (a) For physical illness, injury, or incapacity, a "qualified professional" means a licensed physician, physician assistant, nurse practitioner, physical therapist, occupational therapist, or licensed chiropractor.

(b) For developmental disability, learning disability, and intelligence testing, a "qualified professional" means a licensed physician, physician assistant, nurse practitioner, licensed independent clinical social worker, licensed psychologist, certified school psychologist, or certified psychometrist working under the supervision of a licensed psychologist.

(c) For mental health, a "qualified professional" means a licensed physician, physician assistant, nurse practitioner, or qualified mental health professional under section 245.462, subdivision 18, clauses (1) to (6).

(d) For substance use disorder, a "qualified professional" means an individual as defined in section 245G.11, subdivision 3, 4, or 5.

Sec. 48. **DIRECTION TO THE COMMISSIONER; EVALUATION OF CONTINUOUS LICENSES.**

By January 1, 2021, the commissioner of human services shall consult with family child care license holders and county agencies to determine whether family child care licenses should automatically renew instead of requiring license holders to reapply for licensure. If

the commissioner determines that family child care licenses should automatically renew, the commissioner must propose legislation for the 2021 legislative session to make the required amendments to statute and administrative rules, as necessary.

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

Sec. 49. **REVISOR INSTRUCTION; CORRECTING TERMINOLOGY.**

In Minnesota Statutes, sections 256.01, subdivisions 2 and 24; 256.975, subdivision 7; 256B.0911, subdivisions 1a, 3b, and 4d; and 256B.439, subdivision 4, the revisor of statutes must substitute the term "Disability Linkage Line" or similar terms for "Disability Hub" or similar terms. The revisor must also make grammatical changes related to the changes in terms.

Sec. 50. **REPEALER.**

(a) Minnesota Statutes 2018, sections 245A.144; 245A.175; and 245F.02, subdivision 20, are repealed.

(b) Minnesota Rules, parts 2960.3070; and 2960.3210, are repealed.

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

ARTICLE 7
CIVIL COMMITMENT

Section 1. Minnesota Statutes 2018, section 253B.02, subdivision 4b, is amended to read:

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

Sec. 2. Minnesota Statutes 2018, section 253B.02, subdivision 7, is amended to read:

Subd. 7. **Examiner.** "Examiner" means a person who is knowledgeable, trained, and practicing in the diagnosis and assessment or in the treatment of the alleged impairment, and who is~~:~~ a licensed physician, a mental health professional as defined in section 245.462, subdivision 18, clauses (1) to (6), a licensed physician assistant, or an advanced practice registered nurse (APRN) as defined in section 148.171, subdivision 3, who is practicing in the emergency room of a designated critical access hospital established under section 144.1483, clause (9), so long as the critical access hospital has a process for credentialing and recredentialing any APRN acting as an examiner in an emergency room.

~~(1) a licensed physician;~~

~~(2) a licensed psychologist who has a doctoral degree in psychology or who became a licensed consulting psychologist before July 2, 1975; or~~

~~(3) an advanced practice registered nurse certified in mental health or a licensed physician assistant, except that only a physician or psychologist meeting these requirements may be appointed by the court as described by sections 253B.07, subdivision 3; 253B.092, subdivision 8, paragraph (b); 253B.17, subdivision 3; 253B.18, subdivision 2; and 253B.19, subdivisions 1 and 2, and only a physician or psychologist may conduct an assessment as described by Minnesota Rules of Criminal Procedure, rule 20.~~

Sec. 3. Minnesota Statutes 2018, section 253B.02, is amended by adding a subdivision to read:

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

Sec. 4. Minnesota Statutes 2018, section 253B.02, subdivision 8, is amended to read:

Subd. 8. **Head of the ~~treatment~~ facility or program.** "Head of the ~~treatment~~ facility or program" means the person who is charged with overall responsibility for the professional program of care and treatment of the ~~facility or the person's designee~~ treatment facility, state-operated treatment program, or community-based treatment program.

Sec. 5. Minnesota Statutes 2018, section 253B.02, subdivision 9, is amended to read:

Subd. 9. **Health officer.** "Health officer" means:

(1) a licensed physician;

(2) ~~a licensed psychologist~~ a mental health professional as defined in section 245.462, subdivision 18, clauses (1) to (6);

(3) a licensed social worker;

(4) a registered nurse working in an emergency room of a hospital;

~~(5) a psychiatric or public health nurse as defined in section 145A.02, subdivision 18;~~

~~(6)~~ (5) an advanced practice registered nurse (APRN) as defined in section 148.171, subdivision 3; or

~~(7)~~ (6) a mental health ~~professional~~ practitioner as defined in section 245.462, subdivision 17, providing mental health mobile crisis intervention services as described under section 256B.0624 with the consultation and approval by a mental health professional; or

~~(8)~~ (7) a formally designated member of a prepetition screening unit established by section 253B.07.

Sec. 6. Minnesota Statutes 2018, section 253B.02, subdivision 10, is amended to read:

Subd. 10. **Interested person.** "Interested person" means:

(1) an adult who has a specific interest in the patient or proposed patient, including but not limited to~~,~~ a public official, including a local welfare agency acting under section 626.5561~~, and~~; a health care or mental health provider or the provider's employee or agent; the legal guardian, spouse, parent, legal counsel, adult child, or next of kin~~,~~; or other person designated by a patient or proposed patient; or

(2) a health plan company that is providing coverage for a proposed patient.

Sec. 7. Minnesota Statutes 2018, section 253B.02, subdivision 13, is amended to read:

Subd. 13. **Person who ~~is mentally ill~~ poses a risk of harm due to a mental illness.** (a) A "person who ~~is mentally ill~~ poses a risk of harm due to a mental illness" means any person who has an organic disorder of the brain or a substantial psychiatric disorder of thought, mood, perception, orientation, or memory ~~which~~ that grossly impairs judgment, behavior, capacity to recognize reality, or to reason or understand, ~~which~~ that is manifested by instances of grossly disturbed behavior or faulty perceptions and who, due to this impairment, poses a substantial likelihood of physical harm to self or others as demonstrated by:

(1) a failure to obtain necessary food, clothing, shelter, or medical care as a result of the impairment;

(2) an inability for reasons other than indigence to obtain necessary food, clothing, shelter, or medical care as a result of the impairment and it is more probable than not that the person will suffer substantial harm, significant psychiatric deterioration or debilitation, or serious illness, unless appropriate treatment and services are provided;

(3) a recent attempt or threat to physically harm self or others; or

(4) recent and volitional conduct involving significant damage to substantial property.

(b) A person ~~is not mentally ill~~ does not pose a risk of harm due to mental illness under this section if the person's impairment is solely due to:

(1) epilepsy;

(2) developmental disability;

(3) brief periods of intoxication caused by alcohol, drugs, or other mind-altering substances; or

(4) dependence upon or addiction to any alcohol, drugs, or other mind-altering substances.

Sec. 8. Minnesota Statutes 2018, section 253B.02, subdivision 16, is amended to read:

Subd. 16. **Peace officer.** "Peace officer" means a sheriff or deputy sheriff, or municipal or other local police officer, or a State Patrol officer when engaged in the authorized duties of office.

Sec. 9. Minnesota Statutes 2018, section 253B.02, subdivision 17, is amended to read:

Subd. 17. **Person who ~~is mentally ill~~ has a mental illness and is dangerous to the public.** ~~(a)~~ A "person who ~~is mentally ill~~ has a mental illness and is dangerous to the public" is a person:

(1) who ~~is mentally ill~~ has an organic disorder of the brain or a substantial psychiatric disorder of thought, mood, perception, orientation, or memory that grossly impairs judgment, behavior, capacity to recognize reality, or to reason or understand, and is manifested by instances of grossly disturbed behavior or faulty perceptions; and

(2) who as a result of that ~~mental illness~~ impairment presents a clear danger to the safety of others as demonstrated by the facts that (i) the person has engaged in an overt act causing or attempting to cause serious physical harm to another and (ii) there is a substantial likelihood that the person will engage in acts capable of inflicting serious physical harm on another.

~~(b) A person committed as a sexual psychopathic personality or sexually dangerous person as defined in subdivisions 18a and 18b is subject to the provisions of this chapter that apply to persons who are mentally ill and dangerous to the public.~~

Sec. 10. Minnesota Statutes 2018, section 253B.02, subdivision 18, is amended to read:

Subd. 18. **~~Regional~~ State-operated treatment ~~center~~ program.** "~~Regional~~ State-operated treatment ~~center~~ program" ~~means any state-operated facility for persons who are mentally ill, developmentally disabled, or chemically dependent under the direct administrative authority of the commissioner~~ means any state-operated program including community behavioral health hospitals, crisis centers, residential facilities, outpatient services, and other community-based services developed and operated by the state and under the commissioner's control for a person who has a mental illness, developmental disability, or chemical dependency.

Sec. 11. Minnesota Statutes 2018, section 253B.02, subdivision 19, is amended to read:

Subd. 19. **Treatment facility.** "Treatment facility" means a non-state-operated hospital, ~~community mental health center, or other treatment provider~~ residential treatment provider, crisis residential withdrawal management center, or corporate foster care home qualified to provide care and treatment for persons ~~who are mentally ill, developmentally disabled, or chemically dependent~~ who have a mental illness, developmental disability, or chemical dependency.

Sec. 12. Minnesota Statutes 2018, section 253B.02, subdivision 21, is amended to read:

Subd. 21. **Pass.** "Pass" means any authorized temporary, unsupervised absence from a state-operated treatment ~~facility~~ program.

Sec. 13. Minnesota Statutes 2018, section 253B.02, subdivision 22, is amended to read:

Subd. 22. **Pass plan.** "Pass plan" means the part of a treatment plan for a ~~person~~ patient who has been committed as ~~mentally ill and~~ a person who has a mental illness and is dangerous to the public that specifies the terms and conditions under which the patient may be released on a pass.

Sec. 14. Minnesota Statutes 2018, section 253B.02, subdivision 23, is amended to read:

Subd. 23. **Pass-eligible status.** "Pass-eligible status" means the status under which a ~~person~~ patient committed as ~~mentally ill and~~ a person who has a mental illness and is

dangerous to the public may be released on passes after approval of a pass plan by the head of a state-operated treatment ~~facility~~ program.

Sec. 15. Minnesota Statutes 2018, section 253B.03, subdivision 1, is amended to read:

Subdivision 1. **Restraints.** (a) A patient has the right to be free from restraints. Restraints shall not be applied to a patient in a treatment facility or state-operated treatment program unless the head of the treatment facility, head of the state-operated treatment program, a member of the medical staff, or a licensed peace officer who has custody of the patient determines that ~~they~~ restraints are necessary for the safety of the patient or others.

(b) Restraints shall not be applied to patients with developmental disabilities except as permitted under section 245.825 and rules of the commissioner of human services. Consent must be obtained from the ~~person~~ patient or ~~person's~~ patient's guardian except for emergency procedures as permitted under rules of the commissioner adopted under section 245.825.

(c) Each use of a restraint and reason for it shall be made part of the clinical record of the patient under the signature of the head of the treatment facility.

Sec. 16. Minnesota Statutes 2018, section 253B.03, subdivision 2, is amended to read:

Subd. 2. **Correspondence.** A patient has the right to correspond freely without censorship. The head of the treatment facility or head of the state-operated treatment program may restrict correspondence if the patient's medical welfare requires this restriction. For ~~patients~~ a patient in ~~regional~~ a state-operated treatment ~~centers~~ program, that determination may be reviewed by the commissioner. Any limitation imposed on the exercise of a patient's correspondence rights and the reason for it shall be made a part of the clinical record of the patient. Any communication which is not delivered to a patient shall be immediately returned to the sender.

Sec. 17. Minnesota Statutes 2018, section 253B.03, subdivision 3, is amended to read:

Subd. 3. **Visitors and phone calls.** Subject to the general rules of the treatment facility or state-operated treatment program, a patient has the right to receive visitors and make phone calls. The head of the treatment facility or head of the state-operated treatment program may restrict visits and phone calls on determining that the medical welfare of the patient requires it. Any limitation imposed on the exercise of the patient's visitation and phone call rights and the reason for it shall be made a part of the clinical record of the patient.

Sec. 18. Minnesota Statutes 2018, section 253B.03, subdivision 4a, is amended to read:

Subd. 4a. **Disclosure of patient's admission.** Upon admission to a treatment facility or state-operated treatment program where federal law prohibits unauthorized disclosure of patient or resident identifying information to callers and visitors, the patient or resident, or the legal guardian of the patient or resident, shall be given the opportunity to authorize disclosure of the patient's or resident's presence in the facility to callers and visitors who may seek to communicate with the patient or resident. To the extent possible, the legal guardian of a patient or resident shall consider the opinions of the patient or resident regarding the disclosure of the patient's or resident's presence in the facility.

Sec. 19. Minnesota Statutes 2018, section 253B.03, subdivision 5, is amended to read:

Subd. 5. **Periodic assessment.** A patient has the right to periodic medical assessment, including assessment of the medical necessity of continuing care and, if the treatment facility, state-operated treatment program, or community-based treatment program declines to provide continuing care, the right to receive specific written reasons why continuing care is declined at the time of the assessment. The treatment facility, state-operated treatment program, or community-based treatment program shall assess the physical and mental condition of every patient as frequently as necessary, but not less often than annually. If the patient refuses to be examined, the treatment facility, state-operated treatment program, or community-based treatment program shall document in the patient's chart its attempts to examine the patient. If a ~~person~~ patient is committed as developmentally disabled for an indeterminate period of time, the three-year judicial review must include the annual reviews for each year ~~as outlined in Minnesota Rules, part 9525.0075, subpart 6~~ regarding the patient's need for continued commitment.

Sec. 20. Minnesota Statutes 2018, section 253B.03, subdivision 6, is amended to read:

Subd. 6. **Consent for medical procedure.** (a) A patient has the right to give prior consent to any medical or surgical treatment, other than treatment for chemical dependency or nonintrusive treatment for mental illness.

(b) The following procedures shall be used to obtain consent for any treatment necessary to preserve the life or health of any committed patient:

~~(a)~~ (1) the written, informed consent of a competent adult patient for the treatment is sufficient~~.~~;

~~(b)~~ (2) if the patient is subject to guardianship which includes the provision of medical care, the written, informed consent of the guardian for the treatment is sufficient~~.~~;

~~(c)~~ (3) if the head of the treatment facility or state-operated treatment program determines that the patient is not competent to consent to the treatment and the patient has not been adjudicated incompetent, written, informed consent for the surgery or medical treatment shall be obtained from the person appointed the health care power of attorney, the patient's agent under the health care directive, or the nearest proper relative. For this purpose, the following persons are proper relatives, in the order listed: the patient's spouse, parent, adult child, or adult sibling. If the nearest proper relatives cannot be located, refuse to consent to the procedure, or are unable to consent, the head of the treatment facility or state-operated treatment program or an interested person may petition the committing court for approval for the treatment or may petition a court of competent jurisdiction for the appointment of a guardian. The determination that the patient is not competent, and the reasons for the determination, shall be documented in the patient's clinical record~~.~~;

~~(d)~~ (4) consent to treatment of any minor patient shall be secured in accordance with sections 144.341 to 144.346. A minor 16 years of age or older may consent to hospitalization, routine diagnostic evaluation, and emergency or short-term acute care~~.~~; and

~~(e)~~ (5) in the case of an emergency when the persons ordinarily qualified to give consent cannot be located in sufficient time to address the emergency need, the head of the treatment facility or state-operated treatment program may give consent.

(c) No person who consents to treatment pursuant to the provisions of this subdivision shall be civilly or criminally liable for the performance or the manner of performing the treatment. No person shall be liable for performing treatment without consent if written, informed consent was given pursuant to this subdivision. This provision shall not affect any other liability which may result from the manner in which the treatment is performed.

Sec. 21. Minnesota Statutes 2018, section 253B.03, subdivision 6b, is amended to read:

Subd. 6b. **Consent for mental health treatment.** A competent ~~person~~ patient admitted voluntarily to a treatment facility or state-operated treatment program may be subjected to intrusive mental health treatment only with the ~~person's~~ patient's written informed consent. For purposes of this section, "intrusive mental health treatment" means ~~electroshock~~ electroconvulsive therapy and neuroleptic medication and does not include treatment for a developmental disability. An incompetent ~~person~~ patient who has prepared a directive under subdivision 6d regarding intrusive mental health treatment ~~with intrusive therapies~~ must be treated in accordance with this section, except in cases of emergencies.

Sec. 22. Minnesota Statutes 2018, section 253B.03, subdivision 6d, is amended to read:

Subd. 6d. **Adult mental health treatment.** (a) A competent adult patient may make a declaration of preferences or instructions regarding intrusive mental health treatment. These preferences or instructions may include, but are not limited to, consent to or refusal of these treatments. A declaration of preferences or instructions may include a health care directive under chapter 145C or a psychiatric directive.

(b) A declaration may designate a proxy to make decisions about intrusive mental health treatment. A proxy designated to make decisions about intrusive mental health treatments and who agrees to serve as proxy may make decisions on behalf of a declarant consistent with any desires the declarant expresses in the declaration.

(c) A declaration is effective only if it is signed by the declarant and two witnesses. The witnesses must include a statement that they believe the declarant understands the nature and significance of the declaration. A declaration becomes operative when it is delivered to the declarant's physician or other mental health treatment provider. The physician or provider must comply with ~~it~~ the declaration to the fullest extent possible, consistent with reasonable medical practice, the availability of treatments requested, and applicable law. The physician or provider shall continue to obtain the declarant's informed consent to all intrusive mental health treatment decisions if the declarant is capable of informed consent. A treatment provider ~~may~~ must not require a ~~person~~ patient to make a declaration under this subdivision as a condition of receiving services.

(d) The physician or other provider shall make the declaration a part of the declarant's medical record. If the physician or other provider is unwilling at any time to comply with the declaration, the physician or provider must promptly notify the declarant and document the notification in the declarant's medical record. ~~If the declarant has been committed as a patient under this chapter, the physician or provider may subject a declarant to intrusive treatment in a manner contrary to the declarant's expressed wishes, only upon order of the committing court. If the declarant is not a committed patient under this chapter,~~ The physician or provider may subject the declarant to intrusive treatment in a manner contrary to the declarant's expressed wishes, only if the declarant is committed as ~~mentally ill~~ a person who poses a risk of harm due to mental illness or ~~mentally ill~~ as a person who has a mental illness and is dangerous to the public and a court order authorizing the treatment has been issued or an emergency has been declared under section 253B.092, subdivision 3.

(e) A declaration under this subdivision may be revoked in whole or in part at any time and in any manner by the declarant if the declarant is competent at the time of revocation.

A revocation is effective when a competent declarant communicates the revocation to the attending physician or other provider. The attending physician or other provider shall note the revocation as part of the declarant's medical record.

(f) A provider who administers intrusive mental health treatment according to and in good faith reliance upon the validity of a declaration under this subdivision is held harmless from any liability resulting from a subsequent finding of invalidity.

(g) In addition to making a declaration under this subdivision, a competent adult may delegate parental powers under section 524.5-211 or may nominate a guardian under sections 524.5-101 to 524.5-502.

Sec. 23. Minnesota Statutes 2018, section 253B.03, subdivision 7, is amended to read:

Subd. 7. **~~Program~~ Treatment plan.** A ~~person~~ patient receiving services under this chapter has the right to receive proper care and treatment, best adapted, according to contemporary professional standards, to rendering further supervision unnecessary. The treatment facility, state-operated treatment program, or community-based treatment program shall devise a written ~~program~~ treatment plan for each ~~person~~ patient which describes in behavioral terms the case problems, the precise goals, including the expected period of time for treatment, and the specific measures to be employed. ~~Each plan shall be reviewed at least quarterly to determine progress toward the goals, and to modify the program plan as necessary.~~ The development and review of treatment plans must be conducted as required under the license or certification of the treatment facility, state-operated treatment program, or community-based treatment program. If there are no review requirements under the license or certification, the treatment plan must be reviewed quarterly. The ~~program~~ treatment plan shall be devised and reviewed with the designated agency and with the patient. The clinical record shall reflect the ~~program~~ treatment plan review. If the designated agency or the patient does not participate in the planning and review, the clinical record shall include reasons for nonparticipation and the plans for future involvement. The commissioner shall monitor the ~~program~~ treatment plan and review process for ~~regional centers~~ state-operated treatment programs to ~~insure~~ ensure compliance with the provisions of this subdivision.

Sec. 24. Minnesota Statutes 2018, section 253B.03, subdivision 10, is amended to read:

Subd. 10. **Notification.** (a) All ~~persons~~ patients admitted or committed to a treatment facility or state-operated treatment program, or temporarily confined under section 253B.045, shall be notified in writing of their rights regarding hospitalization and other treatment ~~at the time of admission~~.

(b) This notification must include:

(1) patient rights specified in this section and section 144.651, including nursing home discharge rights;

(2) the right to obtain treatment and services voluntarily under this chapter;

(3) the right to voluntary admission and release under section 253B.04;

(4) rights in case of an emergency admission under section ~~253B.05~~ 253B.051, including the right to documentation in support of an emergency hold and the right to a summary hearing before a judge if the patient believes an emergency hold is improper;

(5) the right to request expedited review under section 62M.05 if additional days of inpatient stay are denied;

(6) the right to continuing benefits pending appeal and to an expedited administrative hearing under section 256.045 if the patient is a recipient of medical assistance or MinnesotaCare; and

(7) the right to an external appeal process under section 62Q.73, including the right to a second opinion.

Sec. 25. Minnesota Statutes 2018, section 253B.04, subdivision 1, is amended to read:

Subdivision 1. **Voluntary admission and treatment.** (a) Voluntary admission is preferred over involuntary commitment and treatment. Any person 16 years of age or older may request to be admitted to a treatment facility or state-operated treatment program as a voluntary patient for observation, evaluation, diagnosis, care and treatment without making formal written application. Any person under the age of 16 years may be admitted as a patient with the consent of a parent or legal guardian if it is determined by independent examination that there is reasonable evidence that (1) the proposed patient has a mental illness, ~~or is developmentally disabled~~ developmental disability, or ~~chemically dependent~~ chemical dependency; and (2) the proposed patient is suitable for treatment. The head of the treatment facility or head of the state-operated treatment program shall not arbitrarily refuse any person seeking admission as a voluntary patient. In making decisions regarding admissions, the treatment facility or state-operated treatment program shall use clinical admission criteria consistent with the current applicable inpatient admission standards established by professional organizations including the American Psychiatric Association ~~or~~, the American Academy of Child and Adolescent Psychiatry, the Joint Commission, and the American Society of Addiction Medicine. These criteria must be no more restrictive than, and must be consistent with, the requirements of section 62Q.53. The treatment facility

or head of the state-operated treatment program may not refuse to admit a person voluntarily solely because the person does not meet the criteria for involuntary holds under section ~~253B.05~~ 253B.051 or the definition of a person who poses a risk of harm due to mental illness under section 253B.02, subdivision 13.

(b) In addition to the consent provisions of paragraph (a), a person who is 16 or 17 years of age who refuses to consent personally to admission may be admitted as a patient for mental illness or chemical dependency treatment with the consent of a parent or legal guardian if it is determined by an independent examination that there is reasonable evidence that the proposed patient is chemically dependent or has a mental illness and is suitable for treatment. The person conducting the examination shall notify the proposed patient and the parent or legal guardian of this determination.

(c) A person who is voluntarily participating in treatment for a mental illness is not subject to civil commitment under this chapter if the person:

(1) has given informed consent or, if lacking capacity, is a person for whom legally valid substitute consent has been given; and

(2) is participating in a medically appropriate course of treatment, including clinically appropriate and lawful use of neuroleptic medication and electroconvulsive therapy. The limitation on commitment in this paragraph does not apply if, based on clinical assessment, the court finds that it is unlikely that the ~~person~~ patient will remain in and cooperate with a medically appropriate course of treatment absent commitment and the standards for commitment are otherwise met. This paragraph does not apply to a person for whom commitment proceedings are initiated pursuant to rule 20.01 or 20.02 of the Rules of Criminal Procedure, or a person found by the court to meet the requirements under section 253B.02, subdivision 17.

(d) Legally valid substitute consent may be provided by a proxy under a health care directive, a guardian or conservator with authority to consent to mental health treatment, or consent to admission under subdivision 1a or 1b.

Sec. 26. Minnesota Statutes 2018, section 253B.04, subdivision 1a, is amended to read:

Subd. 1a. **Voluntary treatment or admission for persons with a mental illness.** (a) A person with a mental illness may seek or voluntarily agree to accept treatment or admission to a state-operated treatment program or treatment facility. If the mental health provider determines that the person lacks the capacity to give informed consent for the treatment or admission, and in the absence of a health care ~~power of attorney~~ directive or health care

power of attorney that authorizes consent, the designated agency or its designee may give informed consent for mental health treatment or admission to a treatment facility or state-operated treatment program on behalf of the person.

(b) The designated agency shall apply the following criteria in determining the person's ability to give informed consent:

(1) whether the person demonstrates an awareness of the person's illness, and the reasons for treatment, its risks, benefits and alternatives, and the possible consequences of refusing treatment; and

(2) whether the person communicates verbally or nonverbally a clear choice concerning treatment that is a reasoned one, not based on delusion, even though it may not be in the person's best interests.

(c) The basis for the designated agency's decision that the person lacks the capacity to give informed consent for treatment or admission, and that the patient has voluntarily accepted treatment or admission, must be documented in writing.

(d) A ~~mental health provider~~ treatment facility or state-operated treatment program that provides treatment in reliance on the written consent given by the designated agency under this subdivision or by a substitute decision maker appointed by the court is not civilly or criminally liable for performing treatment without consent. This paragraph does not affect any other liability that may result from the manner in which the treatment is performed.

(e) A ~~person~~ patient who receives treatment or is admitted to a treatment facility or state-operated treatment program under this subdivision or subdivision 1b has the right to refuse treatment at any time or to be released from a treatment facility or state-operated treatment program as provided under subdivision 2. The ~~person~~ patient or any interested person acting on the ~~person's~~ patient's behalf may seek court review within five days for a determination of whether the ~~person's~~ patient's agreement to accept treatment or admission is voluntary. At the time a ~~person~~ patient agrees to treatment or admission to a treatment facility or state-operated treatment program under this subdivision, the designated agency or its designee shall inform the ~~person~~ patient in writing of the ~~person's~~ patient's rights under this paragraph.

~~(f) This subdivision does not authorize the administration of neuroleptic medications. Neuroleptic medications may be administered only as provided in section 253B.092.~~

Sec. 27. Minnesota Statutes 2018, section 253B.04, subdivision 2, is amended to read:

Subd. 2. **Release.** Every patient admitted for mental illness or developmental disability under this section shall be informed in writing at the time of admission that the patient has a right to leave the treatment facility or state-operated treatment program within 12 hours of making a request, unless held under another provision of this chapter. Every patient admitted for chemical dependency under this section shall be informed in writing at the time of admission that the patient has a right to leave the treatment facility or state-operated treatment program within 72 hours, exclusive of Saturdays, Sundays, and legal holidays, of making a request, unless held under another provision of this chapter. The request shall be submitted in writing to the head of the treatment facility or state-operated treatment program or the person's designee.

Sec. 28. **[253B.041] SERVICES FOR ENGAGEMENT IN TREATMENT.**

Subdivision 1. **Eligibility.** (a) The purpose of engagement services is to avoid the need for commitment and to enable the proposed patient to voluntarily engage in needed treatment. An interested person may apply to the county where a proposed patient resides to request engagement services.

(b) To be eligible for engagement services, the proposed patient must be at least 18 years of age, have a mental illness, and either:

(1) be exhibiting symptoms of serious mental illness including hallucinations, mania, delusional thoughts, or be unable to obtain necessary food, clothing, shelter, medical care, or provide necessary hygiene due to the patient's mental illness; or

(2) have a history of failing to adhere to treatment for mental illness, in that:

(i) the proposed patient's mental illness has been a substantial factor in necessitating hospitalization, or incarceration in a state or local correctional facility, not including any period during which the person was hospitalized or incarcerated immediately preceding filing the application for engagement; or

(ii) the proposed patient is exhibiting symptoms or behavior that may lead to hospitalization, incarceration, or court-ordered treatment.

Subd. 2. **Administration.** (a) Upon receipt of a request for engagement services, the county's prepetition screening team shall conduct an investigation to determine whether the proposed patient is eligible. In making this determination, the screening team shall seek any relevant information from an interested person.

(b) If the screening team determines that the proposed patient is eligible, engagement services must begin and include, but are not limited to:

(1) assertive attempts to engage the patient in voluntary treatment for mental illness for at least 90 days. Engagement services must be person-centered and continue even if the patient is an inmate in a non-state-operated correctional facility;

(2) efforts to engage the patient's existing systems of support, including interested persons, unless the engagement provider determines that involvement is not helpful to the patient. This includes education on restricting means of harm, suicide prevention, and engagement; and

(3) collaboration with the patient to meet immediate needs including access to housing, food, income, disability verification, medications, and treatment for medical conditions.

(c) Engagement services regarding potential treatment options must take into account the patient's preferences for services and supports. The county may offer engagement services through the designated agency or another agency under contract. Engagement services staff must have training in person-centered care. Engagement services staff may include but are not limited to mobile crisis teams under section 245.462, certified peer specialists under section 256B.0615, community-based treatment programs, and homeless outreach workers.

(d) If the patient voluntarily consents to receive mental health treatment, the engagement services staff must facilitate the referral to an appropriate mental health treatment provider including support obtaining health insurance if the proposed patient is currently or may become uninsured. If the proposed patient initially consents to treatment, but fails to initiate or continue treatment, the engagement services team must continue outreach efforts to the patient.

Subd. 3. **Commitment.** Engagement services for a patient to seek treatment may be stopped if the proposed patient is in need of commitment and satisfies the commitment criteria under section 253B.09, subdivision 1. In such a case, the engagement services team must immediately notify the designated agency, initiate the prepetition screening process under section 253B.07, or seek an emergency hold if necessary to ensure the safety of the patient or others.

Subd. 4. **Evaluation.** Counties may, but are not required to, provide engagement services. The commissioner may conduct a pilot project evaluating the impact of engagement services in decreasing commitments, increasing engagement in treatment, and other measures.

Sec. 29. Minnesota Statutes 2018, section 253B.045, subdivision 2, is amended to read:

Subd. 2. **Facilities.** (a) Each county or a group of counties shall maintain or provide by contract a facility for confinement of persons held temporarily for observation, evaluation, diagnosis, treatment, and care. When the temporary confinement is provided at a ~~regional~~ state-operated treatment ~~center~~ program, the commissioner shall charge the county of financial responsibility for the costs of confinement of ~~persons~~ patients hospitalized under ~~section 253B.05, subdivisions 1 and 2,~~ sections 253B.051 and ~~section~~ 253B.07, subdivision 2b, except that the commissioner shall bill the responsible health plan first. Any charges not covered, including co-pays and deductibles shall be the responsibility of the county. If the ~~person~~ patient has health plan coverage, but the hospitalization does not meet the criteria in subdivision 6 or section 62M.07, 62Q.53, or 62Q.535, the county is responsible. ~~When a person is temporarily confined in a Department of Corrections facility solely under subdivision 1a, and not based on any separate correctional authority:~~

~~(1) the commissioner of corrections may charge the county of financial responsibility for the costs of confinement; and~~

~~(2) the Department of Human Services shall use existing appropriations to fund all remaining nonconfinement costs. The funds received by the commissioner for the confinement and nonconfinement costs are appropriated to the department for these purposes.~~

(b) For the purposes of this subdivision, "county of financial responsibility" has the meaning specified in section 253B.02, subdivision 4c, or, if the ~~person~~ patient has no residence in this state, the county which initiated the confinement. The charge for confinement in a facility operated by the commissioner ~~of human services~~ shall be based on the commissioner's determination of the cost of care pursuant to section 246.50, subdivision 5. When there is a dispute as to which county is the county of financial responsibility, the county charged for the costs of confinement shall pay for them pending final determination of the dispute over financial responsibility.

Sec. 30. Minnesota Statutes 2018, section 253B.045, subdivision 3, is amended to read:

Subd. 3. **Cost of care.** Notwithstanding subdivision 2, a county shall be responsible for the cost of care as specified under section 246.54 for ~~persons~~ a patient hospitalized at a ~~regional~~ state-operated treatment ~~center~~ program in accordance with section 253B.09 and the ~~person's~~ patient's legal status has been changed to a court hold under section 253B.07, subdivision 2b, pending a judicial determination regarding continued commitment pursuant to sections 253B.12 and 253B.13.

Sec. 31. Minnesota Statutes 2018, section 253B.045, subdivision 5, is amended to read:

Subd. 5. **Health plan company; definition.** For purposes of this section, "health plan company" has the meaning given it in section 62Q.01, subdivision 4, and also includes a demonstration provider as defined in section 256B.69, subdivision 2, paragraph (b)~~,~~; and a county or group of counties participating in county-based purchasing according to section 256B.692~~, and a children's mental health collaborative under contract to provide medical assistance for individuals enrolled in the prepaid medical assistance and MinnesotaCare programs according to sections 245.493 to 245.495~~.

Sec. 32. Minnesota Statutes 2018, section 253B.045, subdivision 6, is amended to read:

Subd. 6. **Coverage.** (a) For purposes of this section, "mental health services" means all covered services that are intended to treat or ameliorate an emotional, behavioral, or psychiatric condition and that are covered by the policy, contract, or certificate of coverage of the enrollee's health plan company or by law.

(b) All health plan companies that provide coverage for mental health services must cover or provide mental health services ordered by a court of competent jurisdiction ~~under a court order that is issued on the basis of a behavioral care evaluation performed by a licensed psychiatrist or a doctoral level licensed psychologist, which includes a diagnosis and an individual treatment plan for care in the most appropriate, least restrictive environment. The health plan company must be given a copy of the court order and the behavioral care evaluation. The health plan company shall be financially liable for the evaluation if performed by a participating provider of the health plan company and shall be financially liable for the care included in the court-ordered individual treatment plan if the care is covered by the health plan company and ordered to be provided by a participating provider or another provider as required by rule or law~~. This court-ordered coverage must not be subject to a separate medical necessity determination by a health plan company under its utilization procedures.

Sec. 33. **[253B.051] EMERGENCY ADMISSION.**

Subdivision 1. **Peace officer or health officer authority.** (a) If a peace officer or health officer has reason to believe, either through direct observation of the person's behavior or upon reliable information of the person's recent behavior and, if available, knowledge or reliable information concerning the person's past behavior or treatment that the person:

(1) has a mental illness or developmental disability and is in danger of harming self or others if the officer does not immediately detain the patient, the peace officer or health

officer may take the person into custody and transport the person to an examiner or a treatment facility, state-operated treatment program, or community-based treatment program;

(2) is chemically dependent or intoxicated in public and in danger of harming self or others if the officer does not immediately detain the patient, the peace officer or health officer may take the person into custody and transport the person to a treatment facility, state-operated treatment program, or community-based treatment program; or

(3) is chemically dependent or intoxicated in public and not in danger of harming self, others, or property, the peace officer or health officer may take the person into custody and transport the person to the person's home.

(b) An examiner's written statement or a health officer's written statement in compliance with the requirements of subdivision 2 is sufficient authority for a peace officer or health officer to take the person into custody and transport the person to a treatment facility, state-operated treatment program, or community-based treatment program.

(c) A peace officer or health officer who takes a person into custody and transports the person to a treatment facility, state-operated treatment program, or community-based treatment program under this subdivision shall make written application for admission of the person containing:

(1) the officer's statement specifying the reasons and circumstances under which the person was taken into custody;

(2) identifying information on specific individuals to the extent practicable, if danger to those individuals is a basis for the emergency hold; and

(3) the officer's name, the agency that employs the officer, and the telephone number or other contact information for purposes of receiving notice under subdivision 3.

(d) A copy of the examiner's written statement and officer's application shall be made available to the person taken into custody.

(e) The officer may provide the transportation personally or may arrange to have the person transported by a suitable medical or mental health transportation provider. As far as practicable, a peace officer who provides transportation for a person placed in a treatment facility, state-operated treatment program, or community-based treatment program under this subdivision must not be in uniform and must not use a vehicle visibly marked as a law enforcement vehicle.

Subd. 2. **Emergency hold.** (a) A treatment facility, state-operated treatment program, or community-based treatment program, other than a facility operated by the Minnesota sex

offender program, may admit or hold a patient, including a patient transported under subdivision 1, for emergency care and treatment if the head of the facility or program consents to holding the patient and an examiner provides a written statement in support of holding the patient.

(b) The written statement must indicate that:

(1) the examiner examined the patient not more than 15 days prior to admission;

(2) the examiner interviewed the patient, or if not, the specific reasons why the examiner did not interview the patient;

(3) the examiner has the opinion that the patient has a mental illness or developmental disability, or is chemically dependent and is in danger of causing harm to self or others if a facility or program does not immediately detain the patient. The statement must include observations of the patient's behavior and avoid conclusory language. The statement must be specific enough to provide an adequate record for review. If danger to specific individuals is a basis for the emergency hold, the statement must identify those individuals to the extent practicable; and

(4) the facility or program cannot obtain a court order in time to prevent the anticipated injury.

(c) Prior to an examiner writing a statement, if another person brought the patient to the treatment facility, state-operated treatment program, or community-based treatment program, the examiner shall make a good-faith effort to obtain information from that person, which the examiner must consider in deciding whether to place the patient on an emergency hold. To the extent available, the statement must include direct observations of the patient's behaviors, reliable knowledge of the patient's recent and past behavior, and information regarding the patient's psychiatric history, past treatment, and current mental health providers. The examiner shall also inquire about health care directives under chapter 145C and advance psychiatric directives under section 253B.03, subdivision 6d.

(d) The facility or program must give a copy of the examiner's written statement to the patient immediately upon initiating the emergency hold. The treatment facility, state-operated treatment program, or community-based treatment program shall maintain a copy of the examiner's written statement. The program or facility must inform the patient in writing of the right to (1) leave after 72 hours, (2) have a medical examination within 48 hours, and (3) request a change to voluntary status. The facility or program shall assist the patient in exercising the rights granted in this subdivision.

(e) The facility or program must not allow the patient nor require the patient's consent to participate in a clinical drug trial during an emergency admission or hold under this subdivision. If a patient gives consent to participate in a drug trial during a period of an emergency admission or hold, it is void and unenforceable. This paragraph does not prohibit a patient from continuing participation in a clinical drug trial if the patient was participating in the clinical drug trial at the time of the emergency admission or hold.

Subd. 3. **Duration of hold, release procedures, and change of status.** (a) If a peace officer or health officer transports a person to a treatment facility, state-operated treatment program, or community-based treatment program under subdivision 1, an examiner at the facility or program must examine the patient and make a determination about the need for an emergency hold as soon as possible and within 12 hours of the person's arrival. The peace officer or health officer hold ends upon whichever occurs first: (1) initiation of an emergency hold on the person under subdivision 2; (2) the person's voluntary admission; (3) the examiner's decision not to admit the person; or (4) 12 hours after the person's arrival.

(b) Under this section, the facility or program may hold a patient up to 72 hours, exclusive of Saturdays, Sundays, and legal holidays, after the examiner signs the written statement for an emergency hold of the patient. The facility or program must release a patient when the emergency hold expires unless the facility or program obtains a court order to hold the patient. The facility or program may not place the patient on a consecutive emergency hold under this section.

(c) If the interested person files a petition to civilly commit the patient, the court may issue a judicial hold order pursuant to section 253B.07, subdivision 2b.

(d) During the 72-hour hold, a court must not release a patient under this section unless the court received a written petition for the patient's release and the court has held a summary hearing regarding the patient's release.

(e) The written petition for the patient's release must include the patient's name, the basis for the hold, the location of the hold, and a statement explaining why the hold is improper. The petition must also include copies of any written documentation under subdivision 1 or 2 that support the hold, unless the facility or program holding the patient refuses to supply the documentation. Upon receipt of a petition, the court must comply with the following:

(1) the court must hold the hearing as soon as practicable and the court may conduct the hearing by telephone conference call, interactive video conference, or similar method by which the participants are able to simultaneously hear each other;

(2) before deciding to release the patient, the court shall make every reasonable effort to provide notice of the proposed release and reasonable opportunity to be heard to:

(i) any specific individuals identified in a statement under subdivision 1 or 2 or individuals identified in the record who might be endangered if the person is not held;

(ii) the examiner whose written statement was the basis for the hold under subdivision 2; and

(iii) the peace officer or health officer who applied for a hold under subdivision 1; and

(3) if the court decides to release the patient, the court shall direct the patient's release and shall issue written findings supporting the decision. The facility or program must not delay the patient's release pending the written order.

(f) Notwithstanding section 144.293, subdivisions 2 and 4, if a treatment facility, state-operated treatment program, or community-based treatment program releases or discharges a patient during the 72-hour hold; the examiner refuses to admit the patient; or the patient leaves without the consent of the treating health care provider, the head of the treatment facility, state-operated treatment program, or community-based treatment program shall immediately notify the agency that employs the peace officer or health officer who initiated the transport hold. This paragraph does not apply to the extent that the notice would violate federal law governing the confidentiality of alcohol and drug abuse patient records under Code of Federal Regulations, title 42, part 2.

(g) If a patient is intoxicated in public and a facility or program holds the patient under this section for detoxification, a treatment facility, state-operated treatment program, or community-based treatment program may release the patient without providing notice under paragraph (f) as soon as the treatment facility, state-operated treatment program, or community-based treatment program determines that the person is no longer in danger of causing harm to self or others. The facility or program must provide notice to the peace officer or health officer who transported the person, or to the appropriate law enforcement agency, if the officer or agency requests notification.

(h) A treatment facility or state-operated treatment program must change a patient's status to voluntary status as provided in section 253B.04 upon the patient's request in writing if the head of the facility or program consents to the change.

Sec. 34. Minnesota Statutes 2018, section 253B.06, subdivision 1, is amended to read:

Subdivision 1. **Persons ~~who are mentally ill or developmentally disabled~~ with mental illness or developmental disability.** A physician must examine every patient hospitalized

~~as mentally ill or developmentally disabled~~ due to mental illness or developmental disability pursuant to section 253B.04 or ~~253B.05 must be examined by a physician~~ 253B.051 as soon as possible but no more than 48 hours following the patient's admission. The physician ~~shall~~ must be knowledgeable and trained in ~~the diagnosis of~~ diagnosing the ~~alleged disability related to the need for~~ patient's mental illness or developmental disability, forming the basis of the patient's admission ~~as a person who is mentally ill or developmentally disabled~~.

Sec. 35. Minnesota Statutes 2018, section 253B.06, subdivision 2, is amended to read:

Subd. 2. **Chemically dependent persons.** ~~Patients hospitalized~~ A treatment facility, state-operated treatment program, or community-based treatment program must examine a patient hospitalized as chemically dependent pursuant to section 253B.04 or ~~253B.05 shall also be examined~~ 253B.051 within 48 hours of admission. At a minimum, ~~the examination shall consist of a physical evaluation by facility staff~~ the facility or program must physically examine the patient according to procedures established by a physician, and ~~an evaluation by~~ staff examining the patient must be knowledgeable and trained in the diagnosis of the alleged disability ~~related to the need for~~ forming the basis of the patient's admission as a chemically dependent person.

Sec. 36. Minnesota Statutes 2018, section 253B.06, subdivision 3, is amended to read:

Subd. 3. **Discharge.** At the end of a 48-hour period, ~~any~~ the facility or program shall discharge a patient admitted pursuant to section ~~253B.05 shall be discharged~~ 253B.051 if an examination has not been held or if the examiner or evaluation staff person fails to notify the head of the ~~treatment~~ facility or program in writing that in the examiner's or staff person's opinion the patient is ~~apparently~~ in need of care, treatment, and evaluation as a ~~mentally ill, developmentally disabled, or chemically dependent~~ person who has a mental illness, developmental disability, or chemical dependency.

Sec. 37. Minnesota Statutes 2018, section 253B.07, subdivision 1, is amended to read:

Subdivision 1. **Prepetition screening.** (a) Prior to filing a petition for commitment of ~~or early intervention for~~ a proposed patient, an interested person shall apply to the designated agency in the county of financial responsibility or the county where the proposed patient is present for conduct of a preliminary investigation as provided in section 253B.23, subdivision 1b, except when the proposed patient has been acquitted of a crime under section 611.026 and the county attorney is required to file a petition for commitment. The designated agency shall appoint a screening team to conduct an investigation. The petitioner may not be a member of the screening team. The investigation must include:

(1) ~~a personal~~ an interview with the proposed patient and other individuals who appear to have knowledge of the condition of the proposed patient, if practicable. In-person interviews with the proposed patient are preferred. If the proposed patient is not interviewed, specific reasons must be documented;

(2) identification and investigation of specific alleged conduct which is the basis for application;

(3) identification, exploration, and listing of the specific reasons for rejecting or recommending alternatives to involuntary placement;

(4) in the case of a commitment based on mental illness, ~~the following~~ information~~, if it is known or available,~~ that may be relevant to the administration of neuroleptic medications, including the existence of a declaration under section 253B.03, subdivision 6d, or a health care directive under chapter 145C or a guardian, conservator, proxy, or agent with authority to make health care decisions for the proposed patient; information regarding the capacity of the proposed patient to make decisions regarding administration of neuroleptic medication; and whether the proposed patient is likely to consent or refuse consent to administration of the medication;

(5) seeking input from the proposed patient's health plan company to provide the court with information about ~~services the enrollee needs and the least restrictive alternatives~~ the patient's relevant treatment history and current treatment providers; and

(6) in the case of a commitment based on mental illness, information listed in clause (4) for other purposes relevant to treatment.

(b) In conducting the investigation required by this subdivision, the screening team shall have access to all relevant medical records of proposed patients currently in treatment facilities, state-operated treatment programs, or community-based treatment programs. The interviewer shall inform the proposed patient that any information provided by the proposed patient may be included in the prepetition screening report and may be considered in the commitment proceedings. Data collected pursuant to this clause shall be considered private data on individuals. The prepetition screening report is not admissible as evidence except by agreement of counsel or as permitted by this chapter or the rules of court and is not admissible in any court proceedings unrelated to the commitment proceedings.

(c) The prepetition screening team shall provide a notice, written in easily understood language, to the proposed patient, the petitioner, persons named in a declaration under chapter 145C or section 253B.03, subdivision 6d, and, with the proposed patient's consent, other interested parties. The team shall ask the patient if the patient wants the notice read

and shall read the notice to the patient upon request. The notice must contain information regarding the process, purpose, and legal effects of civil commitment ~~and early intervention~~. The notice must inform the proposed patient that:

(1) if a petition is filed, the patient has certain rights, including the right to a court-appointed attorney, the right to request a second court examiner, the right to attend hearings, and the right to oppose the proceeding and to present and contest evidence; and

(2) if the proposed patient is committed to a ~~state regional treatment center or group home~~ state-operated treatment program, the patient may be billed for the cost of care and the state has the right to make a claim against the patient's estate for this cost.

The ombudsman for mental health and developmental disabilities shall develop a form for the notice which includes the requirements of this paragraph.

(d) When the prepetition screening team recommends commitment, a written report shall be sent to the county attorney for the county in which the petition is to be filed. The statement of facts contained in the written report must meet the requirements of subdivision 2, paragraph (b).

(e) The prepetition screening team shall refuse to support a petition if the investigation does not disclose evidence sufficient to support commitment. Notice of the prepetition screening team's decision shall be provided to the prospective petitioner, any specific individuals identified in the examiner's statement, and to the proposed patient.

(f) If the interested person wishes to proceed with a petition contrary to the recommendation of the prepetition screening team, application may be made directly to the county attorney, who shall determine whether or not to proceed with the petition. Notice of the county attorney's determination shall be provided to the interested party.

(g) If the proposed patient has been acquitted of a crime under section 611.026, the county attorney shall apply to the designated county agency in the county in which the acquittal took place for a preliminary investigation unless substantially the same information relevant to the proposed patient's current mental condition, as could be obtained by a preliminary investigation, is part of the court record in the criminal proceeding or is contained in the report of a mental examination conducted in connection with the criminal proceeding. If a court petitions for commitment pursuant to the Rules of Criminal or Juvenile Procedure or a county attorney petitions pursuant to acquittal of a criminal charge under section 611.026, the prepetition investigation, if required by this section, shall be completed within seven days after the filing of the petition.

Sec. 38. Minnesota Statutes 2018, section 253B.07, subdivision 2, is amended to read:

Subd. 2. **The petition.** (a) Any interested person, except a member of the prepetition screening team, may file a petition for commitment in the district court of the county of financial responsibility or the county where the proposed patient is present. If the head of the treatment facility, state-operated treatment program, or community-based treatment program believes that commitment is required and no petition has been filed, ~~the head of the treatment facility~~ that person shall petition for the commitment of the ~~person~~ proposed patient.

(b) The petition shall set forth the name and address of the proposed patient, the name and address of the patient's nearest relatives, and the reasons for the petition. The petition must contain factual descriptions of the proposed patient's recent behavior, including a description of the behavior, where it occurred, and the time period over which it occurred. Each factual allegation must be supported by observations of witnesses named in the petition. Petitions shall be stated in behavioral terms and shall not contain judgmental or conclusory statements.

(c) The petition shall be accompanied by a written statement by an examiner stating that the examiner has examined the proposed patient within the 15 days preceding the filing of the petition and is of the opinion that the proposed patient ~~is suffering~~ has a designated disability and should be committed to a treatment facility, state-operated treatment program, or community-based treatment program. The statement shall include the reasons for the opinion. In the case of a commitment based on mental illness, the petition and the examiner's statement shall include~~, to the extent this information is available,~~ a statement and opinion regarding the proposed patient's need for treatment with neuroleptic medication and the patient's capacity to make decisions regarding the administration of neuroleptic medications, and the reasons for the opinion. If use of neuroleptic medications is recommended by the treating ~~physician~~ medical practitioner or other qualified medical provider, the petition for commitment must, if applicable, include or be accompanied by a request for proceedings under section 253B.092. Failure to include the required information regarding neuroleptic medications in the examiner's statement, or to include a request for an order regarding neuroleptic medications with the commitment petition, is not a basis for dismissing the commitment petition. If a petitioner has been unable to secure a statement from an examiner, the petition shall include documentation that a reasonable effort has been made to secure the supporting statement.

Sec. 39. Minnesota Statutes 2018, section 253B.07, subdivision 2a, is amended to read:

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

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

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

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

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

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

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

Sec. 40. Minnesota Statutes 2018, section 253B.07, subdivision 2b, is amended to read:

Subd. 2b. **Apprehend and hold orders.** (a) The court may order the treatment facility or state-operated treatment program to hold the ~~person in a treatment facility~~ proposed patient or direct a health officer, peace officer, or other person to take the proposed patient into custody and transport the proposed patient to a treatment facility or state-operated

treatment program for observation, evaluation, diagnosis, care, treatment, and, if necessary, confinement, when:

(1) there has been a particularized showing by the petitioner that serious physical harm to the proposed patient or others is likely unless the proposed patient is immediately apprehended;

(2) the proposed patient has not voluntarily appeared for the examination or the commitment hearing pursuant to the summons; or

(3) a person is held pursuant to section ~~253B.05~~ 253B.051 and a request for a petition for commitment has been filed.

(b) The order of the court may be executed on any day and at any time by the use of all necessary means including the imposition of necessary restraint upon the proposed patient. Where possible, a peace officer taking the proposed patient into custody pursuant to this subdivision shall not be in uniform and shall not use a ~~motor~~ vehicle visibly marked as a ~~police~~ law enforcement vehicle. Except as provided in section 253D.10, subdivision 2, in the case of an individual on a judicial hold due to a petition for civil commitment under chapter 253D, assignment of custody during the hold is to the commissioner ~~of human services~~. The commissioner is responsible for determining the appropriate placement within a secure treatment facility under the authority of the commissioner.

(c) A proposed patient must not be allowed or required to consent to nor participate in a clinical drug trial while an order is in effect under this subdivision. A consent given while an order is in effect is void and unenforceable. This paragraph does not prohibit a patient from continuing participation in a clinical drug trial if the patient was participating in the clinical drug trial at the time the order was issued under this subdivision.

Sec. 41. Minnesota Statutes 2018, section 253B.07, subdivision 2d, is amended to read:

Subd. 2d. **Change of venue.** Either party may move to have the venue of the petition changed to the district court of the Minnesota county where the person currently lives, whether independently or pursuant to a placement. The county attorney of the proposed county of venue must be notified of the motion and provided the opportunity to respond before the court rules on the motion. The court shall grant the motion if it determines that the transfer is appropriate and is in the interests of justice. If the petition has been filed pursuant to the Rules of Criminal or Juvenile Procedure, venue may not be changed without the agreement of the county attorney of the proposed county of venue and the approval of the court in which the juvenile or criminal proceedings are pending.

Sec. 42. Minnesota Statutes 2018, section 253B.07, subdivision 3, is amended to read:

Subd. 3. **Court-appointed examiners.** After a petition has been filed, the court shall appoint ~~an~~ a court examiner. Prior to the hearing, the court shall inform the proposed patient of the right to an independent second examination. At the proposed patient's request, the court shall appoint a second court examiner of the patient's choosing to be paid for by the county at a rate of compensation fixed by the court.

Sec. 43. Minnesota Statutes 2018, section 253B.07, subdivision 5, is amended to read:

Subd. 5. **Prehearing examination; report.** The examination shall be held at a treatment facility or other suitable place the court determines is not likely to harm the health of the proposed patient. The county attorney and the patient's attorney may be present during the examination. Either party may waive this right. Unless otherwise agreed by the parties, a ~~court-appointed~~ court examiner shall file the report with the court not less than 48 hours prior to the commitment hearing. The court shall ensure that copies of the court examiner's report are provided to the county attorney, the proposed patient, and the patient's counsel.

Sec. 44. Minnesota Statutes 2018, section 253B.07, subdivision 7, is amended to read:

Subd. 7. **Preliminary hearing.** (a) No proposed patient may be held in a treatment facility or state-operated treatment program under a judicial hold pursuant to subdivision 2b longer than 72 hours, exclusive of Saturdays, Sundays, and legal holidays, unless the court holds a preliminary hearing and determines that the standard is met to hold the ~~person~~ proposed patient.

(b) The proposed patient, patient's counsel, the petitioner, the county attorney, and any other persons as the court directs shall be given at least 24 hours written notice of the preliminary hearing. The notice shall include the alleged grounds for confinement. The proposed patient shall be represented at the preliminary hearing by counsel. The court may admit reliable hearsay evidence, including written reports, for the purpose of the preliminary hearing.

(c) The court, on its motion or on the motion of any party, may exclude or excuse a proposed patient who is seriously disruptive or who is incapable of comprehending and participating in the proceedings. In such instances, the court shall, with specificity on the record, state the behavior of the proposed patient or other circumstances which justify proceeding in the absence of the proposed patient.

(d) The court may continue the judicial hold of the proposed patient if it finds, by a preponderance of the evidence, that serious physical harm to the proposed patient or others is likely if the proposed patient is not immediately confined. If a proposed patient was acquitted of a crime against the person under section 611.026 immediately preceding the filing of the petition, the court may presume that serious physical harm to the patient or others is likely if the proposed patient is not immediately confined.

(e) Upon a showing that a ~~person~~ proposed patient subject to a petition for commitment may need treatment with neuroleptic medications and that the ~~person~~ proposed patient may lack capacity to make decisions regarding that treatment, the court may appoint a substitute decision-maker as provided in section 253B.092, subdivision 6. The substitute decision-maker shall meet with the proposed patient and provider and make a report to the court at the hearing under section 253B.08 regarding whether the administration of neuroleptic medications is appropriate under the criteria of section 253B.092, subdivision 7. If the substitute decision-maker consents to treatment with neuroleptic medications and the proposed patient does not refuse the medication, neuroleptic medication may be administered to the proposed patient. If the substitute decision-maker does not consent or the proposed patient refuses, neuroleptic medication may not be administered without a court order, or in an emergency as set forth in section 253B.092, subdivision 3.

Sec. 45. Minnesota Statutes 2018, section 253B.08, subdivision 1, is amended to read:

Subdivision 1. **Time for commitment hearing.** (a) The hearing on the commitment petition shall be held within 14 days from the date of the filing of the petition, except that the hearing on a commitment petition pursuant to section 253D.07 shall be held within 90 days from the date of the filing of the petition. For good cause shown, the court may extend the time of hearing up to an additional 30 days. The proceeding shall be dismissed if the proposed patient has not had a hearing on a commitment petition within the allowed time.

(b) The proposed patient, or the head of the treatment facility or state-operated treatment program in which the ~~person~~ patient is held, may demand in writing at any time that the hearing be held immediately. Unless the hearing is held within five days of the date of the demand, exclusive of Saturdays, Sundays, and legal holidays, the petition shall be automatically dismissed if the patient is being held in a treatment facility or state-operated treatment program pursuant to court order. For good cause shown, the court may extend the time of hearing on the demand for an additional ten days. This paragraph does not apply to a commitment petition brought under section 253B.18 or chapter 253D.

Sec. 46. Minnesota Statutes 2018, section 253B.08, subdivision 2a, is amended to read:

Subd. 2a. **Place of hearing.** The hearing shall be conducted in a manner consistent with orderly procedure. The hearing shall be held at a courtroom meeting standards prescribed by local court rule which may be at a treatment facility or state-operated treatment program. The hearing may be conducted by interactive video conference under General Rules of Practice, rule 131, and Minnesota Rules of Civil Commitment, rule 14.

Sec. 47. Minnesota Statutes 2018, section 253B.08, subdivision 5, is amended to read:

Subd. 5. **Absence permitted.** (a) The court may permit the proposed patient to waive the right to attend the hearing if it determines that the waiver is freely given. At the time of the hearing, the proposed patient shall not be so under the influence of drugs, medication, or other treatment so as to be hampered in participating in the proceedings. When the ~~licensed physician or licensed psychologist attending the patient~~ professional responsible for the proposed patient's treatment is of the opinion that the discontinuance of ~~drugs,~~ medication~~,~~ or other treatment is not in the best interest of the proposed patient, the court, at the time of the hearing, shall be presented a record of all ~~drugs,~~ medication or other treatment which the proposed patient has received during the 48 hours immediately prior to the hearing.

(b) The court, on its own motion or on the motion of any party, may exclude or excuse a proposed patient who is seriously disruptive or who is incapable of comprehending and participating in the proceedings. In such instances, the court shall, with specificity on the record, state the behavior of the proposed patient or other circumstances justifying proceeding in the absence of the proposed patient.

Sec. 48. Minnesota Statutes 2018, section 253B.08, subdivision 5a, is amended to read:

Subd. 5a. **Witnesses.** The proposed patient or the patient's counsel and the county attorney may present and cross-examine witnesses, including court examiners, at the hearing. The court may in its discretion receive the testimony of any other person. Opinions of ~~court-appointed~~ court examiners may not be admitted into evidence unless the court examiner is present to testify, except by agreement of the parties.

Sec. 49. Minnesota Statutes 2018, section 253B.09, subdivision 1, is amended to read:

Subdivision 1. **Standard of proof.** (a) If the court finds by clear and convincing evidence that the proposed patient is a person ~~who is mentally ill, developmentally disabled, or chemically dependent~~ who poses a risk of harm due to mental illness, or is a person who has a developmental disability or chemical dependency, and after careful consideration of

reasonable alternative dispositions~~,~~ including but not limited to~~,~~ dismissal of petition~~,~~; voluntary outpatient care~~,~~; voluntary admission to a treatment facility, state-operated treatment program, or community-based treatment program; appointment of a guardian or conservator~~,~~; or release before commitment as provided for in subdivision 4, it finds that there is no suitable alternative to judicial commitment, the court shall commit the patient to the least restrictive treatment program or alternative programs which can meet the patient's treatment needs consistent with section 253B.03, subdivision 7.

(b) In deciding on the least restrictive program, the court shall consider a range of treatment alternatives including~~,~~ but not limited to~~,~~ community-based nonresidential treatment, community residential treatment, partial hospitalization, acute care hospital, assertive community treatment teams, and ~~regional~~ state-operated treatment ~~center services~~ programs. The court shall also consider the proposed patient's treatment preferences and willingness to participate voluntarily in the treatment ordered. The court may not commit a patient to a facility or program that is not capable of meeting the patient's needs.

(c) If, after careful consideration of reasonable alternative dispositions, the court finds no suitable alternative to judicial commitment and the court finds that the least restrictive alternative as determined in paragraph (a) is a treatment facility or community-based treatment program that is less restrictive or more community based than a state-operated treatment program, and there is a treatment facility or a community-based treatment program willing to accept the civilly committed patient, the court may commit the patient to both the treatment facility or community-based treatment program and to the commissioner, in the event that treatment in a state-operated treatment program becomes the least restrictive alternative. If there is a change in the patient's level of care, then:

(1) if the patient needs a higher level of care requiring admission to a state-operated treatment program, custody of the patient and authority and responsibility for the commitment may be transferred to the commissioner for as long as the patient needs a higher level of care; and

(2) when the patient no longer needs treatment in a state-operated treatment program, the program may provisionally discharge the patient to an appropriate placement or release the patient to the treatment facility or community-based treatment program if the program continues to be willing and able to readmit the patient, in which case the commitment, its authority, and responsibilities revert to the non-state-operated treatment program. Both agencies accepting commitment shall coordinate admission and discharge planning to facilitate timely access to the other's services to meet the patient's needs and shall coordinate treatment planning consistent with section 253B.03, subdivision 7.

~~(c)~~ (d) If ~~the commitment as mentally ill, chemically dependent, or developmentally disabled is to a service facility provided by the commissioner of human services~~ a person is committed to a state-operated treatment program as a person who poses a risk of harm due to mental illness or as a person who has a developmental disability or chemical dependency, the court shall order the commitment to the commissioner. The commissioner shall designate the placement of the person to the court.

~~(d)~~ (e) If the court finds a proposed patient to be a person who ~~is mentally ill~~ poses a risk of harm due to mental illness under section 253B.02, subdivision 13, ~~paragraph (a),~~ clause ~~(2) or~~ (4), the court shall commit the patient to a treatment facility or community-based treatment program that meets the proposed patient's needs. ~~For purposes of this paragraph, a community-based program may include inpatient mental health services at a community hospital.~~

Sec. 50. Minnesota Statutes 2018, section 253B.09, subdivision 2, is amended to read:

Subd. 2. **Findings.** (a) The court shall find the facts specifically, and separately state its conclusions of law. Where commitment is ordered, the findings of fact and conclusions of law shall specifically state the proposed patient's conduct which is a basis for determining that each of the requisites for commitment is met.

(b) If commitment is ordered, the findings shall also identify less restrictive alternatives considered and rejected by the court and the reasons for rejecting each alternative.

(c) If the proceedings are dismissed, the court may direct that the person be transported back to a suitable location including to the person's home.

Sec. 51. Minnesota Statutes 2018, section 253B.09, subdivision 3a, is amended to read:

Subd. 3a. **Reporting judicial commitments; private treatment program or facility.** Notwithstanding section 253B.23, subdivision 9, when a court commits a patient to a non-state-operated treatment facility or program ~~or facility other than a state-operated program or facility~~, the court shall report the commitment to the commissioner through the supreme court information system for purposes of providing commitment information for firearm background checks under section 245.041. If the patient is committed to a state-operated treatment program, the court shall send a copy of the commitment order to the commissioner.

Sec. 52. Minnesota Statutes 2018, section 253B.09, subdivision 5, is amended to read:

Subd. 5. **Initial commitment period.** The initial commitment begins on the date that the court issues its order or warrant under section 253B.10, subdivision 1. For ~~persons~~ a person committed as ~~mentally ill, developmentally disabled,~~ a person who poses a risk of harm due to mental illness, a developmental disability, or ~~chemically dependent~~ chemical dependency, the initial commitment shall not exceed six months.

Sec. 53. Minnesota Statutes 2018, section 253B.092, is amended to read:

253B.092 ADMINISTRATION OF NEUROLEPTIC MEDICATION.

Subdivision 1. **General.** Neuroleptic medications may be administered, only as provided in this section, to patients subject to ~~early intervention or~~ civil commitment ~~as mentally ill, mentally ill and dangerous, a sexually dangerous person, or a person with a sexual psychopathic personality~~ under this chapter or chapter 253D. For purposes of this section, "patient" includes a proposed patient who is the subject of a petition for ~~early intervention or~~ commitment and a committed person as defined in section 253D.02, subdivision 4.

Subd. 2. **Administration without judicial review.** (a) Neuroleptic medications may be administered without judicial review in the following circumstances:

(1) the patient has the capacity to make an informed decision under subdivision 4;

(2) the patient does not have the present capacity to consent to the administration of neuroleptic medication, but prepared a health care power of attorney, a health care directive under chapter 145C, or a declaration under section 253B.03, subdivision 6d, requesting treatment or authorizing an agent or proxy to request treatment, and the agent or proxy has requested the treatment;

(3) the patient has been prescribed neuroleptic medication prior to admission to a treatment facility, but lacks the present capacity to consent to the administration of that neuroleptic medication; continued administration of the medication is in the patient's best interest; and the patient does not refuse administration of the medication. In this situation, the previously prescribed neuroleptic medication may be continued for up to 14 days while the treating ~~physician~~ medical practitioner:

(i) is obtaining a substitute decision-maker appointed by the court under subdivision 6; or

(ii) is requesting a court order authorizing administering neuroleptic medication or an amendment to a current court order authorizing administration of neuroleptic medication;

(4) a substitute decision-maker appointed by the court consents to the administration of the neuroleptic medication and the patient does not refuse administration of the medication; or

(5) the substitute decision-maker does not consent or the patient is refusing medication, and the patient is in an emergency situation.

(b) For the purposes of paragraph (a), clause (3), if a person requests a substitute decision-maker or requests a court order administering neuroleptic medication within 14 days, the treating medical practitioner may continue administering the medication to the patient through the hearing date or until the court otherwise issues an order.

Subd. 3. **Emergency administration.** A treating ~~physician~~ medical practitioner may administer neuroleptic medication to a patient who does not have capacity to make a decision regarding administration of the medication if the patient is in an emergency situation. Medication may be administered for so long as the emergency continues to exist, up to 14 days, if the treating ~~physician~~ medical practitioner determines that the medication is necessary to prevent serious, immediate physical harm to the patient or to others. If a request for authorization to administer medication is made to the court within the 14 days, the treating ~~physician~~ medical practitioner may continue the medication through the date of the first court hearing, if the emergency continues to exist. If the request for authorization to administer medication is made to the court in conjunction with a petition for commitment ~~or early intervention~~ and the court makes a determination at the preliminary hearing under section 253B.07, subdivision 7, that there is sufficient cause to continue the ~~physician's~~ medical practitioner's order until the hearing under section 253B.08, the treating ~~physician~~ medical practitioner may continue the medication until that hearing, if the emergency continues to exist. The treatment facility, state-operated treatment program, or community-based treatment program shall document the emergency in the patient's medical record in specific behavioral terms.

Subd. 4. **Patients with capacity to make informed decision.** A patient who has the capacity to make an informed decision regarding the administration of neuroleptic medication may consent or refuse consent to administration of the medication. The informed consent of a patient must be in writing.

Subd. 5. **Determination of capacity.** (a) There is a rebuttable presumption that a patient ~~is presumed to have~~ has the capacity to make decisions regarding administration of neuroleptic medication.

(b) ~~In determining~~ A ~~person's~~ patient has the capacity to make decisions regarding the administration of neuroleptic medication~~, the court shall consider~~ if the patient:

(1) ~~whether the person demonstrates~~ has an awareness of the nature of the ~~person's~~ patient's situation, including the reasons for hospitalization, and the possible consequences of refusing treatment with neuroleptic medications;

(2) ~~whether the person demonstrates~~ has an understanding of treatment with neuroleptic medications and the risks, benefits, and alternatives; and

(3) ~~whether the person~~ communicates verbally or nonverbally a clear choice regarding treatment with neuroleptic medications that is a reasoned one not based on ~~delusion~~ a symptom of the patient's mental illness, even though it may not be in the ~~person's~~ patient's best interests.

(c) Disagreement with the ~~physician's~~ medical practitioner's recommendation alone is not evidence of an unreasonable decision.

Subd. 6. **Patients without capacity to make informed decision; substitute decision-maker.** (a) Upon request of any person, and upon a showing that administration of neuroleptic medications may be recommended and that the ~~person~~ patient may lack capacity to make decisions regarding the administration of neuroleptic medication, the court shall appoint a substitute decision-maker with authority to consent to the administration of neuroleptic medication as provided in this section. A hearing is not required for an appointment under this paragraph. The substitute decision-maker must be an individual or a community or institutional multidisciplinary panel designated by the local mental health authority. In appointing a substitute decision-maker, the court shall give preference to a guardian ~~or conservator~~, proxy, or health care agent with authority to make health care decisions for the patient. The court may provide for the payment of a reasonable fee to the substitute decision-maker for services under this section or may appoint a volunteer.

(b) If the ~~person's treating physician~~ patient's treating medical practitioner recommends treatment with neuroleptic medication, the substitute decision-maker may give or withhold consent to the administration of the medication, based on the standards under subdivision 7. If the substitute decision-maker gives informed consent to the treatment and the ~~person~~ patient does not refuse, the substitute decision-maker shall provide written consent to the treating ~~physician~~ medical practitioner and the medication may be administered. The substitute decision-maker shall also notify the court that consent has been given. If the substitute decision-maker refuses or withdraws consent or the ~~person~~ patient refuses the

medication, neuroleptic medication ~~may~~ must not be administered to the ~~person without~~ patient except with a court order or in an emergency.

(c) A substitute decision-maker appointed under this section has access to the relevant sections of the patient's health records on the past or present administration of medication. The designated agency or a person involved in the patient's physical or mental health care may disclose information to the substitute decision-maker for the sole purpose of performing the responsibilities under this section. The substitute decision-maker may not disclose health records obtained under this paragraph except to the extent necessary to carry out the duties under this section.

(d) At a hearing under section 253B.08, the petitioner has the burden of proving incapacity by a preponderance of the evidence. If a substitute decision-maker has been appointed by the court, the court shall make findings regarding the patient's capacity to make decisions regarding the administration of neuroleptic medications and affirm or reverse its appointment of a substitute decision-maker. If the court affirms the appointment of the substitute decision-maker, and if the substitute decision-maker has consented to the administration of the medication and the patient has not refused, the court shall make findings that the substitute decision-maker has consented and the treatment is authorized. If a substitute decision-maker has not yet been appointed, upon request the court shall make findings regarding the patient's capacity and appoint a substitute decision-maker if appropriate.

(e) If an order for civil commitment ~~or early intervention~~ did not provide for the appointment of a substitute decision-maker or for the administration of neuroleptic medication, ~~the~~ a treatment facility, state-operated treatment program, or community-based treatment program may later request the appointment of a substitute decision-maker upon a showing that administration of neuroleptic medications is recommended and that the ~~person~~ patient lacks capacity to make decisions regarding the administration of neuroleptic medications. A hearing is not required in order to administer the neuroleptic medication unless requested under subdivision 10 or if the substitute decision-maker withholds or refuses consent or the ~~person~~ patient refuses the medication.

(f) The substitute decision-maker's authority to consent to treatment lasts for the duration of the court's order of appointment or until modified by the court.

~~If the substitute decision-maker withdraws consent or the patient refuses consent, neuroleptic medication may not be administered without a court order.~~

(g) If there is no hearing after the preliminary hearing, then the court shall, upon the request of any interested party, review the reasonableness of the substitute decision-maker's

decision based on the standards under subdivision 7. The court shall enter an order upholding or reversing the decision within seven days.

Subd. 7. **When ~~person~~ patient lacks capacity to make decisions about medication.** (a) When a ~~person~~ patient lacks capacity to make decisions regarding the administration of neuroleptic medication, the substitute decision-maker or the court shall use the standards in this subdivision in making a decision regarding administration of the medication.

(b) If the ~~person~~ patient clearly stated what the ~~person~~ patient would choose to do in this situation when the ~~person~~ patient had the capacity to make a reasoned decision, the ~~person's~~ patient's wishes must be followed. Evidence of the ~~person's~~ patient's wishes may include written instruments, including a durable power of attorney for health care under chapter 145C or a declaration under section 253B.03, subdivision 6d.

(c) If evidence of the ~~person's~~ patient's wishes regarding the administration of neuroleptic medications is conflicting or lacking, the decision must be based on what a reasonable person would do, taking into consideration:

(1) the ~~person's~~ patient's family, community, moral, religious, and social values;

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

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

(4) any other relevant factors.

Subd. 8. **Procedure when patient refuses neuroleptic medication.** (a) If the substitute decision-maker or the patient refuses to consent to treatment with neuroleptic medications, and absent an emergency as set forth in subdivision 3, neuroleptic medications may not be administered without a court order. Upon receiving a written request for a hearing, the court shall schedule the hearing within 14 days of the request. The matter may be heard as part of any other district court proceeding under this chapter. By agreement of the parties or for good cause shown, the court may extend the time of hearing an additional 30 days.

(b) The patient must be examined by a court examiner prior to the hearing. If the patient refuses to participate in an examination, the court examiner may rely on the patient's medical records to reach an opinion as to the appropriateness of neuroleptic medication. The patient is entitled to counsel and a second court examiner, if requested by the patient or patient's counsel.

(c) The court may base its decision on relevant and admissible evidence, including the testimony of a treating ~~physician~~ medical practitioner or other qualified physician, a member

of the patient's treatment team, a ~~court-appointed~~ court examiner, witness testimony, or the patient's medical records.

(d) If the court finds that the patient has the capacity to decide whether to take neuroleptic medication or that the patient lacks capacity to decide and the standards for making a decision to administer the medications under subdivision 7 are not met, the ~~treating~~ treatment facility, state-operated treatment program, or community-based treatment program may not administer medication without the patient's informed written consent or without the declaration of an emergency, or until further review by the court.

(e) If the court finds that the patient lacks capacity to decide whether to take neuroleptic medication and has applied the standards set forth in subdivision 7, the court may authorize the ~~treating~~ treatment facility, state-operated treatment program, or community-based treatment program and any other ~~community or treatment~~ facility or program to which the patient may be transferred or provisionally discharged, to involuntarily administer the medication to the patient. A copy of the order must be given to the patient, the patient's attorney, the county attorney, and the treatment facility, state-operated treatment program, or community-based treatment program. The treatment facility, state-operated treatment program, or community-based treatment program may not begin administration of the neuroleptic medication until it notifies the patient of the court's order authorizing the treatment.

(f) A finding of lack of capacity under this section must not be construed to determine the patient's competence for any other purpose.

(g) The court may authorize the administration of neuroleptic medication until the termination of a determinate commitment. If the patient is committed for an indeterminate period, the court may authorize treatment of neuroleptic medication for not more than two years, subject to the patient's right to petition the court for review of the order. The treatment facility, state-operated treatment program, or community-based treatment program must submit annual reports to the court, which shall provide copies to the patient and the respective attorneys.

(h) The court may limit the maximum dosage of neuroleptic medication that may be administered.

(i) If physical force is required to administer the neuroleptic medication, the facility or program may only use injectable medications. If physical force is needed to administer the medication, medication may only ~~take place~~ be administered in a ~~treatment facility or therapeutic~~ setting where the person's condition can be reassessed and ~~appropriate~~ medical

~~staff~~ personnel qualified to administer medication are available, including in the community, a county jail, or a correctional facility. The facility or program may not use a nasogastric tube to administer neuroleptic medication involuntarily.

Subd. 9. **Immunity.** A substitute decision-maker who consents to treatment is not civilly or criminally liable for the performance of or the manner of performing the treatment. A person is not liable for performing treatment without consent if the substitute decision-maker has given written consent. This provision does not affect any other liability that may result from the manner in which the treatment is performed.

Subd. 10. **Review.** A patient or other person may petition the court under section 253B.17 for review of any determination under this section or for a decision regarding the administration of neuroleptic medications, appointment of a substitute decision-maker, or the patient's capacity to make decisions regarding administration of neuroleptic medications.

Sec. 54. Minnesota Statutes 2018, section 253B.0921, is amended to read:

253B.0921 ACCESS TO MEDICAL RECORDS.

A treating ~~physician~~ medical practitioner who makes medical decisions regarding the prescription and administration of medication for treatment of a mental illness has access to the relevant sections of a patient's health records on past administration of medication at any ~~treatment~~ facility, program, or treatment provider, if the patient lacks the capacity to authorize the release of records. Upon request of a treating ~~physician~~ medical practitioner under this section, a ~~treatment~~ facility, program, or treatment provider shall supply complete information relating to the past records on administration of medication of a patient subject to this chapter. A patient who has the capacity to authorize the release of data retains the right to make decisions regarding access to medical records as provided by sections 144.291 to 144.298.

Sec. 55. Minnesota Statutes 2018, section 253B.095, subdivision 3, is amended to read:

Subd. 3. **Duration.** The maximum duration of a stayed order under this section is six months. The court may continue the order for a maximum of an additional 12 months if, after notice and hearing, under sections 253B.08 and 253B.09 the court finds that (1) the person continues to ~~be mentally ill, chemically dependent, or developmentally disabled,~~ have a mental illness, developmental disability, or chemical dependency, and (2) an order is needed ~~to protect the patient or others~~ because the person is likely to attempt to physically harm self or others or fail to obtain necessary food, clothing, shelter, or medical care unless the person is under the supervision of a stayed commitment.

Sec. 56. Minnesota Statutes 2018, section 253B.097, subdivision 1, is amended to read:

Subdivision 1. **Findings.** In addition to the findings required under section 253B.09, subdivision 2, an order committing a person to a community-based treatment program must include:

(1) a written plan for services to the patient;

(2) a finding that the proposed treatment is available and accessible to the patient and that public or private financial resources are available to pay for the proposed treatment;

(3) conditions the patient must meet in order to obtain an early release from commitment or to avoid a hearing for further commitment; and

(4) consequences of the patient's failure to follow the commitment order. Consequences may include commitment to another setting for treatment.

Sec. 57. Minnesota Statutes 2018, section 253B.097, subdivision 2, is amended to read:

Subd. 2. **Case manager.** When a court commits a patient with mental illness to a community-based treatment program, the court shall appoint a case manager from the county agency or other entity under contract with the county agency to provide case management services.

Sec. 58. Minnesota Statutes 2018, section 253B.097, subdivision 3, is amended to read:

Subd. 3. **Reports.** The case manager shall report to the court at least once every 90 days. The case manager shall immediately report to the court a substantial failure of the patient or provider to comply with the conditions of the commitment.

Sec. 59. Minnesota Statutes 2018, section 253B.097, subdivision 6, is amended to read:

Subd. 6. **Immunity from liability.** No treatment facility, community-based treatment program, or person is financially liable, personally or otherwise, for the patient's actions ~~of the patient~~ if the facility or person follows accepted community standards of professional practice in the management, supervision, and treatment of the patient. For purposes of this subdivision, "person" means official, staff, employee of the treatment facility, community-based treatment program, physician, or other individual who is responsible for ~~the~~ a patient's management, supervision, or treatment ~~of a patient's community-based treatment~~ under this section.

Sec. 60. Minnesota Statutes 2018, section 253B.10, is amended to read:

253B.10 PROCEDURES UPON COMMITMENT.

Subdivision 1. **Administrative requirements.** (a) When a person is committed, the court shall issue a warrant or an order committing the patient to the custody of the head of the treatment facility, state-operated treatment program, or community-based treatment program. The warrant or order shall state that the patient meets the statutory criteria for civil commitment.

(b) The commissioner shall prioritize patients being admitted from jail or a correctional institution who are:

(1) ordered confined in a ~~state hospital~~ state-operated treatment program for an examination under Minnesota Rules of Criminal Procedure, rules 20.01, subdivision 4, paragraph (a), and 20.02, subdivision 2;

(2) under civil commitment for competency treatment and continuing supervision under Minnesota Rules of Criminal Procedure, rule 20.01, subdivision 7;

(3) found not guilty by reason of mental illness under Minnesota Rules of Criminal Procedure, rule 20.02, subdivision 8, and under civil commitment or are ordered to be detained in a ~~state hospital or other facility~~ state-operated treatment program pending completion of the civil commitment proceedings; or

(4) committed under this chapter to the commissioner after dismissal of the patient's criminal charges.

Patients described in this paragraph must be admitted to a ~~service operated by the commissioner~~ state-operated treatment program within 48 hours. The commitment must be ordered by the court as provided in section 253B.09, subdivision 1, paragraph ~~(c)~~ (d).

(c) Upon the arrival of a patient at the designated treatment facility, state-operated treatment program, or community-based treatment program, the head of the facility or program shall retain the duplicate of the warrant and endorse receipt upon the original warrant or acknowledge receipt of the order. The endorsed receipt or acknowledgment must be filed in the court of commitment. After arrival, the patient shall be under the control and custody of the head of the ~~treatment~~ facility or program.

(d) Copies of the petition for commitment, the court's findings of fact and conclusions of law, the court order committing the patient, the report of the court examiners, and the prepetition report, and any medical and behavioral information available shall be provided at the time of admission of a patient to the designated treatment facility or program to which

the patient is committed. Upon a patient's referral to the commissioner of human services for admission pursuant to subdivision 1, paragraph (b), any inpatient hospital, treatment facility, jail, or correctional facility that has provided care or supervision to the patient in the previous two years shall, when requested by the treatment facility or commissioner, provide copies of the patient's medical and behavioral records to the Department of Human Services for purposes of preadmission planning. This information shall be provided by the head of the treatment facility to treatment facility staff in a consistent and timely manner and pursuant to all applicable laws. ~~This information shall also be provided by the head of the treatment facility to treatment facility staff in a consistent and timely manner and pursuant to all applicable laws.~~

Subd. 2. **Transportation.** (a) When a patient is about to be placed in a treatment facility, state-operated treatment program, or community-based treatment program, the court may order the designated agency, the treatment facility, state-operated treatment program, or community-based treatment program, or any responsible adult to transport the patient ~~to the treatment facility~~. A protected transport provider may transport the patient according to section 256B.0625, subdivision 17. Whenever possible, a peace officer who provides the transportation shall not be in uniform and shall not use a vehicle visibly marked as a ~~police~~ law enforcement vehicle. The proposed patient may be accompanied by one or more interested persons.

(b) When a patient who is at a ~~regional~~ state-operated treatment ~~center~~ program requests a hearing for adjudication of a patient's status pursuant to section 253B.17, the commissioner shall provide transportation.

Subd. 3. **Notice of admission.** Whenever a committed person has been admitted to a treatment facility, state-operated treatment program, or community-based treatment program under the provisions of section 253B.09 or 253B.18, the head of the ~~treatment~~ facility or program shall immediately notify the patient's spouse, health care agent, or parent and the county of financial responsibility if the county may be liable for a portion of the cost of treatment. If the committed person was admitted upon the petition of a spouse, health care agent, or parent, the head of the treatment facility, state-operated treatment program, or community-based treatment program shall notify an interested person other than the petitioner.

Subd. 3a. **Interim custody and treatment of committed person.** When the patient is present in a treatment facility or state-operated treatment program at the time of the court's commitment order, unless the court orders otherwise, the commitment order constitutes

authority for that facility or program to confine and provide treatment to the patient until the patient is transferred to the facility or program to which the patient has been committed.

Subd. 4. **Private treatment.** Patients or other responsible persons are required to pay the necessary charges for patients committed or transferred to ~~private~~ treatment facilities or community-based treatment programs. ~~Private~~ Treatment facilities or community-based treatment programs may not refuse to accept a committed person solely based on the person's court-ordered status. Insurers must provide treatment and services as ordered by the court under section 253B.045, subdivision 6, or as required under chapter 62M.

Subd. 5. **Transfer to voluntary status.** At any time prior to the expiration of the initial commitment period, a patient who has not been committed as ~~mentally ill~~ a person who has a mental illness and is dangerous to the public or ~~as~~ a sexually dangerous person or ~~as~~ a sexual psychopathic personality may be transferred to voluntary status upon the patient's application in writing with the consent of the head of the facility or program to which the person is committed. Upon transfer, the head of the treatment facility, state-operated treatment program, or community-based treatment program shall immediately notify the court in writing and the court shall terminate the proceedings.

Sec. 61. Minnesota Statutes 2018, section 253B.12, subdivision 1, is amended to read:

Subdivision 1. **Reports.** (a) If a patient who was committed as a person ~~who is mentally ill, developmentally disabled, or chemically dependent~~ who poses a risk of harm due to a mental illness, or as a person who has a developmental disability or chemical dependency, is discharged from commitment within the first 60 days after the date of the initial commitment order, the head of the treatment facility, state-operated treatment program, or community-based treatment program shall file a written report with the committing court describing the patient's need for further treatment. A copy of the report must be provided to the county attorney, the patient, and the patient's counsel.

(b) If a patient who was committed as a person ~~who is mentally ill, developmentally disabled, or chemically dependent~~ who poses a risk of harm due to a mental illness, or as a person who has a developmental disability or chemical dependency, remains in treatment more than 60 days after the date of the commitment, then at least 60 days, but not more than 90 days, after the date of the order, the head of the facility or program that has custody of the patient shall file a written report with the committing court and provide a copy to the county attorney, the patient, and the patient's counsel. The report must set forth in detailed narrative form at least the following:

(1) the diagnosis of the patient with the supporting data;

(2) the anticipated discharge date;

(3) an individualized treatment plan;

(4) a detailed description of the discharge planning process with suggested after care plan;

(5) whether the patient is in need of further care and treatment, the treatment facility ~~which~~, state-operated treatment program, or community-based treatment program that is needed, and evidence to support the response;

(6) whether the patient satisfies the statutory requirement for continued commitment ~~to a treatment facility,~~ with documentation to support the opinion; ~~and~~

(7) a statement from the patient related to accepting treatment, if possible; and

~~(7)~~ (8) whether the administration of neuroleptic medication is clinically indicated, whether the patient is able to give informed consent to that medication, and the basis for these opinions.

(c) Prior to the termination of the initial commitment order or final discharge of the patient, the head of the ~~treatment~~ facility or program that has custody or care of the patient shall file a written report with the committing court with a copy to the county attorney, the patient, and the patient's counsel that sets forth the information required in paragraph (b).

(d) If the patient has been provisionally discharged from a ~~treatment~~ facility or program, the report shall be filed by the designated agency, which may submit the discharge report as part of its report.

(e) ~~If no written report is filed within the required time, or~~ If a report describes the patient as not in need of further ~~institutional care and~~ court-ordered treatment, the proceedings must be terminated by the committing court and the patient discharged from the treatment facility, state-operated treatment program, or community-based treatment program, unless the patient chooses to voluntarily receive services.

(f) If no written report is filed within the required time, the court must notify the county, facility or program to which the person is committed, and designated agency and require a report be filed within five business days. If a report is not filed within five business days a hearing must be held within three business days.

Sec. 62. Minnesota Statutes 2018, section 253B.12, subdivision 3, is amended to read:

Subd. 3. **Examination.** Prior to the review hearing, the court shall inform the patient of the right to an independent examination by ~~an~~ a court examiner chosen by the patient and

appointed in accordance with provisions of section 253B.07, subdivision 3. The report of the court examiner may be submitted at the hearing.

Sec. 63. Minnesota Statutes 2018, section 253B.12, subdivision 4, is amended to read:

Subd. 4. **Hearing; standard of proof.** (a) The committing court shall not make a final determination of the need to continue commitment unless the court finds by clear and convincing evidence that (1) the ~~person~~ patient continues to ~~be mentally ill, developmentally disabled, or chemically dependent~~ have a mental illness, developmental disability, or chemical dependency; (2) involuntary commitment is necessary for the protection of the patient or others; and (3) there is no alternative to involuntary commitment.

(b) In determining whether a ~~person~~ patient continues to ~~be mentally ill, chemically dependent, or developmentally disabled,~~ require commitment due to mental illness, developmental disability, or chemical dependency, the court need not find that there has been a recent attempt or threat to physically harm self or others, or a recent failure to provide necessary ~~personal~~ food, clothing, shelter, or medical care. Instead, the court must find that the patient is likely to attempt to physically harm self or others, or to fail to ~~provide~~ obtain necessary ~~personal~~ food, clothing, shelter, or medical care unless involuntary commitment is continued.

Sec. 64. Minnesota Statutes 2018, section 253B.12, subdivision 7, is amended to read:

Subd. 7. **Record required.** Where continued commitment is ordered, the findings of fact and conclusions of law shall specifically state the conduct of the proposed patient which is the basis for the final determination, that the statutory criteria of commitment continue to be met, and that less restrictive alternatives have been considered and rejected by the court. Reasons for rejecting each alternative shall be stated. A copy of the final order for continued commitment shall be forwarded to the head of the ~~treatment~~ facility or program to which the person is committed and, if the patient has been provisionally discharged, to the designated agency responsible for monitoring the provisional discharge.

Sec. 65. Minnesota Statutes 2018, section 253B.13, subdivision 1, is amended to read:

Subdivision 1. ~~**Mentally ill or chemically dependent**~~ **Persons with mental illness or chemical dependency.** (a) If at the conclusion of a review hearing the court finds that the person continues to ~~be mentally ill or chemically dependent~~ have mental illness or chemical dependency and ~~in~~ need ~~of~~ treatment or supervision, the court shall determine the length of

continued commitment. No period of commitment shall exceed this length of time or 12 months, whichever is less.

(b) At the conclusion of the prescribed period under paragraph (a), commitment may not be continued unless a new petition is filed pursuant to section 253B.07 and hearing and determination made on it. If the petition was filed before the end of the previous commitment and, for good cause shown, the court has not completed the hearing and the determination by the end of the commitment period, the court may for good cause extend the previous commitment for up to 14 days to allow the completion of the hearing and the issuance of the determination. The standard of proof for the new petition is the standard specified in section 253B.12, subdivision 4. Notwithstanding the provisions of section 253B.09, subdivision 5, the initial commitment period under the new petition shall be the probable length of commitment necessary or 12 months, whichever is less. ~~The standard of proof at the hearing on the new petition shall be the standard specified in section 253B.12, subdivision 4.~~

Sec. 66. Minnesota Statutes 2018, section 253B.14, is amended to read:

253B.14 TRANSFER OF COMMITTED PERSONS.

The commissioner may transfer any committed person, other than a person committed as ~~mentally ill and~~ a person who has a mental illness and is dangerous to the public, ~~or as~~ a sexually dangerous person or ~~as~~ a sexual psychopathic personality, from one ~~regional~~ state-operated treatment ~~center~~ program to any other state-operated treatment ~~facility under the commissioner's jurisdiction which is~~ program capable of providing proper care and treatment. When a committed person is transferred from one state-operated treatment ~~facility~~ program to another, written notice shall be given to the committing court, the county attorney, the patient's counsel, and to the person's parent, health care agent, or spouse or, if none is known, to an interested person, and the designated agency.

Sec. 67. Minnesota Statutes 2018, section 253B.141, is amended to read:

253B.141 AUTHORITY TO DETAIN AND TRANSPORT A MISSING PATIENT.

Subdivision 1. **Report of absence.** (a) If a patient committed under this chapter or detained in a treatment facility or state-operated treatment program under a judicial hold is absent without authorization, and either: (1) does not return voluntarily within 72 hours of the time the unauthorized absence began; or (2) is considered by the head of the ~~treatment~~ facility or program to be a danger to self or others, then the head of the ~~treatment~~ facility or program shall report the absence to the local law enforcement agency. The head of the

~~treatment~~ facility or program shall also notify the committing court that the patient is absent and that the absence has been reported to the local law enforcement agency. The committing court may issue an order directing the law enforcement agency to transport the patient to an appropriate treatment facility, state-operated treatment program, or community-based treatment program.

(b) Upon receiving a report that a patient subject to this section is absent without authorization, the local law enforcement agency shall enter information on the patient into the missing persons file of the National Crime Information Center computer according to the missing persons practices.

Subd. 2. **Apprehension; return to facility or program.** (a) Upon receiving the report of absence from the head of the treatment facility, state-operated treatment program, or community-based treatment program or the committing court, a patient may be apprehended and held by a peace officer in any jurisdiction pending return to the facility or program from which the patient is absent without authorization. A patient may also be returned to any ~~facility operated by the commissioner~~ state-operated treatment program or any other treatment facility or community-based treatment program willing to accept the person. A person who ~~is mentally ill~~ has a mental illness and is dangerous to the public and detained under this subdivision may be held in a jail or lockup only if:

(1) there is no other feasible place of detention for the patient;

(2) the detention is for less than 24 hours; and

(3) there are protections in place, including segregation of the patient, to ensure the safety of the patient.

(b) If a patient is detained under this subdivision, the head of the ~~treatment~~ facility or program from which the patient is absent shall arrange to pick up the patient within 24 hours of the time detention was begun and shall be responsible for securing transportation for the patient to the facility or program. The expense of detaining and transporting a patient shall be the responsibility of the ~~treatment~~ facility or program from which the patient is absent. The expense of detaining and transporting a patient to a state-operated treatment ~~facility operated by the Department of Human Services~~ program shall be paid by the commissioner unless paid by the patient or persons on behalf of the patient.

Subd. 3. **Notice of apprehension.** Immediately after an absent patient is located, the head of the ~~treatment~~ facility or program from which the patient is absent, or the law enforcement agency that located or returned the absent patient, shall notify the law enforcement agency that first received the absent patient report under this section and that

agency shall cancel the missing persons entry from the National Crime Information Center computer.

Sec. 68. Minnesota Statutes 2018, section 253B.15, subdivision 1, is amended to read:

Subdivision 1. **Provisional discharge.** (a) The head of the treatment facility, state-operated treatment program, or community-based treatment program may provisionally discharge any patient without discharging the commitment, unless the patient was found by the committing court to be a person who ~~is mentally ill and~~ has a mental illness and is dangerous to the public, ~~or~~ a sexually dangerous person, or a sexual psychopathic personality.

(b) When a patient committed to the commissioner becomes ready for provisional discharge before being placed in a state-operated treatment program, the head of the treatment facility or community-based treatment program where the patient is placed pending transfer to the commissioner may provisionally discharge the patient pursuant to this subdivision.

(c) Each patient released on provisional discharge shall have a written ~~aftercare~~ provisional discharge plan developed with input from the patient and the designated agency which specifies the services and treatment to be provided as part of the ~~aftercare~~ provisional discharge plan, the financial resources available to pay for the services specified, the expected period of provisional discharge, the precise goals for the granting of a final discharge, and conditions or restrictions on the patient during the period of the provisional discharge. The ~~aftercare~~ provisional discharge plan shall be provided to the patient, the patient's attorney, and the designated agency.

(d) The ~~aftercare~~ provisional discharge plan shall be reviewed on a quarterly basis by the patient, designated agency and other appropriate persons. The ~~aftercare~~ provisional discharge plan shall contain the grounds upon which a provisional discharge may be revoked. The provisional discharge shall terminate on the date specified in the plan unless specific action is taken to revoke or extend it.

Sec. 69. Minnesota Statutes 2018, section 253B.15, subdivision 1a, is amended to read:

Subd. 1a. **Representative of designated agency.** Before a provisional discharge is granted, a representative of the designated agency must be identified to ensure continuity of care by being involved with the treatment facility, state-operated treatment program, or community-based treatment program and the patient prior to the provisional discharge. The representative of the designated agency shall coordinate plans for and monitor the patient's aftercare program. When the patient is on a provisional discharge, the representative of the

designated agency shall provide the treatment report to the court required under section 253B.12, subdivision 1.

Sec. 70. Minnesota Statutes 2018, section 253B.15, subdivision 2, is amended to read:

Subd. 2. **Revocation of provisional discharge.** (a) The designated agency may ~~revoke~~ initiate with the court a revocation of a provisional discharge if revocation is the least restrictive alternative and either:

(1) the patient has violated material conditions of the provisional discharge, and the violation creates the need to return the patient to a more restrictive setting or more intensive community services; or

(2) there exists a serious likelihood that the safety of the patient or others will be jeopardized, in that either the patient's need for food, clothing, shelter, or medical care are not being met, or will not be met in the near future, or the patient has attempted or threatened to seriously physically harm self or others~~; and~~.

~~(3) revocation is the least restrictive alternative available.~~

(b) Any interested person may request that the designated agency revoke the patient's provisional discharge. Any person making a request shall provide the designated agency with a written report setting forth the specific facts, including witnesses, dates and locations, supporting a revocation, demonstrating that every effort has been made to avoid revocation and that revocation is the least restrictive alternative available.

Sec. 71. Minnesota Statutes 2018, section 253B.15, subdivision 3, is amended to read:

Subd. 3. **Procedure; notice.** Revocation shall be commenced by the designated agency's written notice of intent to revoke provisional discharge given or sent to the patient, the patient's attorney, ~~and~~ the ~~treatment~~ facility or program from which the patient was provisionally discharged, and the current community services provider. The notice shall set forth the grounds upon which the intention to revoke is based, and shall inform the patient of the rights of a patient under this chapter.

Sec. 72. Minnesota Statutes 2018, section 253B.15, subdivision 3a, is amended to read:

Subd. 3a. **Report to the court.** Within 48 hours, excluding weekends and legal holidays, of giving notice to the patient, the designated agency shall file with the court a copy of the notice and a report setting forth the specific facts, including witnesses, dates and locations, which (1) support revocation, (2) demonstrate that revocation is the least restrictive alternative

available, and (3) show that specific efforts were made to avoid revocation. The designated agency shall provide copies of the report to the patient, the patient's attorney, the county attorney, and the treatment facility or program from which the patient was provisionally discharged within 48 hours of giving notice to the patient under subdivision 3.

Sec. 73. Minnesota Statutes 2018, section 253B.15, subdivision 3b, is amended to read:

Subd. 3b. **Review.** The patient or patient's attorney may request judicial review of the intended revocation by filing a petition for review and an affidavit with the committing court. The affidavit shall state specific grounds for opposing the revocation. If the patient does not file a petition for review within five days of receiving the notice under subdivision 3, revocation of the provisional discharge is final and the court, without hearing, may order the patient into a ~~treatment~~ facility or program from which the patient was provisionally discharged, another treatment facility, state-operated treatment program, or community-based treatment program that consents to receive the patient, or more intensive community treatment. If the patient files a petition for review, the court shall review the petition and determine whether a genuine issue exists as to the propriety of the revocation. The burden of proof is on the designated agency to show that no genuine issue exists as to the propriety of the revocation. If the court finds that no genuine issue exists as to the propriety of the revocation, the revocation of the provisional discharge is final.

Sec. 74. Minnesota Statutes 2018, section 253B.15, subdivision 3c, is amended to read:

Subd. 3c. **Hearing.** (a) If the court finds under subdivision 3b that a genuine issue exists as to the propriety of the revocation, the court shall hold a hearing on the petition within three days after the patient files the petition. The court may continue the review hearing for an additional five days upon any party's showing of good cause. At the hearing, the burden of proof is on the designated agency to show a factual basis for the revocation. At the conclusion of the hearing, the court shall make specific findings of fact. The court shall affirm the revocation if it finds:

(1) a factual basis for revocation due to:

(i) a violation of the material conditions of the provisional discharge that creates a need for the patient to return to a more restrictive setting or more intensive community services; or

(ii) a probable danger of harm to the patient or others if the provisional discharge is not revoked; and

(2) that revocation is the least restrictive alternative available.

(b) If the court does not affirm the revocation, the court shall order the patient returned to provisional discharge status.

Sec. 75. Minnesota Statutes 2018, section 253B.15, subdivision 5, is amended to read:

Subd. 5. **Return to facility.** When the designated agency gives or sends notice of the intent to revoke a patient's provisional discharge, it may also apply to the committing court for an order directing that the patient be returned to ~~a~~ the facility or program from which the patient was provisionally discharged or another treatment facility, state-operated treatment program, or community-based treatment program that consents to receive the patient. The court may order the patient returned to a facility or program prior to a review hearing only upon finding that immediate return ~~to a facility~~ is necessary because there is a serious likelihood that the safety of the patient or others will be jeopardized, in that (1) the patient's need for food, clothing, shelter, or medical care is not being met, or will not be met in the near future, or (2) the patient has attempted or threatened to seriously harm self or others. If a voluntary return is not arranged, the head of the treatment facility, state-operated treatment program, or community-based treatment program may request a health officer or a peace officer to return the patient to the ~~treatment~~ facility or program from which the patient was released or to any other treatment facility ~~which~~, state-operated treatment program, or community-based treatment program that consents to receive the patient. If necessary, the head of the treatment facility, state-operated treatment program, or community-based treatment program may request the committing court to direct a health officer or peace officer in the county where the patient is located to return the patient to the ~~treatment~~ facility or program or to another treatment facility ~~which~~, state-operated treatment program, or community-based treatment program that consents to receive the patient. The expense of returning the patient to a ~~regional~~ state-operated treatment ~~center~~ program shall be paid by the commissioner unless paid by the patient or the patient's relatives. If the court orders the patient to return to the ~~treatment~~ facility or program, or if a health officer or peace officer returns the patient to the ~~treatment~~ facility or program, and the patient wants judicial review of the revocation, the patient or the patient's attorney must file the petition for review and affidavit required under subdivision 3b within 14 days of receipt of the notice of the intent to revoke.

Sec. 76. Minnesota Statutes 2018, section 253B.15, subdivision 7, is amended to read:

Subd. 7. **Modification and extension of provisional discharge.** (a) A provisional discharge may be modified upon agreement of the parties.

(b) A provisional discharge may be extended only in those circumstances where the patient has not achieved the goals set forth in the provisional discharge plan or continues to need the supervision or assistance provided by an extension of the provisional discharge. In determining whether the provisional discharge is to be extended, the ~~head of the facility~~ designated agency shall consider the willingness and ability of the patient to voluntarily obtain needed care and treatment.

~~(c) The designated agency shall recommend extension of a provisional discharge only after a preliminary conference with the patient and other appropriate persons. The patient shall be given the opportunity to object or make suggestions for alternatives to extension.~~

~~(d)~~ (c) The designated agency must provide any ~~recommendation for~~ proposed extension ~~shall be made~~ in writing ~~to the head of the facility and~~ to the patient and the patient's attorney at least 30 days prior to the expiration of the provisional discharge unless the patient cannot be located or is unavailable to receive the notice. The ~~written recommendation submitted~~ proposal for extension shall include: the specific grounds for ~~recommending~~ proposing the extension, ~~the date of the preliminary conference and results,~~ the anniversary date of the provisional discharge, the termination date of the provisional discharge, and the proposed length of extension. If the grounds for ~~recommending~~ proposing the extension occur less than 30 days before its expiration, the designated agency must submit the written ~~recommendation shall occur~~ proposal for extension as soon as practicable.

~~(e) The head of the facility~~ (d) The designated agency shall extend a provisional discharge only after providing the patient an opportunity for a meeting to object or make suggestions for alternatives to an extension. The designated agency shall ~~issue~~ provide a written decision to the patient and the patient's attorney regarding extension within five days after receiving ~~the recommendation from the designated agency~~ the patient's input or after holding a meeting with the patient or after the patient has declined to provide input or participate in the meeting. The designated agency may seek input from the community-based treatment team or other persons the patient chooses.

Sec. 77. Minnesota Statutes 2018, section 253B.15, is amended by adding a subdivision to read:

Subd. 8a. **Provisional discharge extension.** If the provisional discharge extends until the end of the period of commitment and, before the commitment expires, the court extends the commitment under section 253B.12 or issues a new commitment order under section 253B.13, the provisional discharge shall continue for the duration of the new or extended period of commitment ordered unless the commitment order provides otherwise or the designated agency revokes the patient's provisional discharge pursuant to this section. To continue the patient's provisional discharge under this subdivision, the designated agency is not required to comply with the procedures in subdivision 7.

Sec. 78. Minnesota Statutes 2018, section 253B.15, subdivision 9, is amended to read:

Subd. 9. **Expiration of provisional discharge.** (a) Except as otherwise provided, a provisional discharge is absolute when it expires. If, while on provisional discharge or extended provisional discharge, a patient is discharged as provided in section 253B.16, the discharge shall be absolute.

(b) The designated agency shall give notice of the expiration of the provisional discharge ~~shall be given by the head of the treatment facility~~ to the committing court; the petitioner, if known; the patient's attorney; the county attorney in the county of commitment; ~~the commissioner;~~ and the ~~designated agency~~ facility or program that provisionally discharged the patient.

Sec. 79. Minnesota Statutes 2018, section 253B.15, subdivision 10, is amended to read:

Subd. 10. **Voluntary return.** (a) With the consent of the head of the treatment facility or state-operated treatment program, a patient may voluntarily return to inpatient status ~~at the treatment facility~~ as follows:

(1) as a voluntary patient, in which case the patient's commitment is discharged;

(2) as a committed patient, in which case the patient's provisional discharge is voluntarily revoked; or

(3) on temporary return from provisional discharge, in which case both the commitment and the provisional discharge remain in effect.

(b) Prior to readmission, the patient shall be informed of status upon readmission.

Sec. 80. Minnesota Statutes 2018, section 253B.16, is amended to read:

253B.16 DISCHARGE OF COMMITTED PERSONS.

Subdivision 1. **Date.** The head of a treatment facility, state-operated treatment program, or community-based treatment program shall discharge any patient admitted as a person ~~who is mentally ill or chemically dependent, or a person with a~~ who poses a risk of harm due to mental illness, or a person who has a chemical dependency or a developmental disability ~~admitted under Minnesota Rules of Criminal Procedure, rules 20.01 and 20.02, to the secure bed component of the Minnesota extended treatment options~~ when the head of the facility or program certifies that the person is no longer in need of care and treatment under commitment or at the conclusion of any period of time specified in the commitment order, whichever occurs first. The head of a ~~treatment~~ facility or program shall discharge any person admitted as ~~developmentally disabled, except those admitted under Minnesota Rules of Criminal Procedure, rules 20.01 and 20.02, to the secure bed component of the Minnesota extended treatment options,~~ a person with a developmental disability when that person's screening team has determined, under section 256B.092, subdivision 8, that the person's needs can be met by services provided in the community and a plan has been developed in consultation with the interdisciplinary team to place the person in the available community services.

Subd. 2. **Notification of discharge.** Prior to the discharge or provisional discharge of any committed ~~person~~ patient, the head of the treatment facility, state-operated treatment program, or community-based treatment program shall notify the designated agency and the patient's spouse or health care agent, or if there is no spouse or health care agent, then an adult child, or if there is none, the next of kin of the patient, of the proposed discharge. The facility or program shall send the notice ~~shall be sent to the last known address of the person to be notified by certified mail with return receipt. The notice~~ in writing and shall include the following: (1) the proposed date of discharge or provisional discharge; (2) the date, time and place of the meeting of the staff who have been treating the patient to discuss discharge and discharge planning; (3) the fact that the patient will be present at the meeting; and (4) the fact that the next of kin or health care agent may attend that staff meeting and present any information relevant to the discharge of the patient. ~~The notice shall be sent at least one week prior to the date set for the meeting.~~

Sec. 81. Minnesota Statutes 2018, section 253B.17, is amended to read:

253B.17 RELEASE; JUDICIAL DETERMINATION.

Subdivision 1. **Petition.** Any patient, except one committed as a sexually dangerous person or a person with a sexual psychopathic personality or as a person who ~~is mentally ill and~~ has a mental illness and is dangerous to the public as provided in section 253B.18, subdivision 3, or any interested person may petition the committing court or the court to which venue has been transferred for an order that the patient is not in need of continued care and treatment under commitment or for an order that an individual is no longer a person ~~who is mentally ill, developmentally disabled, or chemically dependent~~ who poses a risk of harm due to mental illness, or a person who has a developmental disability or chemical dependency, or for any other relief. A patient committed as a person ~~who is mentally ill or mentally ill and~~ who poses a risk of harm due to mental illness, a person who has a mental illness and is dangerous ~~or~~ to the public, a sexually dangerous person, or a person with a sexual psychopathic personality may petition the committing court or the court to which venue has been transferred for a hearing concerning the administration of neuroleptic medication.

Subd. 2. **Notice of hearing.** Upon the filing of the petition, the court shall fix the time and place for the hearing on it. Ten days' notice of the hearing shall be given to the county attorney, the patient, patient's counsel, the person who filed the initial commitment petition, the head of the ~~treatment~~ facility or program to which the person is committed, and other persons as the court directs. Any person may oppose the petition.

Subd. 3. **Court examiners.** The court shall appoint ~~an~~ a court examiner and, at the patient's request, shall appoint a second court examiner of the patient's choosing to be paid for by the county at a rate of compensation to be fixed by the court. Unless otherwise agreed by the parties, ~~the examiners~~ a court examiner shall file a report with the court not less than 48 hours prior to the hearing under this section.

Subd. 4. **Evidence.** The patient, patient's counsel, the petitioner, and the county attorney shall be entitled to be present at the hearing and to present and cross-examine witnesses, including court examiners. The court may hear any relevant testimony and evidence ~~which is~~ offered at the hearing.

Subd. 5. **Order.** Upon completion of the hearing, the court shall enter an order stating its findings and decision and mail ~~it~~ the order to the head of the treatment facility, state-operated treatment program, or community-based treatment program.

Sec. 82. Minnesota Statutes 2018, section 253B.18, subdivision 1, is amended to read:

Subdivision 1. **Procedure.** (a) Upon the filing of a petition alleging that a proposed patient is a person who ~~is mentally ill and~~ has a mental illness and is dangerous to the public, the court shall hear the petition as provided in sections 253B.07 and 253B.08. If the court finds by clear and convincing evidence that the proposed patient is a person who ~~is mentally ill and~~ has a mental illness and is dangerous to the public, it shall commit the person to a secure treatment facility or to a treatment facility or state-operated treatment program willing to accept the patient under commitment. The court shall commit the patient to a secure treatment facility unless the patient ~~establishes~~ or others establish by clear and convincing evidence that a less restrictive state-operated treatment program or treatment ~~program~~ facility is available that is consistent with the patient's treatment needs and the requirements of public safety. In any case where the petition was filed immediately following the acquittal of the proposed patient for a crime against the person pursuant to a verdict of not guilty by reason of mental illness, the verdict constitutes evidence that the proposed patient is a person who ~~is mentally ill and~~ has a mental illness and is dangerous to the public within the meaning of this section. The proposed patient has the burden of going forward in the presentation of evidence. The standard of proof remains as required by this chapter. Upon commitment, admission procedures shall be carried out pursuant to section 253B.10.

(b) Once a patient is admitted to a treatment facility or state-operated treatment program pursuant to a commitment under this subdivision, treatment must begin regardless of whether a review hearing will be held under subdivision 2.

Sec. 83. Minnesota Statutes 2018, section 253B.18, subdivision 2, is amended to read:

Subd. 2. **Review; hearing.** (a) A written treatment report shall be filed by the treatment facility or state-operated treatment program with the committing court within 60 days after commitment. If the person is in the custody of the commissioner of corrections when the initial commitment is ordered under subdivision 1, the written treatment report must be filed within 60 days after the person is admitted to ~~a secure~~ the state-operated treatment program or treatment facility. The court shall hold a hearing to make a final determination as to whether the ~~person~~ patient should remain committed as a person who ~~is mentally ill and~~ has a mental illness and is dangerous to the public. The hearing shall be held within the earlier of 14 days of the court's receipt of the written treatment report, or within 90 days of the date of initial commitment or admission, unless otherwise agreed by the parties.

(b) The court may, with agreement of the county attorney and the patient's attorney ~~for the patient~~:

(1) waive the review hearing under this subdivision and immediately order an indeterminate commitment under subdivision 3; or

(2) continue the review hearing for up to one year.

(c) If the court finds that the patient should be committed as a person ~~who is mentally ill~~ who poses a risk of harm due to mental illness, but not as a person who ~~is mentally ill and~~ has a mental illness and is dangerous to the public, the court may commit the ~~person~~ patient as a person ~~who is mentally ill~~ who poses a risk of harm due to mental illness and the ~~person shall be deemed~~ court shall deem the patient not to ~~have been found to~~ be dangerous to the public for the purposes of subdivisions 4a to 15. Failure of the treatment facility or state-operated treatment program to provide the required treatment report at the end of the 60-day period shall not result in automatic discharge of the patient.

Sec. 84. Minnesota Statutes 2018, section 253B.18, subdivision 3, is amended to read:

Subd. 3. **Indeterminate commitment.** If the court finds at the final determination hearing held pursuant to subdivision 2 that the patient continues to be a person who ~~is mentally ill and~~ has a mental illness and is dangerous to the public, then the court shall order commitment of the proposed patient for an indeterminate period of time. After a final determination that a patient is a person who ~~is mentally ill and~~ has a mental illness and is dangerous to the public, the patient shall be transferred, provisionally discharged or discharged, only as provided in this section.

Sec. 85. Minnesota Statutes 2018, section 253B.18, subdivision 4a, is amended to read:

Subd. 4a. **Release on pass; notification.** A patient who has been committed as a person who ~~is mentally ill and~~ has a mental illness and is dangerous to the public and who is confined at a secure treatment facility or has been transferred out of a ~~state-operated services~~ secure treatment facility according to section 253B.18, subdivision 6, shall not be released on a pass unless the pass is part of a pass plan that has been approved by the medical director of the secure treatment facility. The pass plan must have a specific therapeutic purpose consistent with the treatment plan, must be established for a specific period of time, and must have specific levels of liberty delineated. The county case manager must be invited to participate in the development of the pass plan. At least ten days prior to a determination on the plan, the medical director shall notify the designated agency, the committing court, the county attorney of the county of commitment, an interested person, the local law enforcement agency where the facility is located, the county attorney and the local law enforcement agency in the location where the pass is to occur, the petitioner, and the

petitioner's counsel of the plan, the nature of the passes proposed, and their right to object to the plan. If any notified person objects prior to the proposed date of implementation, the person shall have an opportunity to appear, personally or in writing, before the medical director, within ten days of the objection, to present grounds for opposing the plan. The pass plan shall not be implemented until the objecting person has been furnished that opportunity. Nothing in this subdivision shall be construed to give a patient an affirmative right to a pass plan.

Sec. 86. Minnesota Statutes 2018, section 253B.18, subdivision 4b, is amended to read:

Subd. 4b. **Pass-eligible status; notification.** (a) The following patients committed to a secure treatment facility shall not be placed on pass-eligible status unless that status has been approved by the medical director of the secure treatment facility:

~~(a)~~ (1) a patient who has been committed as a person who ~~is mentally ill and~~ has a mental illness and is dangerous to the public and who:

~~(1)~~ (i) was found incompetent to proceed to trial for a felony or was found not guilty by reason of mental illness of a felony immediately prior to the filing of the commitment petition;

~~(2)~~ (ii) was convicted of a felony immediately prior to or during commitment as a person who ~~is mentally ill and~~ has a mental illness and is dangerous to the public; or

~~(3)~~ (iii) is subject to a commitment to the commissioner of corrections; and

~~(b)~~ (2) a patient who has been committed as a psychopathic personality, a sexually psychopathic personality, or a sexually dangerous person.

(b) At least ten days prior to a determination on the status, the medical director shall notify the committing court, the county attorney of the county of commitment, the designated agency, an interested person, the petitioner, and the petitioner's counsel of the proposed status, and their right to request review by the special review board. If within ten days of receiving notice any notified person requests review by filing a notice of objection with the commissioner and the head of the secure treatment facility, a hearing shall be held before the special review board. The proposed status shall not be implemented unless it receives a favorable recommendation by a majority of the board and approval by the commissioner. The order of the commissioner is appealable as provided in section 253B.19.

(c) Nothing in this subdivision shall be construed to give a patient an affirmative right to seek pass-eligible status from the special review board.

Sec. 87. Minnesota Statutes 2018, section 253B.18, subdivision 4c, is amended to read:

Subd. 4c. **Special review board.** (a) The commissioner shall establish one or more panels of a special review board. The board shall consist of three members experienced in the field of mental illness. One member of each special review board panel shall be a psychiatrist or a doctoral level psychologist with forensic experience and one member shall be an attorney. No member shall be affiliated with the Department of Human Services. The special review board shall meet at least every six months and at the call of the commissioner. It shall hear and consider all petitions for a reduction in custody or to appeal a revocation of provisional discharge. A "reduction in custody" means transfer from a secure treatment facility, discharge, and provisional discharge. Patients may be transferred by the commissioner between secure treatment facilities without a special review board hearing.

Members of the special review board shall receive compensation and reimbursement for expenses as established by the commissioner.

(b) The special review board must review each denied petition under subdivision 5 for barriers and obstacles preventing the patient from progressing in treatment. Based on the cases before the board in the previous year, the special review board shall provide to the commissioner an annual summation of the barriers to treatment progress, and recommendations to achieve the common goal of making progress in treatment.

(c) A petition filed by a person committed as ~~mentally ill and~~ a person who has a mental illness and is dangerous to the public under this section must be heard as provided in subdivision 5 and, as applicable, subdivision 13. A petition filed by a person committed as a sexual psychopathic personality or as a sexually dangerous person under chapter 253D, or committed as both ~~mentally ill and~~ a person who has a mental illness and is dangerous to the public under this section and as a sexual psychopathic personality or as a sexually dangerous person must be heard as provided in section 253D.27.

Sec. 88. Minnesota Statutes 2018, section 253B.18, subdivision 5, is amended to read:

Subd. 5. **Petition; notice of hearing; attendance; order.** (a) A petition for a reduction in custody or revocation of provisional discharge shall be filed with the commissioner and may be filed by the patient or by the head of the treatment facility or state-operated treatment program to which the person was committed or has been transferred. A patient may not petition the special review board for six months following commitment under subdivision 3 or following the final disposition of any previous petition and subsequent appeal by the patient. The head of the state-operated treatment program or head of the treatment facility must schedule a hearing before the special review board for any patient who has not appeared

before the special review board in the previous three years, and schedule a hearing at least every three years thereafter. The medical director may petition at any time.

(b) Fourteen days prior to the hearing, the committing court, the county attorney of the county of commitment, the designated agency, interested person, the petitioner, and the petitioner's counsel shall be given written notice by the commissioner of the time and place of the hearing before the special review board. Only those entitled to statutory notice of the hearing or those administratively required to attend may be present at the hearing. The patient may designate interested persons to receive notice by providing the names and addresses to the commissioner at least 21 days before the hearing. The board shall provide the commissioner with written findings of fact and recommendations within 21 days of the hearing. The commissioner shall issue an order no later than 14 days after receiving the recommendation of the special review board. A copy of the order shall be mailed to every person entitled to statutory notice of the hearing within five days after ~~it~~ the order is signed. No order by the commissioner shall be effective sooner than 30 days after the order is signed, unless the county attorney, the patient, and the commissioner agree that it may become effective sooner.

(c) The special review board shall hold a hearing on each petition prior to making its recommendation to the commissioner. The special review board proceedings are not contested cases as defined in chapter 14. Any person or agency receiving notice that submits documentary evidence to the special review board prior to the hearing shall also provide copies to the patient, the patient's counsel, the county attorney of the county of commitment, the case manager, and the commissioner.

(d) Prior to the final decision by the commissioner, the special review board may be reconvened to consider events or circumstances that occurred subsequent to the hearing.

(e) In making their recommendations and order, the special review board and commissioner must consider any statements received from victims under subdivision 5a.

Sec. 89. Minnesota Statutes 2018, section 253B.18, subdivision 5a, is amended to read:

Subd. 5a. **Victim notification of petition and release; right to submit statement.** (a) As used in this subdivision:

(1) "crime" has the meaning given to "violent crime" in section 609.1095, and includes criminal sexual conduct in the fifth degree and offenses within the definition of "crime against the person" in section 253B.02, subdivision 4a, and also includes offenses listed in

section 253D.02, subdivision 8, paragraph (b), regardless of whether they are sexually motivated;

(2) "victim" means a person who has incurred loss or harm as a result of a crime the behavior for which forms the basis for a commitment under this section or chapter 253D; and

(3) "convicted" and "conviction" have the meanings given in section 609.02, subdivision 5, and also include juvenile court adjudications, findings under Minnesota Rules of Criminal Procedure, rule 20.02, that the elements of a crime have been proved, and findings in commitment cases under this section or chapter 253D that an act or acts constituting a crime occurred.

(b) A county attorney who files a petition to commit a person under this section or chapter 253D shall make a reasonable effort to provide prompt notice of filing the petition to any victim of a crime for which the person was convicted. In addition, the county attorney shall make a reasonable effort to promptly notify the victim of the resolution of the petition.

(c) Before provisionally discharging, discharging, granting pass-eligible status, approving a pass plan, or otherwise permanently or temporarily releasing a person committed under this section from a state-operated treatment program or treatment facility, the head of the state-operated treatment program or head of the treatment facility shall make a reasonable effort to notify any victim of a crime for which the person was convicted that the person may be discharged or released and that the victim has a right to submit a written statement regarding decisions of the medical director, special review board, or commissioner with respect to the person. To the extent possible, the notice must be provided at least 14 days before any special review board hearing or before a determination on a pass plan. Notwithstanding section 611A.06, subdivision 4, the commissioner shall provide the judicial appeal panel with victim information in order to comply with the provisions of this section. The judicial appeal panel shall ensure that the data on victims remains private as provided for in section 611A.06, subdivision 4.

(d) This subdivision applies only to victims who have requested notification through the Department of Corrections electronic victim notification system, or by contacting, in writing, the county attorney in the county where the conviction for the crime occurred. A request for notice under this subdivision received by the commissioner of corrections through the Department of Corrections electronic victim notification system shall be promptly forwarded to the prosecutorial authority with jurisdiction over the offense to which the notice relates or, following commitment, the head of the state-operated treatment program

or head of the treatment facility. A county attorney who receives a request for notification under this paragraph following commitment shall promptly forward the request to the commissioner of human services.

(e) The rights under this subdivision are in addition to rights available to a victim under chapter 611A. This provision does not give a victim all the rights of a "notified person" or a person "entitled to statutory notice" under subdivision 4a, 4b, or 5 or section 253D.14.

Sec. 90. Minnesota Statutes 2018, section 253B.18, subdivision 6, is amended to read:

Subd. 6. **Transfer.** (a) A patient who is ~~mentally ill and~~ a person who has a mental illness and is dangerous to the public shall not be transferred out of a secure treatment facility unless it appears to the satisfaction of the commissioner, after a hearing and favorable recommendation by a majority of the special review board, that the transfer is appropriate. Transfer may be to ~~other regional centers under the commissioner's control~~ another state-operated treatment program. In those instances where a commitment also exists to the Department of Corrections, transfer may be to a facility designated by the commissioner of corrections.

(b) The following factors must be considered in determining whether a transfer is appropriate:

(1) the person's clinical progress and present treatment needs;

(2) the need for security to accomplish continuing treatment;

(3) the need for continued institutionalization;

(4) which facility can best meet the person's needs; and

(5) whether transfer can be accomplished with a reasonable degree of safety for the public.

Sec. 91. Minnesota Statutes 2018, section 253B.18, subdivision 7, is amended to read:

Subd. 7. **Provisional discharge.** (a) A patient who is ~~mentally ill and~~ a person who has a mental illness and is dangerous to the public shall not be provisionally discharged unless it appears to the satisfaction of the commissioner, after a hearing and a favorable recommendation by a majority of the special review board, that the patient is capable of making an acceptable adjustment to open society.

(b) The following factors are to be considered in determining whether a provisional discharge shall be recommended: (1) whether the patient's course of hospitalization and

present mental status indicate there is no longer a need for treatment and supervision in the patient's current treatment setting; and (2) whether the conditions of the provisional discharge plan will provide a reasonable degree of protection to the public and will enable the patient to adjust successfully to the community.

Sec. 92. Minnesota Statutes 2018, section 253B.18, subdivision 8, is amended to read:

Subd. 8. **Provisional discharge plan.** A provisional discharge plan shall be developed, implemented, and monitored by the designated agency in conjunction with the patient, the treatment facility or state-operated treatment program to which the person is committed, and other appropriate persons. The designated agency shall, at least quarterly, review the provisional discharge plan with the patient and submit a written report to ~~the commissioner and~~ the ~~treatment~~ facility or program concerning the patient's status and compliance with each term of the provisional discharge plan.

Sec. 93. Minnesota Statutes 2018, section 253B.18, subdivision 10, is amended to read:

Subd. 10. **Provisional discharge; revocation.** (a) The head of the treatment facility or state-operated treatment program from which the person was provisionally discharged may revoke a provisional discharge if any of the following grounds exist:

(i) the patient has departed from the conditions of the provisional discharge plan;

(ii) the patient is exhibiting signs of a mental illness which may require in-hospital evaluation or treatment; or

(iii) the patient is exhibiting behavior which may be dangerous to self or others.

(b) Revocation shall be commenced by a notice of intent to revoke provisional discharge, which shall be served upon the patient, patient's counsel, and the designated agency. The notice shall set forth the grounds upon which the intention to revoke is based, and shall inform the patient of the rights of a patient under this chapter.

(c) In all nonemergency situations, prior to revoking a provisional discharge, the head of the ~~treatment~~ facility or program shall obtain a revocation report from the designated agency outlining the specific reasons for recommending the revocation, including but not limited to the specific facts upon which the revocation recommendation is based.

(d) The patient must be provided a copy of the revocation report and informed orally and in writing of the rights of a patient under this section.

Sec. 94. Minnesota Statutes 2018, section 253B.18, subdivision 11, is amended to read:

Subd. 11. **Exceptions.** If an emergency exists, the head of the treatment facility or state-operated treatment program may revoke the provisional discharge and, either orally or in writing, order that the patient be immediately returned to the ~~treatment~~ facility or program. In emergency cases, a revocation report ~~documenting reasons for revocation~~ shall be submitted by the designated agency within seven days after the patient is returned to the ~~treatment~~ facility or program.

Sec. 95. Minnesota Statutes 2018, section 253B.18, subdivision 12, is amended to read:

Subd. 12. **Return of patient.** After revocation of a provisional discharge or if the patient is absent without authorization, the head of the treatment facility or state-operated treatment program may request the patient to return to the ~~treatment~~ facility or program voluntarily. The head of the treatment facility or state-operated treatment program may request a health officer~~, a welfare officer,~~ or a peace officer to return the patient to the ~~treatment~~ facility or program. If a voluntary return is not arranged, the head of the treatment facility or state-operated treatment program shall inform the committing court of the revocation or absence and the court shall direct a health or peace officer in the county where the patient is located to return the patient to the ~~treatment~~ facility or program or to another state-operated treatment program or to another treatment facility willing to accept the patient. The expense of returning the patient to a ~~regional~~ state-operated treatment ~~center~~ program shall be paid by the commissioner unless paid by the patient or other persons on the patient's behalf.

Sec. 96. Minnesota Statutes 2018, section 253B.18, subdivision 14, is amended to read:

Subd. 14. **Voluntary readmission.** (a) With the consent of the head of the treatment facility or state-operated treatment program, a patient may voluntarily return from provisional discharge for a period of up to 30 days, or up to 60 days with the consent of the designated agency. If the patient is not returned to provisional discharge status within 60 days, the provisional discharge is revoked. Within 15 days of receiving notice of the change in status, the patient may request a review of the matter before the special review board. The board may recommend a return to a provisional discharge status.

(b) The treatment facility or state-operated treatment program is not required to petition for a further review by the special review board unless the patient's return to the community results in substantive change to the existing provisional discharge plan. All the terms and conditions of the provisional discharge order shall remain unchanged if the patient is released again.

Sec. 97. Minnesota Statutes 2018, section 253B.18, subdivision 15, is amended to read:

Subd. 15. **Discharge.** (a) A patient who is ~~mentally ill and~~ a person who has a mental illness and is dangerous to the public shall not be discharged unless it appears to the satisfaction of the commissioner, after a hearing and a favorable recommendation by a majority of the special review board, that the patient is capable of making an acceptable adjustment to open society, is no longer dangerous to the public, and is no longer in need of treatment and supervision.

(b) In determining whether a discharge shall be recommended, the special review board and commissioner shall consider whether specific conditions exist to provide a reasonable degree of protection to the public and to assist the patient in adjusting to the community. If the desired conditions do not exist, the discharge shall not be granted.

Sec. 98. Minnesota Statutes 2018, section 253B.19, subdivision 2, is amended to read:

Subd. 2. **Petition; hearing.** (a) A ~~person~~ patient committed as ~~mentally ill and~~ a person who has a mental illness and is dangerous to the public under section 253B.18, or the county attorney of the county from which the ~~person~~ patient was committed or the county of financial responsibility, may petition the judicial appeal panel for a rehearing and reconsideration of a decision by the commissioner under section 253B.18, subdivision 5. The judicial appeal panel must not consider petitions for relief other than those considered by the commissioner from which the appeal is taken. The petition must be filed with the supreme court within 30 days after the decision of the commissioner is signed. The hearing must be held within 45 days of the filing of the petition unless an extension is granted for good cause.

(b) For an appeal under paragraph (a), the supreme court shall refer the petition to the chief judge of the judicial appeal panel. The chief judge shall notify the patient, the county attorney of the county of commitment, the designated agency, the commissioner, the head of the ~~treatment~~ facility or program to which the patient was committed, any interested person, and other persons the chief judge designates, of the time and place of the hearing on the petition. The notice shall be given at least 14 days prior to the date of the hearing.

(c) Any person may oppose the petition. The patient, the patient's counsel, the county attorney of the committing county or the county of financial responsibility, and the commissioner shall participate as parties to the proceeding pending before the judicial appeal panel and shall, except when the patient is committed solely as ~~mentally ill and~~ a person who has a mental illness and is dangerous to the public, no later than 20 days before the hearing on the petition, inform the judicial appeal panel and the opposing party in writing whether they support or oppose the petition and provide a summary of facts in support of

their position. The judicial appeal panel may appoint court examiners and may adjourn the hearing from time to time. It shall hear and receive all relevant testimony and evidence and make a record of all proceedings. The patient, the patient's counsel, and the county attorney of the committing county or the county of financial responsibility have the right to be present and may present and cross-examine all witnesses and offer a factual and legal basis in support of their positions. The petitioning party seeking discharge or provisional discharge bears the burden of going forward with the evidence, which means presenting a prima facie case with competent evidence to show that the person is entitled to the requested relief. If the petitioning party has met this burden, the party opposing discharge or provisional discharge bears the burden of proof by clear and convincing evidence that the discharge or provisional discharge should be denied. A party seeking transfer under section 253B.18, subdivision 6, must establish by a preponderance of the evidence that the transfer is appropriate.

Sec. 99. Minnesota Statutes 2018, section 253B.20, subdivision 1, is amended to read:

Subdivision 1. **Notice to court.** When a committed person is discharged, provisionally discharged, or transferred to another treatment facility, ~~or partially hospitalized~~ state-operated treatment program, or community-based treatment program, or when the ~~person~~ patient dies, is absent without authorization, or is returned, the treatment facility, state-operated treatment program, or community-based treatment program having custody of the patient shall notify the committing court, the county attorney, and the patient's attorney.

Sec. 100. Minnesota Statutes 2018, section 253B.20, subdivision 2, is amended to read:

Subd. 2. **Necessities.** The ~~head of the~~ state-operated treatment ~~facility~~ program shall make necessary arrangements at the expense of the state to insure that no patient is discharged or provisionally discharged without suitable clothing. The head of the state-operated treatment ~~facility~~ program shall, if necessary, provide the patient with a sufficient sum of money to secure transportation home, or to another destination of the patient's choice, if the destination is located within a reasonable distance of the state-operated treatment ~~facility~~ program. The commissioner shall establish procedures by rule to help the patient receive all public assistance benefits provided by state or federal law to which the patient is entitled by residence and circumstances. The rule shall be uniformly applied in all counties. All counties shall provide temporary relief whenever necessary to meet the intent of this subdivision.

Sec. 101. Minnesota Statutes 2018, section 253B.20, subdivision 3, is amended to read:

Subd. 3. **Notice to designated agency.** The head of the treatment facility, state-operated treatment program, or community-based treatment program, upon the provisional discharge of any committed person, shall notify the designated agency before the patient leaves the ~~treatment~~ facility or program. Whenever possible the notice shall be given at least one week before the patient is to leave the facility or program.

Sec. 102. Minnesota Statutes 2018, section 253B.20, subdivision 4, is amended to read:

Subd. 4. **Aftercare services.** Prior to the date of discharge or provisional discharge of any committed person, the designated agency of the county of financial responsibility, in cooperation with the head of the treatment facility, state-operated treatment program, or community-based treatment program, and the patient's ~~physician~~ mental health professional, if notified pursuant to subdivision 6, shall establish a continuing plan of aftercare services for the patient including a plan for medical and psychiatric treatment, nursing care, vocational assistance, and other assistance the patient needs. The designated agency shall provide case management services, supervise and assist the patient in finding employment, suitable shelter, and adequate medical and psychiatric treatment, and aid in the patient's readjustment to the community.

Sec. 103. Minnesota Statutes 2018, section 253B.20, subdivision 6, is amended to read:

Subd. 6. **Notice to ~~physician~~ mental health professional.** The head of the treatment facility, state-operated treatment program, or community-based treatment program shall notify the ~~physician~~ mental health professional of any committed person at the time of the patient's discharge or provisional discharge, unless the patient objects to the notice.

Sec. 104. Minnesota Statutes 2018, section 253B.21, subdivision 1, is amended to read:

Subdivision 1. **Administrative procedures.** If the patient is entitled to care by any agency of the United States in this state, the commitment warrant shall be in triplicate, committing the patient to the joint custody of the head of the treatment facility, state-operated treatment program, or community-based treatment program and the federal agency. If the federal agency is unable or unwilling to receive the patient at the time of commitment, the patient may subsequently be transferred to it upon its request.

Sec. 105. Minnesota Statutes 2018, section 253B.21, subdivision 2, is amended to read:

Subd. 2. **Applicable regulations.** Any person, when admitted to an institution of a federal agency within or without this state, shall be subject to the rules and regulations of the federal agency, except that nothing in this section shall deprive any person of rights secured to patients of ~~state~~ state-operated treatment programs, treatment facilities, and community-based treatment programs by this chapter.

Sec. 106. Minnesota Statutes 2018, section 253B.21, subdivision 3, is amended to read:

Subd. 3. **Powers.** The chief officer of any treatment facility operated by a federal agency to which any person is admitted shall have the same powers as the heads of ~~treatment facilities~~ state-operated treatment programs within this state with respect to admission, retention of custody, transfer, parole, or discharge of the committed person.

Sec. 107. Minnesota Statutes 2018, section 253B.212, subdivision 1, is amended to read:

Subdivision 1. **Cost of care; commitment by tribal court order; Red Lake Band of Chippewa Indians.** The commissioner of human services may contract with and receive payment from the Indian Health Service of the United States Department of Health and Human Services for the care and treatment of those members of the Red Lake Band of Chippewa Indians who have been committed by tribal court order to the Indian Health Service for care and treatment of mental illness, developmental disability, or chemical dependency. The contract shall provide that the Indian Health Service may not transfer any person for admission to a ~~regional center~~ state-operated treatment program unless the commitment procedure utilized by the tribal court provided due process protections similar to those afforded by sections ~~253B.05~~ 253B.051 to 253B.10.

Sec. 108. Minnesota Statutes 2018, section 253B.212, subdivision 1a, is amended to read:

Subd. 1a. **Cost of care; commitment by tribal court order; White Earth Band of Ojibwe Indians.** The commissioner of human services may contract with and receive payment from the Indian Health Service of the United States Department of Health and Human Services for the care and treatment of those members of the White Earth Band of Ojibwe Indians who have been committed by tribal court order to the Indian Health Service for care and treatment of mental illness, developmental disability, or chemical dependency. The tribe may also contract directly with the commissioner for treatment of those members of the White Earth Band who have been committed by tribal court order to the White Earth Department of Health for care and treatment of mental illness, developmental disability, or

chemical dependency. The contract shall provide that the Indian Health Service and the White Earth Band shall not transfer any person for admission to a ~~regional center~~ state-operated treatment program unless the commitment procedure utilized by the tribal court provided due process protections similar to those afforded by sections ~~253B.05~~ 253B.051 to 253B.10.

Sec. 109. Minnesota Statutes 2018, section 253B.212, subdivision 1b, is amended to read:

Subd. 1b. **Cost of care; commitment by tribal court order; any federally recognized Indian tribe within the state of Minnesota.** The commissioner of human services may contract with and receive payment from the Indian Health Service of the United States Department of Health and Human Services for the care and treatment of those members of any federally recognized Indian tribe within the state, who have been committed by tribal court order to the Indian Health Service for care and treatment of mental illness, developmental disability, or chemical dependency. The tribe may also contract directly with the commissioner for treatment of those members of any federally recognized Indian tribe within the state who have been committed by tribal court order to the respective tribal Department of Health for care and treatment of mental illness, developmental disability, or chemical dependency. The contract shall provide that the Indian Health Service and any federally recognized Indian tribe within the state shall not transfer any person for admission to a ~~regional center~~ state-operated treatment program unless the commitment procedure utilized by the tribal court provided due process protections similar to those afforded by sections ~~253B.05~~ 253B.051 to 253B.10.

Sec. 110. Minnesota Statutes 2018, section 253B.212, subdivision 2, is amended to read:

Subd. 2. **Effect given to tribal commitment order.** (a) When, under an agreement entered into pursuant to subdivision 1, 1a, or 1b, the Indian Health Service or the placing tribe applies to a ~~regional center~~ state-operated treatment program for admission of a person committed to the jurisdiction of the health service by the tribal court ~~as a person who is mentally ill, developmentally disabled, or chemically dependent~~ due to mental illness, developmental disability, or chemical dependency, the commissioner may treat the patient with the consent of the Indian Health Service or the placing tribe.

(b) A person admitted to a ~~regional center~~ state-operated treatment program pursuant to this section has all the rights accorded by section 253B.03. In addition, treatment reports, prepared in accordance with the requirements of section 253B.12, subdivision 1, shall be filed with the Indian Health Service or the placing tribe within 60 days of commencement

of the patient's stay at the ~~facility~~ program. A subsequent treatment report shall be filed with the Indian Health Service or the placing tribe within six months of the patient's admission to the ~~facility~~ program or prior to discharge, whichever comes first. Provisional discharge or transfer of the patient may be authorized by the head of the ~~treatment facility~~ program only with the consent of the Indian Health Service or the placing tribe. Discharge from the ~~facility~~ program to the Indian Health Service or the placing tribe may be authorized by the head of the ~~treatment facility~~ program after notice to and consultation with the Indian Health Service or the placing tribe.

Sec. 111. Minnesota Statutes 2018, section 253B.22, subdivision 1, is amended to read:

Subdivision 1. **Establishment.** The commissioner shall establish a review board of three or more persons for ~~each regional center~~ the Anoka-Metro Regional Treatment Center, Minnesota Security Hospital, and Minnesota sex offender program to review the admission and retention of ~~its~~ patients of that program receiving services under this chapter. One member shall be qualified in the diagnosis of mental illness, developmental disability, or chemical dependency, and one member shall be an attorney. The commissioner may, upon written request from the appropriate federal authority, establish a review panel for any federal treatment facility within the state to review the admission and retention of patients hospitalized under this chapter. For any review board established for a federal treatment facility, one of the persons appointed by the commissioner shall be the commissioner of veterans affairs or the commissioner's designee.

Sec. 112. Minnesota Statutes 2018, section 253B.22, subdivision 2, is amended to read:

Subd. 2. **Right to appear.** Each ~~treatment facility~~ program specified in subdivision 1 shall be visited by the review board at least once every six months. Upon request each patient in the ~~treatment facility~~ program shall have the right to appear before the review board during the visit.

Sec. 113. Minnesota Statutes 2018, section 253B.22, subdivision 3, is amended to read:

Subd. 3. **Notice.** The head of ~~the treatment facility~~ each program specified in subdivision 1 shall notify each patient at the time of admission by a simple written statement of the patient's right to appear before the review board and the next date when the board will visit ~~the treatment facility~~ that program. A request to appear before the board need not be in writing. Any employee of the ~~treatment facility~~ program receiving a patient's request to appear before the board shall notify the head of the ~~treatment facility~~ program of the request.

Sec. 114. Minnesota Statutes 2018, section 253B.22, subdivision 4, is amended to read:

Subd. 4. **Review.** The board shall review the admission and retention of patients at ~~its respective treatment facility~~ the program. The board may examine the records of all patients admitted and may examine personally at its own instigation all patients who from the records or otherwise appear to justify reasonable doubt as to continued need of confinement in ~~a treatment facility~~ the program. The review board shall report its findings to the commissioner and to the head of the ~~treatment facility~~ program. The board may also receive reports from patients, interested persons, and ~~treatment facility~~ employees of the program, and investigate conditions affecting the care of patients.

Sec. 115. Minnesota Statutes 2018, section 253B.23, subdivision 1, is amended to read:

Subdivision 1. **Costs of hearings.** (a) In each proceeding under this chapter the court shall allow and order paid to each witness subpoenaed the fees and mileage prescribed by law; to each examiner a reasonable sum for services and for travel; to persons conveying the patient to the place of detention, disbursements for the travel, board, and lodging of the patient and of themselves and their authorized assistants; and to the patient's counsel, when appointed by the court, a reasonable sum for travel and for the time spent in court or in preparing for the hearing. Upon the court's order, the county auditor shall issue a warrant on the county treasurer for payment of the amounts allowed, excluding the costs of the court examiner, which must be paid by the state courts.

(b) Whenever venue of a proceeding has been transferred under this chapter, the costs of the proceedings shall be reimbursed to the county where the proceedings were conducted by the county of financial responsibility.

Sec. 116. Minnesota Statutes 2018, section 253B.23, subdivision 1b, is amended to read:

Subd. 1b. **Responsibility for conducting prepetition screening and filing commitment ~~and early intervention~~ petitions.** (a) The county of financial responsibility is responsible to conduct prepetition screening pursuant to section 253B.07, subdivision 1, and, if statutory conditions for ~~early intervention or~~ commitment are satisfied, to file a petition pursuant to section ~~253B.064, subdivision 1, paragraph (a);~~ 253B.07, ~~subdivision 1~~ subdivision 2, paragraph (a)~~;~~, or 253D.07.

(b) Except in cases under chapter 253D, if the county of financial responsibility refuses or fails to conduct prepetition screening or file a petition, or if it is unclear which county is the county of financial responsibility, the county where the proposed patient is present is

responsible to conduct the prepetition screening and, if statutory conditions for ~~early intervention or~~ commitment are satisfied, file the petition.

(c) In cases under chapter 253D, if the county of financial responsibility refuses or fails to file a petition, or if it is unclear which county is the county of financial responsibility, then (1) the county where the conviction for which the person is incarcerated was entered, or (2) the county where the proposed patient is present, if the person is not currently incarcerated based on conviction, is responsible to file the petition if statutory conditions for commitment are satisfied.

(d) When a proposed patient is an inmate confined to an adult correctional facility under the control of the commissioner of corrections and commitment proceedings are initiated or proposed to be initiated pursuant to section 241.69, the county where the correctional facility is located may agree to perform the responsibilities specified in paragraph (a).

(e) Any dispute concerning financial responsibility for the costs of the proceedings and treatment will be resolved pursuant to chapter 256G.

(f) This subdivision and the sections of law cited in this subdivision address venue only. Nothing in this chapter is intended to limit the statewide jurisdiction of district courts over civil commitment matters.

Sec. 117. Minnesota Statutes 2018, section 253B.23, subdivision 2, is amended to read:

Subd. 2. **Legal results of commitment status.** (a) Except as otherwise provided in this chapter and in sections 246.15 and 246.16, no person by reason of commitment or treatment pursuant to this chapter shall be deprived of any legal right, including but not limited to the right to dispose of property, sue and be sued, execute instruments, make purchases, enter into contractual relationships, vote, and hold a driver's license. Commitment or treatment of any patient pursuant to this chapter is not a judicial determination of legal incompetency except to the extent provided in section 253B.03, subdivision 6.

(b) Proceedings for determination of legal incompetency and the appointment of a guardian for a person subject to commitment under this chapter may be commenced before, during, or after commitment proceedings have been instituted and may be conducted jointly with the commitment proceedings. The court shall notify the head of the ~~treatment~~ facility or program to which the patient is committed of a finding that the patient is incompetent.

(c) Where the person to be committed is a minor or owns property of value and it appears to the court that the person is not competent to manage a personal estate, the court shall appoint a general conservator of the person's estate as provided by law.

Sec. 118. Minnesota Statutes 2018, section 253B.24, is amended to read:

253B.24 TRANSMITTAL OF DATA TO NATIONAL INSTANT CRIMINAL BACKGROUND CHECK SYSTEM.

When a court:

(1) commits a person under this chapter ~~as being mentally ill, developmentally disabled, mentally ill and dangerous, or chemically dependent~~ due to mental illness, developmental disability, or chemical dependency, or as a person who has a mental illness and is dangerous to the public;

(2) determines in a criminal case that a person is incompetent to stand trial or not guilty by reason of mental illness; or

(3) restores a person's ability to possess a firearm under section 609.165, subdivision 1d, or 624.713, subdivision 4,

the court shall ensure that this information is electronically transmitted within three business days to the National Instant Criminal Background Check System.

Sec. 119. Minnesota Statutes 2018, section 253D.02, subdivision 6, is amended to read:

Subd. 6. **Court examiner.** "Court examiner" has the meaning given in section 253B.02, subdivision ~~7~~ 7a.

Sec. 120. Minnesota Statutes 2018, section 253D.07, subdivision 2, is amended to read:

Subd. 2. **Petition.** Upon the filing of a petition alleging that a proposed respondent is a sexually dangerous person or a person with a sexual psychopathic personality, ~~the court shall hear the petition as provided~~ all of the applicable procedures contained in sections 253B.07 and 253B.08 apply to the commitment proceeding.

Sec. 121. Minnesota Statutes 2018, section 253D.10, subdivision 2, is amended to read:

Subd. 2. **Correctional facilities.** (a) A person who is being petitioned for commitment under this chapter and who is placed under a judicial hold order under section 253B.07, subdivision 2b or 7, may be confined at a Department of Corrections or a county correctional or detention facility, rather than a secure treatment facility, until a determination of the commitment petition as specified in this subdivision.

(b) A court may order that a person who is being petitioned for commitment under this chapter be confined in a Department of Corrections facility pursuant to the judicial hold order under the following circumstances and conditions:

(1) The person is currently serving a sentence in a Department of Corrections facility and the court determines that the person has made a knowing and voluntary (i) waiver of the right to be held in a secure treatment facility and (ii) election to be held in a Department of Corrections facility. The order confining the person in the Department of Corrections facility shall remain in effect until the court vacates the order or the person's criminal sentence and conditional release term expire.

In no case may the person be held in a Department of Corrections facility pursuant only to this subdivision, and not pursuant to any separate correctional authority, for more than 210 days.

(2) A person who has elected to be confined in a Department of Corrections facility under this subdivision may revoke the election by filing a written notice of intent to revoke the election with the court and serving the notice upon the Department of Corrections and the county attorney. The court shall order the person transferred to a secure treatment facility within 15 days of the date that the notice of revocation was filed with the court, except that, if the person has additional time to serve in prison at the end of the 15-day period, the person shall not be transferred to a secure treatment facility until the person's prison term expires. After a person has revoked an election to remain in a Department of Corrections facility under this subdivision, the court may not adopt another election to remain in a Department of Corrections facility without the agreement of both parties and the Department of Corrections.

(3) Upon petition by the commissioner of corrections, after notice to the parties and opportunity for hearing and for good cause shown, the court may order that the person's place of confinement be changed from the Department of Corrections to a secure treatment facility.

(4) While at a Department of Corrections facility pursuant to this subdivision, the person shall remain subject to all rules and practices applicable to correctional inmates in the facility in which the person is placed including~~,~~ but not limited to~~,~~ the powers and duties of the commissioner of corrections under section 241.01, powers relating to use of force under section 243.52, and the right of the commissioner of corrections to determine the place of confinement in a prison, reformatory, or other facility.

(5) A person may not be confined in a Department of Corrections facility under this provision beyond the end of the person's executed sentence or the end of any applicable conditional release period, whichever is later. If a person confined in a Department of Corrections facility pursuant to this provision reaches the person's supervised release date and is subject to a period of conditional release, the period of conditional release shall commence on the supervised release date even though the person remains in the Department of Corrections facility pursuant to this provision. At the end of the later of the executed sentence or any applicable conditional release period, the person shall be transferred to a secure treatment facility.

(6) Nothing in this section may be construed to establish a right of an inmate in a state correctional facility to participate in sex offender treatment. This section must be construed in a manner consistent with the provisions of section 244.03.

(c) When a person is temporarily confined in a Department of Corrections facility solely under this subdivision and not based on any separate correctional authority, the commissioner of corrections may charge the county of financial responsibility for the costs of confinement, and the Department of Human Services shall use existing appropriations to fund all remaining nonconfinement costs. The funds received by the commissioner for the confinement and nonconfinement costs are appropriated to the department for these purposes.

~~(c)~~ (d) The committing county may offer a person who is being petitioned for commitment under this chapter and who is placed under a judicial hold order under section 253B.07, subdivision 2b or 7, the option to be held in a county correctional or detention facility rather than a secure treatment facility, under such terms as may be agreed to by the county, the commitment petitioner, and the commitment respondent. If a person makes such an election under this paragraph, the court hold order shall specify the terms of the agreement, including the conditions for revoking the election.

Sec. 122. Minnesota Statutes 2018, section 253D.28, subdivision 2, is amended to read:

Subd. 2. **Procedure.** (a) The supreme court shall refer a petition for rehearing and reconsideration to the chief judge of the judicial appeal panel. The chief judge shall notify the committed person, the county attorneys of the county of commitment and county of financial responsibility, the commissioner, the executive director, any interested person, and other persons the chief judge designates, of the time and place of the hearing on the petition. The notice shall be given at least 14 days prior to the date of the hearing. The hearing may be conducted by interactive video conference under General Rules of Practice, rule 131, and Minnesota Rules of Civil Commitment, rule 14.

(b) Any person may oppose the petition. The committed person, the committed person's counsel, the county attorneys of the committing county and county of financial responsibility, and the commissioner shall participate as parties to the proceeding pending before the judicial appeal panel and shall, no later than 20 days before the hearing on the petition, inform the judicial appeal panel and the opposing party in writing whether they support or oppose the petition and provide a summary of facts in support of their position.

(c) The judicial appeal panel may appoint court examiners and may adjourn the hearing from time to time. It shall hear and receive all relevant testimony and evidence and make a record of all proceedings. The committed person, the committed person's counsel, and the county attorney of the committing county or the county of financial responsibility have the right to be present and may present and cross-examine all witnesses and offer a factual and legal basis in support of their positions.

(d) The petitioning party seeking discharge or provisional discharge bears the burden of going forward with the evidence, which means presenting a prima facie case with competent evidence to show that the person is entitled to the requested relief. If the petitioning party has met this burden, the party opposing discharge or provisional discharge bears the burden of proof by clear and convincing evidence that the discharge or provisional discharge should be denied.

(e) A party seeking transfer under section 253D.29 must establish by a preponderance of the evidence that the transfer is appropriate.

Sec. 123. **REVISOR INSTRUCTION.**

The revisor of statutes shall renumber Minnesota Statutes, section 253B.02, so that the subdivisions are alphabetical. The revisor shall correct any cross-references that arise as a result of the renumbering.

Sec. 124. **REPEALER.**

Minnesota Statutes 2018, sections 253B.02, subdivisions 6 and 12a; 253B.05, subdivisions 1, 2, 2b, 3, and 4; 253B.064; 253B.065; 253B.066; 253B.09, subdivision 3; 253B.12, subdivision 2; 253B.15, subdivision 11; and 253B.20, subdivision 7, are repealed."

Delete the title and insert:

"A bill for an act

relating to .....; amending Minnesota Statutes 2018, sections 119B.21; 119B.26; 144A.484, subdivisions 2, 4, 5, 6; 245.4682, subdivision 2; 245A.02, subdivision 2c; 245A.041, by adding a subdivision; 245A.11, subdivision 2a, by adding a subdivision; 245D.02, by adding a subdivision; 245D.04, subdivision 3;

245D.071, subdivision 3; 245D.081, subdivision 2; 245D.09, subdivisions 4, 4a; 245D.10, subdivision 3a; 245F.02, subdivisions 7, 14; 245F.06, subdivision 2; 245F.12, subdivisions 2, 3; 245G.02, subdivision 2; 245G.09, subdivision 1; 245H.08, subdivisions 4, 5; 253B.02, subdivisions 4b, 7, 8, 9, 10, 13, 16, 17, 18, 19, 21, 22, 23, by adding a subdivision; 253B.03, subdivisions 1, 2, 3, 4a, 5, 6, 6b, 6d, 7, 10; 253B.04, subdivisions 1, 1a, 2; 253B.045, subdivisions 2, 3, 5, 6; 253B.06, subdivisions 1, 2, 3; 253B.07, subdivisions 1, 2, 2a, 2b, 2d, 3, 5, 7; 253B.08, subdivisions 1, 2a, 5, 5a; 253B.09, subdivisions 1, 2, 3a, 5; 253B.092; 253B.0921; 253B.095, subdivision 3; 253B.097, subdivisions 1, 2, 3, 6; 253B.10; 253B.12, subdivisions 1, 3, 4, 7; 253B.13, subdivision 1; 253B.14; 253B.141; 253B.15, subdivisions 1, 1a, 2, 3, 3a, 3b, 3c, 5, 7, 9, 10, by adding a subdivision; 253B.16; 253B.17; 253B.18, subdivisions 1, 2, 3, 4a, 4b, 4c, 5, 5a, 6, 7, 8, 10, 11, 12, 14, 15; 253B.19, subdivision 2; 253B.20, subdivisions 1, 2, 3, 4, 6; 253B.21, subdivisions 1, 2, 3; 253B.212, subdivisions 1, 1a, 1b, 2; 253B.22, subdivisions 1, 2, 3, 4; 253B.23, subdivisions 1, 1b, 2; 253B.24; 253D.02, subdivision 6; 253D.07, subdivision 2; 253D.10, subdivision 2; 253D.28, subdivision 2; 256B.0625, subdivision 5l; 256B.0652, subdivision 10; 256B.0911, subdivisions 1, 3, 3b, 4d, by adding subdivisions; 256B.092, subdivision 1a; 256B.0941, subdivisions 1, 3; 256B.0944, subdivision 1; 256B.0947, subdivisions 2, 3, 4, 5, 6; 256B.0949, subdivisions 2, 5, 6, 9, 13, 14, 15, 16; 256B.49, subdivision 16; 256D.02, subdivision 17; 256I.03, subdivisions 3, 14; 256I.05, subdivisions 1c, 1n, 8; 256I.06, subdivision 2, by adding a subdivision; 256J.08, subdivision 73a; 256P.01, by adding a subdivision; 257.0725; 260C.219; Minnesota Statutes 2019 Supplement, sections 144A.484, subdivision 1; 245.4889, subdivision 1; 245A.03, subdivision 7; 245A.149; 245A.18, subdivision 2; 245A.40, subdivision 7; 245D.071, subdivision 5; 245D.09, subdivision 5; 254A.03, subdivision 3; 254B.05, subdivision 1; 256B.056, subdivision 5c; 256B.064, subdivision 2; 256B.0711, subdivision 1; 256B.0911, subdivisions 1a, 3a, 3f; 256B.092, subdivision 1b; 256B.49, subdivisions 13, 14; 256B.4914, subdivision 10a; 256I.04, subdivision 2b; 256S.01, subdivision 6; 256S.19, subdivision 4; Laws 2017, First Special Session chapter 6, article 7, section 33, subdivisions 2, 3; Laws 2019, First Special Session chapter 9, article 5, section 86; article 14, section 2, subdivision 33; proposing coding for new law in Minnesota Statutes, chapters 120A; 245A; 245D; 253B; 254A; 256B; repealing Minnesota Statutes 2018, sections 245A.144; 245A.175; 245F.02, subdivision 20; 253B.02, subdivisions 6, 12a; 253B.05, subdivisions 1, 2, 2b, 3, 4; 253B.064; 253B.065; 253B.066; 253B.09, subdivision 3; 253B.12, subdivision 2; 253B.15, subdivision 11; 253B.20, subdivision 7; Laws 2005, First Special Session chapter 4, article 7, sections 50; 51; Laws 2012, chapter 247, article 4, section 47, as amended; Laws 2015, chapter 71, article 7, section 54, as amended; Laws 2017, First Special Session chapter 6, article 1, sections 44, as amended; 45, as amended; Minnesota Rules, parts 2960.3070; 2960.3210."