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H.F. 33 HHS Omnibus Summary – 2021 First Special Session

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ARTICLE 1
DEPARTMENT OF HUMAN SERVICES HEALTH CARE PROGRAMS

Section 1 (256.01, subd. 28) authorizes the expansion of the Minnesota encounter alerting system to improve care and lower health care costs.

Section 2 (256B.0371) requires the commissioner to submit an annual report for the most recent complete calendar year on the percentage of adults and children ages one through 20 enrolled in the medical assistance program and receiving dental services through fee-for-service or through a managed care plan or county-based purchasing plan who received at least one dental visit. The report must include statewide utilization, utilization by county, utilization by children, and utilization by adults.

Section 3 (256B.04, subd.14) authorizes the commissioner to utilize volume purchase through competitive bidding for allergen-reducing products.

Section 4 (256B.055, subd. 6) expands medical assistance eligibility for pregnant women to include twelve months postpartum, effective July 1, 2022, or upon federal approval, whichever occurs later.

Section 5 (256B.056, subd. 10) makes a conforming change to the expansion of eligibility to twelve months postpartum by requiring a woman to update their income and asset information following the end of the 12 months.

Section 6 (256B.06, subd. 4) makes a conforming change to the expansion of eligibility to twelve months postpartum for noncitizens. Specifies that if federal approval is not obtained for this section, that this section shall become effective on the same effective date as section 4 and shall be funded with all state funds.

Section 7 (256B.0625, subd. 9) expands adult dental medical assistance coverage to include nonsurgical treatment for periodontal disease effective January 1, 2022.

Section 8 (256B.0625, subd. 13) authorizes prescription refills of 90 days for drugs included on a 90-day supply list published by the commissioner.

Section 9 (256B.0625, subd. 13c) extends the drug formulary committee until June 30, 2023.

Section 10 (256B.0625, subd. 13d) adds medical assistance coverage for weight loss drugs.

Section 11 (256B.0625, subd. 13e) increases the dispensing fee for prescription drugs dispensed under the fee-for-services program from $10.48 to $10.77, effective January 1, 2022. This section also requires the statewide cost of dispensing survey that is required to be completed every three years to be calculated separately for specialty drugs and for non-specialty drugs.

Section 12 (256B.0625, subd. 13g) requires the commissioner, before deleting a drug from the preferred drug list or modifying the inclusion of a drug on the list, to consider any implications the change may have on state public health policies and initiatives and any impact on increasing health disparities in the state. The section also requires the commissioner to conduct a public hearing and to provide public notice prior to the hearing that includes the deletion or modification being considered and the information being relied on by the commissioner in proposing the deletion or modification.

Section 13 (256B.0625, subd.18) authorizes the commissioner to provide a monthly public transit pass for nonemergency medical transportation to medical assistance recipients. Permits any recipient who is eligible for one public transit trip for a medical necessary covered service to select to receive a transit pass for that month. If the recipient receives a monthly transit pass the recipient is not eligible for other modes of transportation unless an unexpected need arises that cannot be accessed through public transit.

Section 14 (256B.0625, subd.31) states that allergen-reducing products shall be considered a durable medical equipment if the product meets the requirements under section 256B.0625, subd. 67, effective January 1, 2022, or upon federal approval whichever is later.

Section 15 (256B.0625, subd.58), paragraph (a) requires the commissioner, when administering the early screening, diagnosis, and treatment services (EPSDT) program, to; (1) provide information on the benefits of preventive visits, services available, and assistance in finding a provider, transportation or interpreter services; (2) maintain an up to date periodicity schedule in the department policy manual; and (3) maintain up to date policies for providers on delivering EPSDT services in the department provider manual on the department website.

Paragraph (b) authorizes the commissioner to contract for the administration of outreach services for EPSDT services as required in the program.

Paragraph (c) authorizes the commissioner to contract for the required EPSDT outreach services including contracting with an integrated health partnership (IHP). If an IHP chooses to provide the outreach services, the IHP shall receive compensation on a PMPM basis for each child.

Section 16 (256B.0625, subd. 67) adds enhanced asthma care services and related products provided in children's homes as a covered medical assistance benefit for children with poorly controlled asthma.

Section 17 (256B.0631, subd. 1) modifies the cost sharing requirement in fee-for-service medical assistance for a brand-named multisource drug listed in preferred status on the preferred drug list from $3 per drug to $1 per drug.

Section 18 (256B.69, subd. 6f) requires applicable fee schedules for covered dental services to be provided to individual dental providers upon request.

Section 19 (256B.69, subd. 9f) requires the commissioner to submit an annual report to the legislature on managed care and county-based purchasing plan provider reimbursement rates.

Section 20 (256B.75) describes the rate methods and rate calculation parameters that the commissioner must use to set prospective payment methodologies for services delivered in outpatient hospital and ambulatory surgical centers.

Section 21 (256B.79, subd. 1) modifies the definition of targeted populations for the integrated care for high-risk pregnant women grant program to refer to MA enrollees residing in "communities" rather than "geographic areas."

Section 22 (256B.79. subd.3) strikes language that gives priority to integrated perinatal care collaboratives that received grants prior to January 1, 2019, when awarding subsequent grants in the integrated care for high-risk pregnant women grant program.

Section 23 (256B.795) requires the commissioner to submit a biennial report to the legislature on the number of pregnant and postpartum women enrolled in MA who received certain benchmark services or treatment during the reporting period.

Section 24 (256L.07, subd. 2) permits an individual who has access to subsidized health coverage through a spouse's or parent's employer that meets the requirements of minimum essential coverage under federal ACA regulations to be eligible for MinnesotaCare, if the amount the employee pays for dependent coverage exceeds the required income contribution for determining whether employer coverage is affordable under the ACA.

Section 25 (256L.15, subd. 2) requires the commissioner to adjust the premium scale for MinnesotaCare to ensure that premiums are not greater than what an individual would be required to pay for a benchmark plan in the exchange. This section is effective retroactively from January 1, 2021.

Section 26 [Federal approval; extension of postpartum coverage] requires the commissioner of human services to seek federal approval to extend medical assistance postpartum coverage.

Section 27 [COVID-19 treatment, testing, and vaccinations] requires MA to cover treatment, testing and vaccinations for COVID-19 as required for the time periods specified in the federal American Rescue Plan Act. This section is effective retroactively from March 11, 2021.

Section 28 [Dental home demonstration project plan] requires the commissioner to develop a plan to implement a dental home demonstration project.

Section 29 [Overpayments for durable medical equipment] requires the commissioner of human services to repay the federal government any amount owed for payments made in excess to the allowable reimbursement amount for payments made between January 1, 2018, and June 30, 2019, for durable medical equipment.

Section 30 [Proposed formulary committee] requires the commissioner of human services to submit to the legislature by March 1, 2022, an overview of the drug formulary committee that includes a review of the current composition and any recommendations of the committee, and a summary of the committee's policies and procedures for the operation of the committee.

Section 31 [Response to COVID-19 public health emergency], paragraph (a) prohibits the commissioner of human services from collecting any unpaid premiums for a coverage month that occurred during the public health emergency declared by the US Secretary of Health and Human Services.

Paragraph (b) suspends periodic data matching for up to six months following the last day of the COVID-19 public health emergency declared by the US Secretary of Health and Human Services.

Paragraph (c) suspends the annual report required to be issued on periodic data matching for one year following the last day of the COVID-19 public health emergency declared by the US Secretary of Health and Human Services.

Section 32 [Dental program delivery study] requires the commissioner of human services to review the Medicaid dental program delivery systems in states that have enacted and implemented a carve out dental program delivery system comparing program design, provider rates, program costs, and quality metrics for children ages one though twenty with at least one preventive dental visit within a year; and submitting the results of this review to the legislature by February 1, 2022.
Section 33 [Repealer], paragraph (a) repeals rules related to the EPSDT program.

Paragraph (b) repeals section 16A.724, subd. 2 effective July 1, 2025, which requires an annual transfer from the health care access fund to the general fund.

ARTICLE 2

DEPARTMENT OF HUMAN SERVICES
LICENSING AND BACKGROUND STUDIES

Sections 1-2, 17, 30-51 and 67-68 modify provisions relating to initiation of background studies by existing provider types and new provider types, including early intensive developmental and behavioral intervention (EIDBI) providers, MNsure, the Professional Educators Licensing Standards Board, and the Board of School Administrators.

Section 1 [62V.05, subdivision 4a] requires the board of MNsure to initiate a background study for each navigator, in-person assister, and certified application counselor, and shall not permit any individual to provide any service or function in those roles until the results of the study. The board is also required to review an individual's request for reconsideration of a background study disqualification.

Section 2 (122A.18, subdivision 8) makes clarifying changes to the statute governing background studies initiated by the Professional Educators Licensing Standards Board and the Board of School Administrators.

Section 17 [245C.03, subdivisions 14-18] authorizes the commissioner of human services to conduct background studies of all first-time applicants for educator licenses with the Professional Educator Licensing and Standards Board. **Subdivision 15** authorizes the commissioner of human services to conduct background studies of all first-time applicants for administrator licenses with the Board of School Administrators. **Subdivision 16** authorizes the commissioner of human services to conduct background studies of all MNsure navigators, in-person assisters, and certified application counselors, and authorizes the board of MNsure to initiate background studies and review requests for reconsideration.

Subdivision 17 requires the commissioner of human services to conduct 245C background studies when a study is initiated by an EIDBI provider.

Sections 30-32 [245C.10, subdivision 1b, 1c, 1d] specify the commissioner's authority to collect, the services covered by, and the terms for payment of for background study fees, fingerprint and photograph processing fees, and national criminal history record check fees.

Sections 33-44 and 46 (245C.10, subdivisions 2-6, 8-14, 16) increase the existing background study fees for various providers from $20 to $42 per study.

Section 45 (245C.10, subdivision 15) specifies when the background study fee for guardians and conservators must be paid by the guardian or conservator, or by the court or an estate.

Section 47 [245C.10, subdivision 17] requires the commissioner of human services to collect a fee not to exceed $42 for each 245C background study initiated by an EIDBI provider.

Section 48 [245C.10, subdivision 18] clarifies that applicants and license holders for occupations regulated by the commissioner of health are responsible for paying background study fees to the Department of Human Services.

Section 49 [245C.10, subdivision 19] directs the commissioner to set a fee for background studies initiated by MNsure, with the amount to be established through an interagency agreement between the commissioner and the board of MNsure.

Section 50 [245C.10, subdivision 20] directs the commissioner to set a fee of up to $51 for background studies initiated by the Professional Educators Licensing Standards Board.

Section 51 [245C.10, subdivision 21] directs the commissioner to set a fee of up to $51 for background studies initiated by the Board of School Administrators.

Section 67 (245C.32, subdivision 2) makes a conforming change to increase the background study fee from $20 to $42.

Section 68 [256B.0949, subdivision 16a] requires EIDBI services agency to fulfill existing background studies requirements under this section by initiating a background study through the commissioner's NETStudy system.

Section 3 [245.975] directs the governor to appoint an ombudsperson for family child care providers to serve a four-year term and carry out duties, including advocating on behalf of family child care providers to address all areas of concern to providing family child care services, licensing and regulatory compliance correction orders, and appeals, recommending program improvement and provider education methods to the commissioner, operating a telephone line to answer questions, receive complaints, and discuss agency actions, and application assistance. The ombudsperson is authorized to hire staff, to access data necessary for discharging the duties of the office, and to receive copies of all provider correction orders, penalty assessments, and complaint

investigations on a quarterly basis. The ombudsperson must operate independently of the department of human services and must have experience as a family child care provider, and experience in interpretation of laws and regulations, investigations, record keeping, report writing, public speaking, and management. A person is not eligible to serve as ombudsperson while running for or holding public office and cannot currently hold a family child care license. At least one of the ombudspersons must have been a licensed family child care provider for at least three years. The commissioner of human services must provide the ombudsperson with office space, supplies, and other support, and must provide child care providers with the contact information for the ombudsperson.

Sections 4-5, 8, 24-26, 28, 53, 55, 61-64, 69, and 75 modify provisions relating to licensed family foster setting background study requirements. All sections are effective July 1, 2022, except that section 28 is effective July 1, 2021, section 69 is effective July 1, 2023, and sections 24 and 25 would be effective by operation of law on July 1, 2021, since they do not specify an effective date.

Section 4 (245A.05, paragraph (a), clause (11)) permits the commissioner of human services to deny a family foster setting license if an individual has non-disqualifying background study information that reflects on the individual's ability to safely care for foster children.

Section 5 (245A.07, subdivision 1, paragraph (a)) authorizes the commissioner to take a licensing action against a license holder based on non-disqualifying background study information that reflects on the individual's ability to safely care for foster children.

Section 8 [245A.16, subdivision 9] lists the information and other materials that must be included and followed by a county agency or designated private agency prior to recommending that the commissioner take a licensing action for a licensed family foster setting.

Sections 24-25 (245C.05, subdivision 2c, paragraph (c), clause (1); 245C.05, subdivision 2d) modify the privacy and fingerprint data notices that must be provided to a background study subject, to inform the subject that the FBI will not retain the subject's fingerprints.

Section 26 (245C.05, subdivision 4, paragraph (a), clause (3)) requires the commissioner's secure electronic information transmission system to accommodate electronic transmission to counties of a summary of non-disqualifying results, except as prohibited by law.

Section 28 (245C.08, subdivision 3, paragraph (c)) removes the prohibition against the commissioner sharing data obtained during a national criminal history check with county agencies, effective July 1, 2021. The prohibition remains with respect to sharing such data private agencies or prospective employers.

Section 53 (245C.14, subdivision 1, paragraph (c)) makes a conforming change to accommodate the new subdivision with the disqualifying crimes and conduct for family foster setting background study subjects.

Section 55 [245C.15, subdivision 4a] lists the disqualifying crimes, acts, and other conduct for licensed family foster setting disqualifications. Paragraphs (a) and (b) establish permanently disqualifying crimes and conduct. Paragraphs (d) and (e) establish five-year disqualifying crimes and conduct. Paragraph (c) establishes that any involuntary termination, or voluntary termination entered to settle an involuntary termination proceeding, of an individual's parental rights, including a substantially similar involuntary termination that takes place in another state, results in a 20-year disqualification period. Paragraphs (f) and (g) establish that aiding or abetting, or committing a substantially similar

offense in another state to the offenses or acts listed in paragraphs (a), (b), (e), or (f) results in the same permanent or 5-year disqualification.

Section 61 (245C.24, subdivision 2, paragraphs (e) and (f)) prohibit the commissioner form setting aside or granting a variance for the disqualification of an individual 18 or older that is based on a crime or conduct listed in 245C.15, subdivision 4a, paragraphs (a) and (b). The commissioner is allowed to grant a variance to the disqualification of an individual who is under 18 years old at the time of the background study.

Sections 62-63 (245C.24, subdivisions 3, 4) make conforming changes to remove references to foster care setting licenses in the existing ten- and seven-year bars to set aside a disqualification.

Section 64 [245C.24, subdivision 6] establishes a five-year bar to set aside a disqualification for foster care setting licenses that is based on conviction of a felony listed in section 245C.15, subdivision 4a, paragraph (c). The commissioner is allowed to set aside or grant a variance to the disqualification of an individual who is under 18 years old at the time of the background study.

Section 69 (260C.215, subdivision 4, clause (7)) revises the commissioner's duties with respect to foster care to add a duty to establish family foster setting licensing guidelines for county agencies or designated private agencies to perform licensing functions. The guidelines are considered directives of the commissioner.

Section 75 (Direction to the Commissioner of Human Services; Child Foster Care Licensing Guidelines) directs the commissioner to consult with relevant stakeholders to develop family foster setting guidelines for use by county agencies or designated private agencies when carrying out licensing functions. The guidelines are due by July 1, 2023.

Section 6 (245C.10, subdivision 4, paragraph (d)) clarifies terminology to clarify which license fees apply to detoxification programs or withdrawal management programs.

Section 7 (245A.14, subdivision 4) clarifies the conditions under which the commissioner may issue up to four special family child care licenses at a single location, which special family child care provider types must designate a person as the primary provider of care in order to receive a license, and that license holders must ensure that all employees must satisfy training and background study requirements.

Section 9 (245A.50, subdivision 7, paragraph (b)) authorizes child care training instructors who are also family child care providers to count up to two hours of training instruction toward certain subject areas (Establishing Healthy Practices and Ensuring Safety) of the annual 16-hour training requirement for family child care providers.

Section 10 (245A.50, subdivision 9, paragraph (d)) adds courses that may satisfy a provider's annual active supervision training requirement, instead of completing the two-hour course developed by the commissioner.

Sections 11, 24, 27, and 66 authorize the commissioner of human services to contract with more than one vendor to collect fingerprints for background studies.

Section 11 (245C.02, subdivision 4a) authorizes the commissioner of human services to contract with more than one qualified organization to serve as an "authorized fingerprint collection vendor" that collects fingerprints for background studies.

Section 24 (245C.05, subdivision 2c, paragraph (c), clause (3)) makes conforming changes.

Section 27 (245C.05, subdivision 5) makes conforming changes.

Section 66 (245C.32, subdivision 1) makes corresponding changes.

Sections 12, 15-17, 52, 54, and 56-60 make clarifying changes to the definitions that apply to the background studies chapter, and clarify the background study requirements for the programs that are subject to chapter 245C.

Section 12 (245C.02, subdivision 5) clarifies the definition of "background study" to include collection and processing of fingerprints and photographs.

Section 15 [245C.02, subdivision 11c] adds a definition of "entity" to mean any program, organization, or agency that initiates a background study.

Section 16 [245C.02, subdivision 16a] adds a definition of "results" to mean the determination of eligibility for employment as a result of the individual's background study.

Section 17 (245C.03) clarifies which licensed and unlicensed service providers are subject to the provisions of chapter 245C governing background studies.

Section 52 (245C.13, subdivision 2) specifies when a personal care provider organization must initiate a background study of a personal care assistant.

Sections 54 [245C.14, subdivision 4] and 56-60 (245C.16, subdivisions 1-2; 245C.17, subdivision 1, 8; 245C.18) specify the consequences of receiving a disqualification, process for determining a disqualification, and requirements for issuing notice of a disqualification regarding background studies for a licensed child care center or certified license-exempt child care center setting.

Sections 13 and 18 establish "alternative background studies," under which the commissioner would share certain background study information with the entity that requested the study, but not make an eligibility determination based upon the shared information.

Section 13 [245C.02, subdivision 5b] makes a conforming change to add a statutory definition for "alternative background study."

Section 18 [245C.031] establishes which individuals are subject to the alternative background study process, under which their employer initiates the background study and receives information as a result of the study from the commissioner.

Sections 14, 19 and 65 establish "public law background studies," which facilitate background studies for individuals having direct contact with persons served by a licensed sex offender treatment program, according to federal requirements.

Section 14 [245C.02, subdivision 11c] makes a conforming change to add a statutory definition for "public law background study."

Section 19 [245C.032] establishes which individuals are subject to the public law background study requirements, as well as which existing background study processes and requirements must be followed when conducting a public law background study.

Section 65 [245C.30, subdivision 1a] establishes that a variance related to a public law background study must state the services that may be provided by the disqualified individual, and the conditions that must be followed for the variance to remain in effect.

Sections 20-23 and 29 make various clarifying changes to the background studies statutes.

Section 20 (245C.05, subdivision 1, paragraph (e)) clarifies that an individual subject of a background study must also submit a consent form for applicable national and state level

record checks.

Sections 21-23 (245C.05, subdivisions 2, 2a-2b) clarify that the entity initiating the background study is responsible for collecting the information produced as a result of the study.

Section 29 [245C.08, subdivision 5] clarifies that the commissioner of human services is authorized to receive background study information.

Section 45 (sic) [245G.031] establishes an alternative licensing procedure for licensed substance abuse disorder providers to be deemed in compliance with the required statutory standards in order to be approved for license renewal, based on a qualified industry accreditation rather than an inspection by the Department of Human Services. Providers are eligible for the alternative licensing procedure if they have had at least one inspection by the commissioner of human services, have been free from licensing actions, have had no substantiated allegations of maltreatment within 10 years, and have maintained substantial compliance with the licensing statutes and regulations. Providers that qualify for alternative licensing status will not be subject to routine licensing inspections so long as the provider maintains the requirements for alternative licensing status.

Section 70 (Laws 2020, First Special Session, chapter 7, section 1, subdivision 1) adds certain modifications to DHS programs that facilitate electronic service visits to the group of waivers that may be extended past the end of the peacetime emergency for purposes of maintaining federal funding.

Sections 71-72 (Laws 2020, First Special Session, chapter 7, section 1, subdivisions 3, 5) extend the expiration of the Department of Human Services background studies modification to 365 days (as opposed to 60 days) following the end of the peacetime public health emergency related to COVID-19.

Section 73 (Legislative Task Force; Human Services Background Study Eligibility) establishes the Human Services Background Study Eligibility Task Force, consisting of 26 members representing interested or affected populations, that would review the statutes relating to human services background study disqualifications in order to evaluate their effectiveness, strengths and weaknesses, unintended consequences, or other areas for improvement or modernization. The task force would develop legislative proposals to address issues it identifies following its review. The task force would meet at least monthly, beginning September 1, 2021, and would submit an interim report of its findings and draft legislation by March 1, 2022, and a final report by December 16, 2022.

Section 74 (Child Care Center Regulation Modernization) directs the commissioner of human services to contract with a consultant in order to develop a proposal that would implement a risk-based model for monitoring and enforcing child care licensing compliance. The consultant must engage with relevant stakeholders and solicit input on how to develop the risk-based compliance system. The commissioner's report and proposed legislation based on the consultant's work must be submitted to the legislature by February 1, 2024.

Section 76 (Direction to Commissioner of Human Services; DHS Family Child Care Frequently Asked Questions Website Modifications) directs the commissioner of human services to expand the "Frequently Asked Questions" website for family child car providers to include more answers to submitted questions, and to implement a function to search for answers based on question topic, by January 1, 2022.

Section 77 (Direction to Commissioner of Human Services; Family Child Care Task Force Recommendations Implementation Plan) directs the commissioner of human services to include family child care provider representatives in any stakeholder groups that participate in

implementing Family Child Care Task Force recommendations.

Section 78 (Direction to Commissioner of Human Services; Family Child Care One-Stop Assistance Network) directs the commissioner of human services to develop a proposal that would create a "one-stop" assistance network resource for new or existing family child care providers to contact individuals with experience starting a licensed family child care program, or individuals with technical expertise regarding the applicable licensing statutes and procedures. The proposal must also include an estimated timeline and budget for the assistance network, as well as a plan to raise awareness of the assistance network.

Section 79 (Direction to the Commissioner of Human Services; Recommended Family Child Care Orientation Training) directs the commissioner of human services to develop recommended orientation training by July 1, 2022, for family child care license applicants to receive uniform materials with basic information about the statutes and rules governing family child care licensure.

Section 80 (Family Child Care Regulation Modernization) directs the commissioner of human services to contract with a consultant in order to develop a proposal that would implement a risk-based model for monitoring and enforcing child care licensing compliance. The consultant must engage with relevant stakeholders and solicit input on how to develop the risk-based compliance system. The commissioner's report and proposed legislation based on the consultant's work must be submitted to the legislature by February 1, 2024.

Section 81 (Family Child Care Training Advisory Committee) establishes a Family Child Care Training Advisory Committee to begin January 1, 2022 and expiring December 1, 2025, with members serving two-year terms. The advisory committee will advise and make recommendations to the commissioner of human services on updates to, modernization of, or difficulties facing providers with family child care training requirements, or other ideas for improving access and quality of family child care provider training.

The advisory committee's membership consists of eight family child care providers (four from greater Minnesota, two from the metropolitan area, one appointed by the Minnesota Association of Child Care Professionals, and one appointed by the Minnesota Child Care Provider Information Network), two members appointed by the Association of Minnesota Child Care Licensors, and five members with expertise in child development, instructional design, or training delivery (two appointed by the speaker of the house, two appointed by the senate majority leader, and one appointed by Achieve, the Minnesota Center for Professional Development). Advisory committee members are not permitted to be employed by DHS, and must represent diverse cultural communities. Initial member appointments must be made by December 1, 2021, and replacement appointments must be made by December 1 of the year in which a member's two-year term expires.

The advisory committee must meet at least twice annually, and the commissioner or commissioner's designee must also attend all meetings. The commissioner must report annually by December 15 to the relevant legislative committees on any recommendations issued by the advisory committee.

Section 82 (Direction to Commissioner of Human Services; Alternative Child Care Licensing Models) requires the commissioner to consult with counties, child care providers, and other stakeholders to review child care licensing models that are not currently allowed under statute or rule, including those related to age, group size, and capacity, to consider whether any modifications could address the state's child care needs while maintaining child safety, health, and wellbeing. The commissioner must report any recommendations to the legislature by January 1, 2023.

Section 83 (Direction to Commissioner of Human Services; Federal Fund and Child Care and Development Block Grant Allocations) directs the commissioner of human services to allocate

amounts from the federal fund and the federal child care and development block grant (CCDBG) fund in fiscal year 2022.

Paragraph (a) allocates $3,000,000 from the CCDBG for grants to organizations that will operate the child care one-stop regional assistance network.

Paragraph (b) allocates $50,000 from the CCDBG for modifications to the DHS family child care provider frequently asked questions website.

Paragraph (c) allocates $4,500,000 from the CCDBG for costs to cover the fees for administering child care background studies.

Paragraph (d) allocates $2,059,000 from the CCDBG for the child care center regulation modernization project.

Paragraph (e) allocates $1,719,000 from the CCDBG for the family child care regulation modernization project.

Paragraph (f) allocates $100,000 from the federal fund for the working group to review alternative child care licensing models.

Paragraph (g) allocates $59,000 from the CCDBG for the family child care training advisory committee.

Paragraph (h) allocates $7,650,000 from the CCDBG for child care information technology and system improvements at DHS.

Paragraph (i) specifies that the allocations in this section are available until June 30, 2025.

Section 84 (Revisor Instruction) instructs the revisor to renumber the statute providing definitions for the background studies chapter, so that the terms appear alphabetically, and to correct any affected cross-references.

Section 85 (Repealer) repeals the portion of session law that would have required certain DHS program waivers and modifications to expire June 30, 2021.

ARTICLE 3
HEALTH DEPARTMENT

Section 1 (62J.495, subd. 1) removes obsolete language regarding the development of uniform standards for interoperable electronic health records systems as part of an annual report to the legislature.

Section 2 (62J.495, subd. 2) eliminates an annual report on the progress in implementing a statewide health information infrastructure.

Section 3 (62J.495, subd. 4) eliminates a reference to a specific federal HIT strategic plan with which the statewide interoperable health information infrastructure plan must be consistent and removes language referring to developing health information technology regional extension centers and gathering best practices by regional centers. Also modifies language to refer to being consistent with updated federal plans and removes references to specific federal legislation.

Section 4 (62J.497, subd. 1) strikes the definition of backward compatible in the definitions for the electronic prescription drug program. Amends other definitions by updating the language and removing references to an obsolete implementation guide.

Section 5 (62J.497, subd. 3) strikes a list of specific transactions that must be conducted using the NCPDP SCRIPT standard for electronic prescribing.

Section 6 (62J.63, subd. 1) removes language requiring the commissioner to establish and administer a center for health care purchasing improvement and assigns certain functions of the center to the commissioner.

Section 7 (62J.63, subd. 2) removes language authorizing the commissioner to appoint staff to the center of health care purchasing improvement. And other duties related to the center.

Section 8 (62U.04, subd. 4) requires health plan companies and third-party administrators to submit encounter data on a monthly basis instead of every six months to the all payer claims data base.

Section 9 (62U.04, subd. 5) requires health plan companies and third-party administrators to submit pricing data on a monthly basis instead of every six months to the all payer claims data base.

Section 10 (103H.201, subd. 1) authorizes the commissioner to adopt health risk limits for substances degrading groundwater that may be probable carcinogens as derived from a quantitative estimate of the chemical's carcinogenic potency either published by the US environmental protection agency or determined by the commissioner to have undergone through scientific review.

Section 11 (144.064) requires the commissioner to make available to practitioners, women who may become pregnant, expectant parents, and parents of infants evidence based information about genital CMV (human herpesvirus cytomegalovirus). The section also requires the commissioner to establish an outreach program to educate women who may become pregnant, expectant parents, and parents or infants about CMV and to raise awareness for CMV among health care providers who provide care to expectant mothers and infants. This section also requires the advisory committee on heritable and congenital disorders to review congenital CMV for inclusion to the list of tests to be performed as part of a newborn screening panel. If the committee recommends inclusion the newborn screening fee shall be increased by $43 to $220.

Section 12 (144.0724, subd. 1) clarifies that the existing residence reimbursement classification system for nursing home residents is a case mix classification following a resident assessment.

Section 13 (144.0724, subd. 2) updates the definition of activities of daily living for the purposes of resident reimbursement case mix classifications by replacing "grooming" with "personal hygiene," "positioning" with "bed mobility, and "mobility" with "locomotion."

Section 14 (144.0724, subd. 3a) adds case mix when referring to resident reimbursement case mix classifications and removes a reference to the case mix classification manual for nursing facilities.

NOTE: for changes to section 144.0724, subdivision 4, see Article 13, section 1.

Section 15 (144.0724, subd.5) modifies an existing option for submitting resident assessments for short stays by allowing a facility that has elected to submit resident assessments for short stay residents to not submit a resident assessment if the resident is admitted and discharged on the same day, in which case the reimbursement for the resident's one-day stay will be based on a case mix index of 1.0.

Section 16 (144.0724, subd. 7, paragraph (a)) makes conforming and stylistic changes and clarifies that a nursing facility must provide a resident or the resident's representative with the

resident's resident classification notice within 3 business days of receipt of the notice from the commissioner.

Paragraph (b) clarifies the timeline for a nursing facility to provide a resident or resident representative with an explanation of a modified assessment that results in the commissioner issuing a modified resident classification for the resident. Under current law, there appears to be no required timeline for providing the explanation. Under the new language, the facility must provide the resident the explanation of the modified assessment within three business days of the facility providing the resident with the notice from the commissioner of a modified resident classification.

Section 17 (144.0724, subd. 8) clarifies the procedures and timelines following a commissioner's audit of a nursing facility's resident assessments for accuracy.

Section 18 (144.0724, subd. 9) clarifies the procedures and timelines for residents and facilities to request of the commissioner that the commissioner reconsider a resident's case mix classifications.

Section 19 (144. 0724, subd. 12) deletes obsolete language.

Section 20 (144.125, subd. 1) increases the newborn screening fee from $135 to $177 per specimen.

Sections 21 – 24 add alcohol and drug counselors to the health professional education loan forgiveness program.

Section 21 (144.1461) requires hospitals with obstetrics and birth centers to develop or access a continuing education curriculum and make available to direct care employees and contractors who routinely care for patients who are pregnant or postpartum a continuing education course on anti-racism training and implicit bias. Specifies the requirements of the continuing education curriculum and course that must be available. This section also requires the commissioner to identify barriers to obtaining midwife and doula services for groups with the most significant disparities in maternal and infant mortality and morbidity; promote diversity in the midwife and doula workforce and explore ways to ensure that midwife and doula training and education are culturally responsive and tailored to the specific needs of groups with the most significant disparities.

Section 22 (144.1501, subd.1) adds a definition for alcohol and drug counselors in the health professional education loan forgiveness program.

Section 23 (144. 1501, subd. 2) adds alcohol and drug counselors to the health professional education loan forgiveness program who agree to practice in designated rural areas or underserved urban communities.

Section 24 (144.1501, subd. 3) adds individuals who are enrolled in a training or education program to become an alcohol and drug counselors to the list of professions eligible for loan forgiveness under the health professional education loan forgiveness program.

Section 25 (144.212, subd. 12) adds a definition of homeless youth to the vital records sections.

Section 26 (144.225, subd. 2) allows confidential data on the birth of a child born to a woman not married to the child's father to be disclosed to the child if the child is under 16 and is a homeless youth.

Section 27 (144.2255) establishes procedures and documentation requirements for a homeless youth to obtain a verified birth record.

Section 28 (144.226) authorizes the state registrar to charge a convenience fee and a transaction fee for electronic transactions and transactions by telephone or the internet for distribution of vital records.

Section 29 (144.226) exempts a homeless youth from being charged a fee for receiving a certified birth record or statement of no vital record found.

Section 30 (144.551, subd. 1), **paragraph (b), clause (8)** amends an existing exception to the hospital construction moratorium to require hospital beds transferred from a closed hospital to another site or complex in a hospital corporate system to be first used to replace the beds within the hospital corporate system that had been used in the closed hospital for mental health services and substance use disorder services before transferring remaining beds for any other purpose.

> **Paragraph (b), clause (29)** exempts from the hospital moratorium a project to add 45 licensed beds at regions hospital, upon submission of a plan to the commissioner for public review and the addition of the 15 inpatient mental health beds specified in the clause 28 exception. Five of the additional 45 beds must be designated for use for inpatient mental health and must be added to the hospital's bed capacity before the remaining 40 beds are added. Permits the hospital to add licensed beds under this clause prior to the completion of the public interest review provided the hospital submits it plan by 2021 deadline and adheres to the timelines for the public interest review.
>
> **Paragraph (b), clause (30)** exempts from the moratorium upon submission of a plan to the commissioner for public review a project to add up to 30 licensed beds in an existing psychiatric hospital in Hennepin County that exclusively provides care to patients who are under the age of 21 years of age on the date of admission. Permits the hospital to add licensed beds under this clause prior to the completion of the public interest review provided the hospital submits it plan by 2021 deadline and adheres to the timelines for the public interest review.

Section 31 (144.555) modifies the current required hospital closing notices and extends the closing notice requirement to any facility licensed under sections 144.50 to 144.56.

> **Subdivision 1** modifies the current notice of closing subdivision to apply to any facility licensed under sections 144.50 to 144.56 other than a hospital when the facility voluntarily plans to cease operations or curtail operations to the extent that patients or residences must be relocated.
>
> **Subd. 1a** creates a new notice of closing for hospitals. Requires the controlling person of a hospital to notify the commissioner of health and the public at least 120 days before the hospital voluntarily plans to implement certain specified scheduled actions.
>
> **Subd. 1b** requires the commissioner to conduct a public hearing within 45 days of receiving notice of closing under subdivision 1a and requires the controlling person of the hospital to participate in the hearing.

Subd. 1c specifies that notwithstanding the time period required in subdivision 1a, the controlling person of a hospital must notify the commissioner and the public as soon as practicable after deciding to take an action specified in subdivision 1a if the action is caused by a natural disaster or other emergency or an inability of a hospital to provide health service due to its inability to retain or secure essential staff after reasonable effort.

Subd. 2 modifies the penalty by for failure to comply with this section by making conforming changes.

Sections 32 to 35 make changes to the lead poisoning prevention act.

Section 32 (144.9501, subd. 17) amends the definition of lead hazard reduction to permit it to take place at any location where lead hazards are identified.

Section 33 (144.9502, subd. 3) authorizes the commissioner to prescribe the way a medical clinic, laboratory, or facility reports results of blood lead analyses to the commissioner.

Section 34 (144.9504, subd. 2) makes several changes to lead risk assessments conducted by assessing agencies: expands the locations where an assessing agency must conduct lead risk assessments; requires a lead risk assessment to be conducted within ten working days if a child has a venous blood lead level of ten micrograms of lead per deciliter of blood; requires a lead assessment to be conducted within 20 working days if a child or pregnant female is at a location where lead hazards are suspected and has a venous blood level of five micrograms of lead per deciliter of blood; and requires that lead assessments be conducted if a child under the age of 18 has one of the listed blood lead levels.

Section 35 (144.9504, subd. 5) expands an assessing agency's authority to order lead hazard reduction.

Section 36 (145.32, subd.1) permits a hospital upon request to destroy medical records of an individual who is a minor when the individual reaches the age of majority or seven years whichever occurs last, unless the hospital is required to retain the records as part of the individual's permanent medical record.

Section 37 (145.901, subd. 2) expands the commissioner's access to medical data and health records as part of the maternal death studies to include family home visiting programs, the WIC program, the prescription monitoring program, behavioral health services, where care was received before, during or related to the pregnancy or death. Also permits the commissioner to access the department of human services data to identify sources of care and services to assist with the evaluations of welfare systems. Also permits the commissioner to request and receive law enforcement reports or incidents reports related to the subject of the data.

Section 38 (145.901, subd. 4) specifies data provided to the commissioner of health by the commissioner of human services as part of the maternal death studies retains the same classification the data held when retained by the commissioner of human services.

Section 39 (145.901, subd. 5) creates in statute a maternal mortality review committee to conduct maternal death study review, make recommendations, and share summary information with the public.

Section 40 (171.07, subd. 3b) authorizes a homeless youth to obtain a Minnesota identification card without paying a transaction or filing fee.

Section 41 (256B.0625, subd. 52) makes a change in medical assistance coverage for lead risk assessments to conform to the changes in the venous blood lead level.

Section 42 [Recommendations on expanding access to data in all-payer claims database] requires the commissioner of health to develop recommendations to expand access to data in the all-payer claims database to additional outside entities for public health or research purposes.

Section 43 [Health professionals education loan forgiveness program; temporary addition of certain providers] permits the commissioner of health to award grants under the health professional education loan forgiveness program to alcohol and drug counselors, medical residents, and mental health professionals: (1) agreeing to deliver at least 25 percent of their yearly patient encounters to public program enrollees or patients receiving sliding fee schedule discounts through a sliding fee schedule that meets federal standards; or (2) specializing in the area of pediatric psychiatry and agreeing to deliver at least 25 percent of their yearly patient encounters to public program enrollees or patients receiving sliding fee schedule discounts through a sliding fee schedule that meets federal standards.

Section 44 [Mental health cultural community continuing education grant program] requires the commissioner of health to develop a grant program to provide for the continuing education necessary for certain mental health professionals to become supervisors for individuals pursuing licensure in mental health professions. The professionals obtaining the continuing education must (1) be members of communities of color or underrepresented communities; and (2) work for community mental health providers and agree to deliver at least 25 percent of their yearly patient encounters to public program enrollees or patients receiving sliding fee schedule discounts through ha sliding fee schedule that meets federal standards.

Section 45 [Public health infrastructure funds] requires the commissioner of health to provide funds to community health boards and Tribal governments for projects to build foundational public health capacity across the state, improve public health services to underserved populations, pilot new organizational models for providing public health services, or otherwise improve the state's public health system.

Section 46 [Revisor Instructions] paragraph (a) requires the revisor to change a headnote in section 62J.63.

Paragraph (b) requires the revisor to change the amount of the newborn screening fee in statute if congenital CMV is added to the newborn screening panel.

ARTICLE 4
HEALTH-RELATED LICENSING BOARDS

Section 1 (148.90, subd. 2) requires that at least two members of the board of psychology reside outside the seven-county metropolitan area and at least two members be members of a community of color or an underrepresented community.

Section 2 (148.9110) requires that for licensure renewal for a license issued by the board of psychology at least four of required continuing education hours must be on increasing the

knowledge, understanding, self-awareness, and practice skills to address the psychological needs of individuals from diverse socioeconomic and cultural backgrounds, effective July 1, 2023.

Sections 3-7 make changes to the doula registry by permitting the commissioner of health to designate doula certification organizations.

> **Section 3 (148.995, subd. 2)** adds another organization to the list of organizations that a doula may receive certification from to be considered a certified doula under the definition and authorizes the commissioner of health to designate doula certification organizations.
>
> **Section 4 (148.996, subd. 2)** clarifies that a doula must submit evidence of maintaining current certification from one of the designated organizations to remain included on the state's doula registry.
>
> **Section 5 (148.996, subd .4)** clarifies that registry renewal is dependent on the doula meeting the registry requirements.
>
> **Section 6 (148.996, subd. 6)** authorizes the commissioner to remove a doula from the registry if the doula fails to meet the requirements. Requires the commissioner to provide notice to the doula and specify the steps necessary to be taken for the doula to remain on the registry.
>
> **Section 7 (148.9965)** establishes the designation process for the commissioner when designating doula certification organizations.

Section 8 (148B.30, subd. 1) requires that at least two members of the board of marriage and family therapy reside outside the seven-county metropolitan area and at least two members be members of a community of color or an underrepresented community.

Section 9 (148B.31) requires that for licensure renewal for a license issued by the board of marriage and family therapy at least forty of required continuing education hours must be on increasing the knowledge, understanding, self-awareness and practice skills to address the psychological needs of individuals from diverse socioeconomic and cultural backgrounds, effective July 1, 2023.

Section 10 (148B.51) requires that at least three members of the board of behavioral health and therapy reside outside the seven-county metropolitan area and at least three members be members of a community of color or an underrepresented community.

Section 11 (148B.54, subd.2) requires that for licensure renewal for a professional counselor or a professional clinical counselor license issued by the board of behavioral health and therapy at least forty of required continuing education hours must be on increasing the knowledge, understanding, self-awareness and practice skills to address the psychological needs of individuals from diverse socioeconomic and cultural backgrounds, effective July 1, 2023.

Section 12 (148E.010, subd. 7f) adds a definition of cultural responsiveness to the board of social work practice chapter.

Section 13 (148E.130, subd. 1) requires that for licensure renewal for a license issued by the board of social work a licensee must complete four hours in cultural responsiveness.

Section 14 (148E.130, subd. 1b) clarifies that the new content clock hours described in section 13 applies to new licenses issued effective July 1, 2021, and for current licensees at the first two-year renewal term after July 1, 2021.

ARTICLE 5
PRESCRIPTION DRUGS

Section 1 (16A.151, subd. 2) clarifies that any money received by the state resulting from a settlement agreement, assurance of discontinuance, or court order that is related to alleged violations of consumer fraud laws in the marketing, sale, or distribution of opioids must be deposited into the separate account required to be created under this section. It also specifies that any investment income or losses attributable to this account must be credited to the account. It also requires the commissioner of management and budget to transfer from any settlement funds received from a consulting firm and deposited into this separate account to the opiate epidemic response fund an amount that is equal to the loss of revenue to the fund due to the exemption from the opiate registration fee opiates used for medication assisted therapy for substance use disorders.

Section 2 (151.066, subd. 3) exempts from the calculation of opiate units distributed within or into the state when determining which opiate manufacturers are going to be required to pay the annual opiate registration fee, any opiate that is used for medication assisted therapy for substance use disorders.

Section 3 (151.335) requires mail order or specialty pharmacies that use the US postal service or other common carrier to deliver a drug to a patient to ensure that the drug is delivered in compliance with manufacturer temperature requirements. Requires the pharmacy to develop policies and procedures consistent with nationally recognized standards issued by entities recognized by the board of pharmacy guidance.

Section 4 (256.043, subd. 4) makes a conforming change like the change made in section 1, clarifying that that any money received by the state resulting from a settlement agreement, assurance of discontinuance, or court order that is related to alleged violations of consumer fraud laws in the marketing, sale or distribution of opioids must be counted towards the $250,000,000 total sum.

Section 5 [Study of temperature monitoring] requires the board of pharmacy to conduct a study to determine the appropriateness and feasibility of requiring mail order and specialty pharmacies to enclose in each medication's packaging a method by which a patient can detect improper storage or temperature variations. The results of the study must be submitted to the legislature by June 15, 2022.

Section 6 [Opiate registration fee reduction] exempts from the calculation of opiate units distributed within or into the state when determining which opiate manufacturers are going to be required to pay the opiate registration fee due on June 1, 2021, any injectable opiate product distributed to a hospital or hospital pharmacy. It also requires the commissioner of management and budget to transfer an amount into the opiate epidemic response fund that equals the estimated revenue loss due to this exemption.

ARTICLE 6
TELEHEALTH

Section 1 (62A.673) rewrites the current telehealth coverage statute by changing the terminology from telemedicine to telehealth and by clarifying definitions and coverage requirements.

Subdivision 1 permits the section to be cited as the "Minnesota Telehealth Act" (current law).

Subd. 2 defines the following terms: distant site; health care provider; health carrier; health plan; originating site; store and forward technology; and telehealth. The changes to current law are as follows:

- Definition of health care provider means any licensed or registered health care provider practicing within their scope of practice in accordance with state law and includes mental health professionals and mental health practitioners, and for services provided by a chapter 245G facility, treatment coordinators, alcohol and drug counselors, and recovery peers.
- Definition of originating site clarifies that this means the site at which the patient is located at the time the health care services are provided to the patient through telehealth and clarifies that for purposes of store-and-forward, it means the location at which the health care provider transfers or transmits information to a distant site.
- Definition of store-and-forward clarifies that this means the asynchronous electronic transfer of a patient's medical information or data from an originating site to a distant site for the purposes of diagnostic and therapeutic assistance in the care of a patient.
- Definition of telehealth is modified to include the use of real-time two-way interactive audio and visual communications to provide or support health care delivery and facilitate the assessment, diagnosis, consultation, treatment, education, and care management of a patient's health care. It specifies that telehealth includes audio-only communication between a health care provider and a patient until July 1, 2023. It specifies that telehealth does not include communication between health care providers that consist solely of a telephone conversation, email, or facsimile transmission. It specifies that telehealth does not include communication a healthcare provider and patient that consists solely of an email or fax. It specifies that the definition of telehealth does not include telemonitoring.
- Adds a definition for telemonitoring services.

Subd. 3 specifies the coverage of services delivered through telehealth. The changes from current law are as follows:

Paragraph (b) specifies that coverage for services delivered through telehealth must not be limited based on geography, location, or distance of travel, subject to the provider network available to the enrollee through the enrollee's health plan.

Paragraph (c) prohibits a health carrier from creating a separate provider network to deliver services through telehealth that does not include network providers who provide in person care to patients for the same service or requiring an enrollee to use a specific provider within the network to receive services through telehealth.

Paragraph (e) specifies that nothing in this section prohibits a health carrier from establishing reasonable medical management techniques, so long as the techniques are not unduly burdensome or unreasonable for that service.

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

Subd. 4 clarifies the parity requirements between services delivered in person and through telehealth. The changes to current law are as follows:

Paragraph (a) specifies that a health carrier must not restrict or deny coverage of a service that is covered under a health plan solely based on the communication technology or application used to deliver the service through telehealth so long as the technology or application complies with this section and is appropriate for the service.

Paragraph (b) specifies that prior authorization may be required for services delivered through telehealth but only if prior authorizations are required before the delivery of the same service through in-person contact.

Paragraph (c) specifies that utilization review may be required for services delivered through telehealth provided that the review is conducted in the same manner and uses the same criteria as a review for the same service delivered through in-person contact.

Paragraph (d) prohibits a health carrier or provider from requiring an enrollee to pay a fee to download a specific communication technology or application.

Subd. 5 clarifies the parity reimbursement requirements between services delivered in person and through telehealth. The changes to current law are as follows:

Paragraph (b) specifies that a health carrier may not deny, or limit reimbursement based solely on a provider delivering the service through telehealth instead of through in-person contact.

Paragraph (c) specifies that a health carrier may not deny, or limit reimbursement based solely on the technology and equipment used by the provider to deliver the service through telehealth, provided that the technology and equipment used meets the requirements of this section and is appropriate for the service.

Paragraph (d) specifies that this subdivision does not prohibit a health carrier and a health care provider from entering into a contract that includes a value-based reimbursement arrangement for the delivery of covered services that may include services delivered through telehealth, and that such an arrangement does not violate this subdivision.

Subd. 6, paragraph (a) prohibits a health carrier from requiring a provider to use specific telecommunication technology or equipment as a condition of coverage provided that the technology and equipment the provider uses complies with current industry interoperable

standards and complies with standards required under HIPPA, unless authorized under this section.

Paragraph (b) clarifies that until July 1, 2023, telehealth coverage includes the use of audio only communication, provided the communication is a scheduled appointment and the standard of care for that service can be met using audio only communication. Creates an exception to the scheduled appointment requirement for mental health and substance use disorder treatment services if the communication was initiated by the enrollee while in an emergency or crisis situation and a scheduled appointment was not possible due to the need of an immediate response.

Subd. 7 requires a health carrier to provide coverage for telemonitoring services if (1) the service is medically appropriate based on the enrollee's medical condition or status; (2) the enrollee is cognitively and physically capable of operating the monitoring device or equipment or has a caregiver who can; and (3) the enrollee resides in a setting that is suitable for telemonitoring and is not in a setting that has health care staff on site.

Subd. 8 specifies that this section does not apply to coverage provided to state public health care program enrollees under medical assistance and MinnesotaCare programs.

Section 2 (147.033) makes conforming changes by changing terminology and cross-references.

Section 3 (151.37, subd. 2) specifies that when a practitioner prescribes a drug used for medication-assisted therapy for a substance use disorder, the required examination of the patient may be completed via telehealth.

Sections 4-6 (245G.01, subd. 13, 26; and 245G.06, subd. 1) make changes within this chapter clarifying that a comprehensive assessment for substance use disorder may be delivered in person or via telehealth. These sections also specify that if a client receives treatment services and an assessment via telehealth, the alcohol and drug counselor may document the client's verbal approval or electronic written approval of the treatment plan or change to the plan in lieu of the client's signature.

Section 7 (254A.19. subd. 5) makes a change in this section clarifying that a chemical use assessment may be conducted via telehealth.

Section 8 (254B.05, subd. 5) makes changes within this section clarifying that chemical dependency services may be provided via telehealth, and that the use of telehealth must be medically appropriate and must meet the needs of the person being served. This section also strikes the requirement that the equipment and connection must comply with Medicare standards in effect at the time the service is provided.

Section 9 (256B.0621, subd. 10) makes a conforming change.

Section 10 (256B.0622, subd. 7a) strikes language prohibiting a psychiatric care provider from providing specific roles or responsibilities by telemedicine unless approved by the commissioner.

Section 11 (256B.0625, subd. 3b) makes modifications to this section updating the medical assistance coverage of services delivered by telehealth. The changes to current law are as follows:

Paragraph (a) removes the current coverage limitation of three telemedicine services per enrollee per calendar week. It also makes conforming changes in terminology.

Paragraph (b) permits the commissioner to establish criteria that a provider must attest to in order to demonstrate the safety and efficacy of delivering a particular service through telehealth. Under current law, the commissioner is required to establish such criteria.

Paragraph (d) authorizes telehealth visits provided through audio and visual communication to be used to satisfy the face-to-face requirement for reimbursement under methods that apply to FQHCs, rural health clinics, Indian health services, tribal clinics, and community behavioral health clinic if the service would have otherwise qualified for payment if performed in person.

Paragraph (e) permits a provider to document a client's verbal approval or electronic written approval of the treatment plan or change to the treatment plan in lieu of the client's signature when mental health services or assessments are delivered through telehealth and are based on an individual treatment plan.

Paragraph (f) modifies the definition of telehealth by updating the definition of health care provider and adds several additional professionals who can deliver services by telehealth. It also adds a cross-reference to the definition of originating site, distant site, and store and forward technology.

Section 12 (256B.0625, subd. 3h) requires medical assistance to cover telemonitoring services if (1) the service is medically appropriate based on the recipient's medical condition or status; (2) the recipient's provider has identified that telemonitoring services would likely prevent the recipient's admission or readmission to a hospital, emergency room, or nursing facility; (3) the recipient is cognitively and physically capable of operating the device or equipment or has a caregiver who can operate the device or equipment; and (4) the recipient resides in a setting that is suitable for telemonitoring and not in a setting that has health care staff on site.

Section 13 (256B.0625, subd. 13h) expands the coverage of medication therapy management (MTM) services that are authorized to be delivered through telehealth. It removes the requirement that services may be delivered through telehealth only if there are no pharmacists practicing within a reasonable geographic distance from the patient. It also removes the requirement that the pharmacist practice within an ambulatory setting and permits the delivery of services by telehealth to occur within the patient's residence.

Section 14 (256B.0625, subd. 20) makes a change to this subdivision clarifying that mental health case management services may be provided as face-to-face contact either in-person or through interactive video.

Section 15 (256B.0625, subd 20b) modifies this subdivision to create requirements for meeting minimum required face-to-face contacts for targeted case management services though interactive video. This section permits face-to-face contact for targeted case management services to be provided by interactive video if it is in the best interest of the person and it is deemed appropriate by the person or the person's legal representative and the case management provider. It also removes the limits as to where a person must reside in order to receive targeted case management services by

interactive video. It prohibits the use of interactive video when a face-to-face contact is required for children receiving case management services for child protection reasons or who are in out-of-home placements. It also defines interactive video.

Section 16 (256B.0625, subd. 46) makes a change to this subdivision clarifying that mental health services that are required to be provided as direct face-to-face services may be provided via telehealth as defined under subdivision 3b. This section also strikes the requirement that the equipment and connection must comply with Medicare standards in effect at the time the service is provided.

Section 17 (256B.0911, subd.1a) modifies the definition of "long term care consultation services" by removing language requiring long term care consultation assessments to be face-to-face and permits the assessments to be conducted through telehealth.

Section 18 (256B.0911, subd.3a) specifies that all long-term care consultation assessments must be conducted face-to-face unless the assessment is a reassessment meeting certain requirements. Permits remote assessments conducted by interactive video or telephone to substitute for face-to-face reassessments if federal approval is received. Specifies under what circumstances remote reassessments may be substituted for a face-to-face reassessment.

Section 19 (256B.0911, subd. 3f) makes a conforming change.

Section 20 (256B.0924, subd. 6) specifies that for payment for targeted case management a provider must document at least one contact per month and not more than two consecutive months without a face-to-face contact either in person or by interactive video.

Section 21 (256B.094, subd. 6) specifies that payment for case management services is based on face-to-face contacts either in person or by interactive video or by telephone contacts. Specifies that for a child receiving case management services for child protection reasons or who is in out-of-home placement face-to-face contact must be through in-person contact.

Section 22 (256B.0943, subd. 1) changes terminology within this section (children's therapeutic services). from telemedicine to telehealth and defines telehealth by referencing section 256B.0625, subdivision 3b.

Section 23 (256B.0949, subd. 13) specifies that travel time is allowable billing for early intensive developmental and behavioral intervention (IEDBI) benefits within providing in-person services. Changes terminology from telemedicine to telehealth.

Section 24 (256B.49, subd.14) removes language requiring assessments to be face-to-face for home and community-based service waivers for persons with disabilities.

Section 25 (256S.05, subd. 2) makes a conforming change to the elderly waiver related to the changes in the long-term care consultation assessments.

Section 26 [Extension of COVID human services program modification] extends until July 1, 2023, the commissioner of human services modifications and waivers that involve expanding access to telemedicine services to CHIP, medical assistance, and MinnesotaCare enrollees; and allowing telemedicine alternatives for school linked and intermediate school district mental health services.

Section 27 [Studies of telehealth expansion and payment parity] paragraph (a) requires the commissioner of health, in consultation with the commissioners of human services and commerce, to study the impact of telehealth expansion and payment parity on the coverage and provision of health care services under private sector health insurance.

Paragraph (b) requires the commissioner of human services, in consultation with the commissioners of health and commerce, to study the impact study the impact of telehealth expansion and payment parity on the coverage and provision of health care services under public health care programs.

Paragraphs (c) and (d) specify what the studies must review and make recommendations on.

Paragraph (e) requires the commissioner to consult with interested stakeholders and permits the commissioners to access the all-payer claims database and to consult with experts in payment policy and health care delivery. Requires health plan companies to submit any information requested by the **commissioners for purposes of the studies.**

Paragraph (f) requires the commissioners to submit a preliminary report to the legislature by January 15, 2023, that includes a recommendation of whether audio-only communication should be continued as a telehealth communication option. Requires the final report to be submitted to the legislature by January 15, 2024.

Section 28 (Revisor Instruction) instructs the revisor to substitute the term "telemedicine" with "telehealth" and to correct necessary cross-references.

Section 29 (Repealer) paragraph (a)repeals the current telemedicine statutes that are being replaced by the new telehealth section in 62A.673.

Paragraph (b) repeals sections 256B.0596 (county contracts for mental health case management); and 256B.0924, subd. 4a (targeted case management through interactive video).

Paragraph (c) repeals changes made in chapter 30, article 17, section 71 (changes to the uniform mental health standards made to section 256B.0625, sub. 3b)

ARTICLE 7

ECONOMIC SUPPORTS

Sections 1, 20-22, and 24 implement methods to count and verify self-employment income and business accounts for purposes of cash assistance programs, effective May 1, 2022.

Section 1 (119B.09, subdivision 4) modifies child care assistance self-employment income to be calculated based on the cash assistance eligibility statutes in chapter 256P.05.

Sections 20-22 and 24 (256P.02, subdivisions 1a, 2; 256P.04, subdivision 4; 256P.05) add the value of business accounts used to pay personal expenses to the list of assets to be valuated and verified as part of an individual's eligibility for cash assistance programs. This proposal aligns the process for individuals to submit forms and calculate self-employment earned income with the process for SNAP applicants.

Sections 2-6 [256D.051, subdivisions 20-24] align state SNAP employment and training program requirements with federal requirements.

Section 7 (256E.30, subdivision 2) adjusts the base funding calculation for community action agencies and Indian reservations by removing the calculation for agencies with low income populations up to 1,999.

Section 8-12, 14-19, 23, and 25-26 (256J.08, subdivisions 15, 53; 256J.10; 256J.21, subdivisions 3, 5; 256J.32, subdivision 1; 256J.33, subdivision 4; 256J.37, subdivisions 1, 1b; 256J.95, subdivision 9; 256P.01, subdivision 3; 256P.04, subdivision 8; 256P.06, subdivisions 2, 3) make clarifying changes to statutes governing public assistance programs.

> **Section 26** also exempts unemployment insurance income obtained by young adults enrolled as students from being included as income for cash assistance eligibility.

Section 13 (256J.24, subdivision 5) requires the commissioner of human services to adjust the cash assistance portion of the MFIP transitional standard for inflation on October 1 every year.

Section 27 [Laws 2020, First Special Session chapter 1, section 1, subdivision 5] extends until December 31, 2021, three executive orders and a DHS program modification relating to human services program eligibility that were issued in response to the COVID-19 peacetime emergency.

Section 28 (Direction to Commissioner; Long-Term Homeless Supportive Services Report) requires the commissioner to report information on the projects funded using long-term homeless supportive services grants, and make the information available on the DHS website, by January 15, 2023. The commissioner must update the information for the next two years, by January 15 2024, and January 15, 2025.

Section 29 (2022 Report to Legislature on Runaway and Homeless Youth) removes the requirement for the commissioner to complete the 2023 homeless youth report and instead requires the commissioner to issue an update to the 2007 report on runaway and homeless youth, using updated data, studies, and analysis from specified sources and entities. The report is due by December 15, 2022.

Section 30 (Repealer) repeals statutes to implement the changes to SNAP employment and training, and to clarify public assistance statutes.

ARTICLE 8

CHILD CARE ASSISTANCE

Section 1 [119B.03, subdivision 4a] temporarily modifies the priority list for the basic sliding fee child care assistance program beginning July 1, 2021, and ending May 31, 2024.

Section 2 (119B.03, subdivision 6) modifies the allocation formula used to allocate funds to counties for the basic sliding fee child care assistance program.

Sections 3-4 and 7-8 (119B.11, subdivision 2a; 119B.125, subdivision 1; 119B.13, subdivisions 6-7) clarify statutes governing the calculation and recovery of CCAP provider overpayments to reflect current practices at the Department of Human Services; reduce the retroactive eligibility for CCAP from six to three months, except that a family at the application stage may be retroactively eligible for up to six months; and clarify the circumstances under which a certified, license-exempt child care provider would have its CCAP authorization or payments refused or revoked.

Sections 3 and 10 (119B.11, subdivision 2a; 245E.07, subdivision 1) preclude the department of human services from recovering CCAP overpayments that are designated solely as agency error,

and not the result of acts or omissions by a provider or recipient.

Section 5 (119B.13, subdivision 1) modifies the maximum provider CCAP reimbursement rate and CCAP registration fee to be at the 40th percentile of the 2021 provider rate survey beginning November 15, 2021, and the 40th percentile of the 2024 provider rate survey beginning January 1, 2025, or the amounts in effect at the time of the surveys, whichever is greater.

Section 6 (119B.13, subdivision 1) increases the maximum CCAP reimbursement rate for legal nonlicensed family child care providers to be 90 percent, increased from 68 percent, of the county maximum hourly rate for licensed family child care providers.

Section 9 (119B.25) amends the statute governing child care improvement grants to distribute funds to more than one nonprofit to coordinate grant awards and projects, and adds training and consultation and facility improvements to the list of authorized grant activities.

Section 11 (Direction to Commissioner of Human Services; Federal Fund and Child Care and Development Block Grant Allocations) directs the commissioner of human services to allocate amounts from the federal fund and the federal child care and development block grant (CCDBG) fund in fiscal year 2022.

Paragraph (a) allocates $1,500,000 from the federal fund for grants to organizations working with family, friend, and neighbor caregivers to promote healthy development, social-emotional learning, early literacy, and school readiness.

Paragraph (b) allocates $13,500,000 from the federal fund and $9,000,000 from the CCDBG for grants to provide grants for child care facility improvements, minor renovations, and related equipment and services to meet licensing requirements needed to establish, maintain, or expand child care sites.

Paragraph (c) allocates $1,500,000 from the federal fund and $1,500,000 from the CCDBG for child care workforce development grants.

Paragraph (d) allocates $3,000,000 from the federal fund for child care business training grants.

Paragraph (e) allocates $35,444,000 in fiscal year 2022, $66,398,000 in fiscal year 2023, $81,755,000 in fiscal year 2024, and $57,737,000 in fiscal year 2025 from the CCDBG for CCAP rate and registration fee increases, including amounts for reprioritization of the basic sliding fee waiting list, amounts for additional funding for the basic sliding fee child care assistance program, and amounts to increase child care assistance rates for legal, nonlicensed family child care providers.

Paragraph (f) specifies that the allocations in this section are available until June 30, 2025.

Section 12 (Repealer) repeals the subdivision authorizing county agencies to issue provisional CCAP authorization and payment to providers while determining the provider's final authorization.

ARTICLE 9

CHILD PROTECTION

Sections 1-4 (256N.25, subdivisions 2-3; 256N.26, subdivisions 11, 13) eliminate provisions in the statutes governing Northstar Care for Children to achieve compliance with federal requirements.

Section 5 (260C.163, subdivision 3) requires a court to appoint counsel to represent each parent, guardian, or custodian before their first hearing and during the proceedings in all child protection matters where: (1) a child risks removal from the care of the parent, guardian, or custodian; and (2)

the parent, guardian, or custodian desires counsel and is financially eligible. The section also removes specific statutory qualifications for attorneys retained by the county to represent parents, guardians, or custodians. This section is effective January 1, 2023.

Section 6 (Direction to the Commissioner; Initial Implementation of Court-Appointed Counsel in Child Protection Proceedings) directs the commissioner of human services to consult with counties and court administration to develop a process to collect data from counties regrading use of court-appointed counsel in child protection proceedings, and to report to the legislature by July 1, 2022, on the plan to collect the data.

ARTICLE 10

CHILD PROTECTION POLICY

Section 1 [260E.055] establishes a duty to report child maltreatment for adult employees or supervisors of private or public youth recreation programs, including provisions prohibiting retaliation for reporting, providing for immunity when reporting in good faith, and penalties for failure to report or filing a false report.

Section 2 [260E.065] requires local welfare agencies to provide training for mandatory reporters, which may be conducted online or in person, and may be completed by directing reporters to training offered by the commissioner of human services.

Section 3 (Legislative Task Force; Child Protection) establishes a task force to review and provide oversight of efforts being made to implement changes to the child welfare system, as well as to evaluate current practices within the child welfare system. The task force includes six members from each legislative body, and the first meeting must convene by August 15, 2021. The task force must issue a report to the legislature and the governor by February 1, 2024, on the progress toward implementing changes to the child protection system, recommendations for additional legislative and procedural changes, and funding needs for those recommendations.

ARTICLE 11

BEHAVIORAL HEALTH

Section 1 (245.462, subdivision 17, paragraph (b), clause (5)) expands the definition of "mental health practitioner" to include a student practitioner with sufficient course hours who is completing a practicum or internship in social work, psychology, or counseling.

Sections 2-5 revise statutes governing placement of a child in a psychiatric residential treatment facility, to comply with the federal family first act requirements, effective September 30, 2021.

Section 2 [245.4876, subdivision 3a] incorporates a conforming change related to compliance with the federal family first act. This section is included to ensure the conforming change becomes effective as intended, and then expires when previously passed language would eliminate the remainder of the subdivision language.

Section 3 (245.4882, subdivision 1) makes a conforming change to require a child's residential treatment placement to be reviewed every 90 days.

Section 4 (245.4882, subdivision 3) requires discharge planning for children to begin 30 days after placement, to be updated every 60 days, and to include identifying and referring the child to home and community supports that meet the child and family's needs.

Section 5 (245.4885, subdivision 1) makes various clarifying changes, deletes references to treatment foster care settings and functional assessments, establishes that the county board

determines the appropriate level of care for a child when county funds pay for the treatment, and requires a child's level of care determination, placement decision, and recommendations for services to be made available to the child's family as appropriate.

Section 6 (245.4889, subdivision 1, paragraph (b), clause (5)) clarifies that mental health services for people from cultural and ethnic minorities that are eligible for grant funding include supervising clinical trainees who are Black, indigenous, or people of color.

Section 7 (245.4901) revises the existing school-linked mental health grants program to include providing substance use disorder treatment services as an authorized use of grant funds.

Section 8 [245.4902] establishes the Culturally Informed and Culturally Responsive Mental Health Task Force, which will meet beginning August 15, 2022 to issue recommendations and provide legislative reports regarding methods to improve the provision of culturally informed and culturally responsive mental health services, including by recruiting diverse providers, training all providers on cultural competency and cultural humility, assessing the extent of diversity and cultural competence in current providers, and increasing the number of provider organizations owned, managed, or led by individuals who are Black, indigenous, or people of color.

Section 9 (254B.01, subdivision 4a) updates the definition of "culturally specific program" to include "culturally responsive" programs, meaning programs that serve a community that shares a common language, racial, ethnic, or social background, utilize input from the community served in providing services, and employs at least 50% individuals from that community.

Section 10 [254B.01, subdivision 4b] adds a definition of "disability responsive program" for purposes of qualifying for a rate enhancement, meaning a program designed to serve individuals with disabilities that employs individuals with the necessary professional training to serve individuals with the specific disability the program is designed to serve.

Section 11 (254B.05, subdivision 5, paragraphs (c) and (h)) replaces the text of the historic rate enhancement for programs serving "special populations" with "culturally specific or culturally responsive" programs, and "disability responsive" programs, which are defined section 254B.01, subdivisions 4a and 4b. The section also adds paragraph (h), which limits payment for outpatient substance use disorder services to six hour per day or 30 hours per week unless prior authorization for more hours is obtained from the commissioner.

Section 12 [254B.12, subdivision 4] authorizes a 5% rate increase for culturally specific or culturally responsive programs, and disability responsive programs.

Section 13 [254B.151] establishes a substance use disorder community of practice, beginning no later than January 1, 2022, in which the commissioner shall convene representatives from the substance use disorder treatment service community to develop recommendations to improve substance use disorder treatment services and outcomes.

Section 14 (256.042, subdivision 4) modifies the timing upon which the opiate epidemic response advisory council must report to the legislature on the grants proposed by the council, by requiring the report to be submitted in December for the upcoming calendar year instead of March and specifies that the council determines grant awards and funding amounts and the commissioner awards and administers the grants.

Section 15 (256.043, subdivision 3) extends the appropriation for evaluation activities from the opiate epidemic response fund beyond fiscal year 2025. This section also requires funds to county social service and tribal social service agencies as well as the grants specified by the opiate epidemic response advisory council to be distributed on a calendar year basis instead of a on a fiscal year basis.

Section 16 (256B.0624, subdivision 7, paragraph (b)) requires the commissioner to establish and recalculate annually a statewide per diem rate for crisis stabilization services provided to MA enrollees in a supervised, licensed residential setting that serves no more than four adults with staff present for at least eight hours per day.

Section 17 (256B.0625, subdivision 20, paragraph (f)) provides an updated cross-reference to the new section of statute governing targeted case management services, and clarifies how payment for mental health case management provided by vendors who contract with a county or a Tribe must calculate the payment rates.

Sections 18-23 modify provisions relating to the federal substance use disorder medical assistance demonstration project. Sections 13 and 14 become effective only upon federal approval.

Section 18 (256B.0759, subdivision 3) permits licensed substance use disorder treatment providers, licensed chemical dependency treatment providers, and out-of-state residential substance use disorder treatment providers until January 1, 2024, to enroll in and meet the quality standards for participation in the demonstration project. The commissioner is authorized to consult with Tribal nations regarding how tribally licensed programs may participate in the demonstration project. Paragraph (f) authorizes the commissioner to issue payment rate enhancements to providers that enrolled prior to July 1, 2021, for services provided on or after July 22, 2020, for fee-for-service enrollees, and on or after January 1, 2021, for managed care enrollees, provided the provider attests to taking meaningful steps toward meeting enhanced requirements. The commissioner is authorized to recoup any improperly issued enhanced payments.

Section 19 (256B.0759, subdivision 4) permits participating providers to receive an increased payment rate of 25% or 20%, depending on the service provided (current statute is a 15% or 10% increase), so long as they meet demonstration project requirements and enhanced provider standards. Providers that have enrolled but have not met the provider standards by July 1, 2022, lose eligibility for the rate increase and will be paid according to the rates in current statute until the date that the provider meets the standards. The commissioner is also authorized to temporarily suspend payments to the provider until the provider achieves compliance.

Section 20 [256B.0759, subdivision 6] establishes a base payment rate of $132.90 per day for medium-intensity residential programs that participate in the demonstration project.

Section 21 [256B.0759, subdivision 7] requires publication on the state's Medicaid website of documentation including monitoring reports and evaluations for demonstration project participants, within 30 days of approval of those documents for use in the demonstration project.

Section 22 [256B.0759, subdivision 8] authorizes the commissioner to seek federal approval to extend the demonstration project to accommodate the delayed enrollment date.

Section 23 [256B.0759, subdivision 9] requires the commissioner to convene a workgroup of relevant stakeholders to meet at least quarterly during the demonstration project to evaluate the long-term sustainability of any improvements to quality or access to treatment services caused by participation in the demonstration project.

Section 24 [256B.076] establishes provisions regarding medical assistance coverage of targeted case management services, including the terms for how the commissioner must calculate and set the reimbursement rate, and a definition for "culturally specific program" for purposes of using that factor in setting the reimbursement rate.

Sections 25-26 (256B.0924, subdivision 6; 256B.094, subdivision 6) make conforming changes incorporating cross-references to the new section 256B.076 governing case management services.

Section 27 (256B.0946, subdivision 1) adds individual treatment plan development to the list of MA-reimbursable services for ITFC providers.

Section 28 (256B.0946, subdivision 4), paragraph (h) authorizes temporary reduction of weekly service units for no more than 60 days if the provider and family agree, and the reasons for the reduction are documented in the case file. New paragraph (n) requires providing either psychotherapy, crisis assistance, or psychoeducation services to be provided in order to receive a daily per-client encounter rate and allows clinical care consultation and individual treatment plan development to be included in that daily per-client encounter rate.

Sections 29-31 modify provisions relating to MA coverage of intensive nonresidential rehabilitative services.

> **Sections 29-30 (256B.0947, subdivisions 2-3)** expand the age range eligibility for intensive nonresidential rehabilitative mental health services from 16-20 years old, to 8 to 26 years old.
>
> **Section 31 (256B.0947, subdivision 5, paragraph (b))** requires a treatment team to have specialized training in providing services either to youth aged 8 to 16 years old, or to youth aged 14 to 26 years old.

Section 32 (Direction to the Commissioner; Rate Recommendations for Opioid Treatment Programs) requires the commissioner to evaluate and report to the legislature by December 1, 2021, on any recommendations to revise the rate structure for opioid treatment programs.

Section 33 (Direction to the Commissioner; Adult Mental Health Initiatives Reform) requires that the commissioner report to the legislature on changes to the funding formula for adult mental health initiatives, including the background and method for the new formula, by February 1, 2022, and prior to the implementation of a new funding formula. The commissioner must consult with all relevant stakeholders in developing a new funding formula.

Section 34 (Direction to the Commissioner; Children's Mental Health Residential Treatment Work Group) requires the commissioner to report to the legislature by February 15, 2022, on methods to improve efficiency of room and board costs for children's mental health treatment, and to reduce barriers to transitioning children out of residential treatment.

Section 35 (First Episode of Psychosis Grant Program; Authorized Uses of Grant Funds) clarifies that first episode of psychosis grant program funds may be used for intensive treatment and support, provider outreach, training, and guidance, ensuring access to services, and housing or travel expenses for individuals receiving services.

Section 36 (Direction to Commissioner of Human Services; Mental Health Grant Programs Statute Revision) directs the commissioner of human services to coordinate with nonpartisan legislative staff to enact as statutes the details of each of the grant programs authorized and funded under section 245.4661, subdivision 1.

Section 37 (Direction to the Commissioner; Sober Housing Program Recommendations) directs the commissioner of human services, in collaboration with stakeholders, to study and recommend a method for increasing access to, promoting person-centered practices and cultural responsiveness in, potential oversight of, and consumer protections for individuals in sober housing programs. The commissioner must complete and submit a report on the study to the legislature by September 1, 2022.

Section 38 (Direction to the Commissioner; Substance Use Disorder Treatment Paperwork Reduction) directs the commissioner of human services to consult with stakeholders to develop, assess, and recommend systems improvements to minimize regulatory paperwork and improve systems for substance use disorder programs. The commissioner shall contract with an experienced vendor to develop statewide system changes and submit a report to the legislature regarding the changes and any recommended legislative changes by December 15, 2022.

Section 39 (Direction to the Commissioner; Tribal Overpayment Protocols) requires the commissioner to work with Tribal nations to develop protocols to resolve any future overpayments involving any Tribal nation in Minnesota.

Section 40 (Direction to the Commissioner; Culturally and Linguistically Appropriate Services) requires the commissioner to consult with SUD treatment providers, service recipients, local agencies, and members of minority communities to develop a plan to implement culturally and linguistically appropriate services, according to national standards.

Section 41 (Substance Use Disorder Treatment Pathfinder Companion Pilot Project) establishes a pilot project, beginning September 1, 2021, for Anoka County, an academic research partner, and the North Metro Mental Health Roundtable, to evaluate the effects of using the Pathfinder Companion technology on treatment outcomes for individuals receiving substance use disorder treatment services. A report on the results of the project is due to the legislature by January 15, 2023.

Sections 42-43 direct the commissioner of human services to allocate funds from the federal community mental health services block grant.

Section 42 allocates $7,511,000 in fiscal year 2022, $0 in fiscal year 2023, and $1,000,000 in fiscal years 2024 and 2025 to fund items proposed by the commissioner to the federal Substance Abuse and Mental Health Services Administration.

Section 43 allocates $2,500,000 annually for school-linked behavioral health grants.

Sections 44-47 direct the commissioner of human services to allocate funds from the federal substance abuse prevention and treatment block grant.

Section 44 allocates $1,750,000 annually for substance use disorder treatment services through the school-linked behavioral health grant program.

Section 45 allocates $550,000 in fiscal year 2022 for a grant to Anoka County for the substance use disorder treatment pathfinder companion pilot project.

Section 46 allocates $2,700,000 in fiscal years 2022 and 2023 for grants to be awarded according to the recommendations of the Opioid Epidemic Response Advisory Council.

Section 47 allocates $10,767,000 in fiscal year 2022 to fund items proposed by the commissioner to the federal Substance Abuse and Mental Health Services Administration.

Section 48 (Opiate Epidemic Response Advisory Council; Initial Membership Terms) specifies which of the Opiate Epidemic Response Advisory Council members' terms will end on September 30, 2022, and which will end on September 30, 2023.

Section 49 (Repealer) repeals sections of statute relating to mental health case management, and the definition of "responsible social services agency" in the Children's Mental Health Act.

ARTICLE 12

DIRECT CARE AND TREATMENT

Section 1 (246.54, subdivision 1b) clarifies the provision imposing a county share of the cost for individuals to stay at a community behavioral health hospital past the date that discharge is recommended, to include community behavioral health hospitals for adults and for children.

Section 2 (Direction to Commissioner; Safety Net Services) requires the commissioner to assess and report to the legislature by October 15, 2023, on the extent to which state-operated direct care and treatment services function as safety net services, and to make recommendations that would enhance, improve, and innovate those services. The commissioner must also seek input from stakeholders in conducting the analysis, and the legislative report must include fiscal estimates and proposed legislation to implement the recommendations.

ARTICLE 13

DISABILITY SERVICES AND CONTINUING CARE FOR OLDER ADULTS

Section 1 (144.0724, subdivision 4) requires updated resident reimbursement classification assessments within 14 days of release from isolation or within 7 days of cessation of therapy services. Resident reimbursement classifications determine who much a nursing facility charges medical assistance or private pay residents per day for the services provided.

Sections 2 and 3 (144A.073, subdivisions 2 and **17)** authorizes the existing nursing facility construction moratorium exception review committee to approve each biennium construction projects for which the full biennial state share of increased medical assistance spending in the years the projects are completed will not exceed $4 million dollars.

Section 4 [245A.02, subdivision 6f] moves a definition for family adult foster care home previously located in the soon the be repealed chapter 144D to the DHS licensing chapter.

Section 5 (245A.03, subdivision 7) clarifies family child foster care homes or family adult foster care homes are subject to the corporate foster care moratorium if the license holder changes the license holder's primary residence away from the physical location of the foster care license.

> **Clause 6** creates a time-limited exception to the corporate foster care and community residential settings licensing moratorium to allow currently operational but unlicensed settings in which customized living services are being provided to BI and CADI waiver participants to become licensed settings.

Section 6 (256.476, subdivision 11) requires the commissioner to increase by 7.5 percent the monthly consumer support grant amount for grantees who are eligible for ten or more hours of PCA or CFSS to offset the enhanced rate for the hours of service required.

Section 7 (256.477, subdivision 1, paragraph (a)) renames the existing statewide Self-Advocacy Network the “The Rick Cardenas Self-Advocacy Network” and expands the purposes of the existing grant program from self-advocacy to include training and support for service option selection, statewide conferences and training focused on self-advocacy, informed choice and community engagement skills, and an annual leadership program.

> **Subdivision 1, paragraph (b)** allows a grantee to use a portion of the grant for administration and general operating costs.

Subdivision 2 establishes a new grant program to provide subgrants to provide peer-led regional training sessions about accessing community options for people with intellectual and developmental disabilities working and living in institutional settings.

Section 8 [256.4772] establishes a new grant program to encourage self-advocacy groups of persons with intellectual and developmental disabilities to develop and organize projects that increase the inclusion of persons with intellectual and developmental disabilities in the community and improve community integration outcomes. The grant program will be administered by a fiscal host and funding decisions will be made by an advisory committee established by the fiscal host.

Section 9 [256.4776] establishes a new grant program for a parent-to-parent peer support program to provide individualized support for families of children with a disability to special health care need from volunteer support parents who have received peer support training.

Section 10 (256.479) removes the requirement that a customized living service provider serve at least 75 waiver participants to be eligible for customized living quality improvement grants.

Section 11 (256B.0653, subdivision 8) provides an annual inflation adjustment to the medical assistance service rates for home health agency services.

Section 12 (256B.0654, subdivision 5) provides an annual inflation adjustment to the medical assistance service rates for home care nursing services.

Section 13 (256B.0659, subdivision 11) reduces from 12 to 10 the required hours of service for which a person must qualify in order for the PCA services provided to the person to qualify for the existing enhanced PCA service rate.

Section 14 (256B.0659, subdivision 17a) reduces from 12 to 10 the required hours of service for which a person must qualify in order for the PCA services provided to the person to qualify for the existing enhanced PCA service rate; specifies that any change in the eligibility criteria for the enhanced PCA rate does not constitute a change in a term or condition with respect to the state's obligation to negotiate with the exclusive representative of individual providers.

Section 15 (256B.0911, subdivision 1a) replaces the existing definition of informed choice for the purposes of long-term care consultation services with the new definition of informed choice in the disability services policy statements in section 256B.4905, subdivision 1a.

Section 16 (256B.092, subdivision 4) is related to waiver reimagine, phase II; effective July 1, 2024, removes language requiring the commissioner to allocate MA developmental disabilities waiver funds to county agencies and requiring county agencies to manage the funds.

Section 17 (256B.092, subdivision 5) is related to waiver reimagine, phase II; requires the commissioner to seek approval to allow for the reconfiguration of the MA home and community-based waivers to implement no sooner than July 1, 2024, a two-waiver program structure and an individual resource allocation methodology.

Section 18 [256B.092, subdivision 11a] requires the commissioner to develop and implement residential support services criteria that limit eligibility for community residential services, customized living services, and 24-hour customized living services. The criteria, which only apply to individuals who do not have an active service agreement as of the effective date of the criteria,

must limit eligibility to individuals who have either complex behavioral health or complex medical needs and for whom other residential support services have be deemed inappropriate by the individual's support planning team.

Section 19 (256B.092, subdivision 12) is related to waiver reimagine, phase II; makes conforming changes related to having the commissioner manage waiver funds rather than county agencies upon implementation of an individual resource allocation methodology.

Section 20 to 23 (256B.097) reconfigures the existing regional quality councils to allow them to continue to perform their remaining functions in the absence of the state quality council, which is being repealed in the bill, and expands the statutory language relating to duties of the councils to examine and improve services for people with disabilities, promote informed decision making, provide advocacy and recommendations for quality improvements; and provide help resolve disputes between lead agencies or providers and people with disabilities.

Section 24 [256B.439, subdivision 3c] for the purposes of gathering survey results for the implementation of the home and community-based services report card, requires providers of home and community-based services to provide the contact information of their clients to the commissioner at the commissioner's request.

Section 25 [256B.439, subdivision 3d] requires the commissioner to develop and administer a resident experience survey for assisted living facility residents and a family survey for families of residents of assisted living facilities.

Section 26 (256B.49, subdivision 11) makes clarifying changes; is related to waiver reimagine, phase II; requires the commissioner to seek federal approval to implement no sooner than July 1, 2024, a two-waiver program structure and an individual resource allocation methodology for the medical assistance home and community-based waivers.

Section 27 (256B.49, subdivision 11a) is related to waiver reimagine, phase II; makes conforming changes related to having the commissioner manage waiver funds rather than county agencies upon implementation of an individual resource allocation methodology.

Section 28 (256B.49, subdivision 17) is related to waiver reimagine, phase II; effective July 1, 2024, removes language requiring the commissioner to allocate medical assistance CAC, BI and CADI waiver funds to county agencies and removes language requiring county agencies to manage the funds; removes obsolete language.

Section 29 [256B.49, subdivision 28] establishes a moratorium on enrolling after June 30, 2021 certain new customized living settings serving in a single-family home four or fewer participants in the BI or CADI wavier.

Section 30 [256B.49, subdivision 29] requires the commissioner to develop and implement residential support services criteria that limit eligibility for community residential services, customized living services, and 24-hour customized living services. The criteria, which only apply to individuals who do not have an active service agreement as of the effective date of the criteria, must limit eligibility to individuals who have either complex behavioral health or complex medical needs and for whom other residential support services have be deemed inappropriate by the individual's support planning team.

Sections 31 to 41 reframe and restate the home and community-based services (HCBS) policy statements enacted in 2020, and includes new language concerning standards for an informed decision-making process. **Section 79, paragraph (b)** repeals the policy language enacted in 2020.

(256B.4905, subdivision 1a) defines "informed choice" for the purposes of Minnesota Statutes, section 256B.4905.

(256B.4905, subdivision 2a) states the policy of the state regarding the ability of people who have disabilities to make informed choices and that they will be offered an informed decision-making process in which to make those informed choices.

(256B.4905, subdivision 3a) specifies required features of an informed decision-making process.

(256B.4905, subdivision 4a) reframes and restates the employment first policy statement from the 2020 legislation that is repealed in this legislation (see repealed subdivision 1)

(256B.4905, subdivision 5a) reframes and restates the employment first implementation language from the 2020 legislation that is repealed in this legislation (see repealed subdivision 2)

(256B.4905, subdivision 7) reframes and restates the independent living first policy statement from the 2020 legislation that is repealed in this legislation (see repealed subdivision 3)

(256B.4905, subdivision 8) reframes and restates the independent living first implementation language from the 2020 legislation that is repealed in this legislation (see repealed subdivision 4).

(256B.4905, subdivision 9) reframes and restates the self-direction first policy statement from the 2020 legislation that is repealed in this legislation (see repealed subdivision 5).

(256B.4905, subdivision 10) reframes and restates self-direction first implementation language from the 2020 legislation that is repealed in this legislation (see repealed subdivision 4).

(256B.4905, subdivision 11) is a new policy statement concerning the state's policy regarding informed choice by people who have disabilities to utilize technology as a means of delivering their services.

(256B.4905, subdivision 12) is new implementation language concerning the state's policy regarding informed choice by people who have disabilities to utilize technology as a means of delivering their services.

Section 42 (256B.4914, subdivision 5, paragraphs (i) and (k)) move forward the next scheduled inflation adjustment by 6 months to January 1, 2022, and delays the subsequent scheduled inflation adjustment by four months to November 1, 2024. The third inflation adjustment will occur as required under current law on July 1, 2026.

Paragraph (o) requires that providers use 80 percent of the marginal increase in revenue attributable to the January 1, 2022, inflation adjustments for compensation-related costs; defines compensation-related costs; and requires providers to create and post a plan to distribute to employees 80 percent of the marginal increase in revenue attributable to the January 1, 2022 inflation adjustments.

Section 43 (256B.4914, subdivision 6, paragraph d) clarifies that the customized living rate floor under section 256S.205 does not apply to customized living services reimbursed under this section; prohibits the authorization of more than 24-hours of support in a daily unit of customized living services; establishes an acuity-based input limit for service rate calculations. Also, strikes obsolete language and incorporates duplicative language from paragraph (g).

Section 44 (256B.5012, subdivision 18) effective January 1, 2022, increases intermediate care facility for persons with developmental disabilities (ICF/DD) rates by five percent over the rates in effect on July 30, 2021.

Section 45 (256B.5013, subdivision 1, paragraph (a)) modifies the conditions under which an intermediate care facility for persons with developmental disabilities (ICF/DD) is eligible for an increased ICF/DD rate to enable the facility to meet a particular individual's documented increase in need. This paragraph also removes an existing 12-month limit on the increased rate and allows the increased rate to remain in place unless the needs of the particular individual for whom the increased rate was granted change.

New Paragraph (b) requires the county of financial responsibility to act on an increased rate request within 30 days of the request.

Old paragraphs (c) to (e) remove various requirements of counties and facilities related to justifying the use of funds made available through an increased rate, reporting on the uses of the funds, and preventing funds from being diverted away from providing services to the individual for whom the increased rate was granted.

New paragraph (c) adds cognitive needs and increased staffing needs as additional circumstances under which a county can recommend that a requested rate increase to meet the needs of a particular individual be granted.

New Paragraph (d) specifies the information a facility must provide when making a request for a rate increase to meet the needs of a particular individual.

Section 46 (256B.5013, subdivision 6) makes a conforming change to the duties of the commissioner of human services.

Section 47 (256B.5015, subdivision 2, paragraph (a)) increases the rate for "services during the day" from 75 percent of the rate that would have been paid for an individual to participate in "day training and habilitation" to 100 percent of that rate.

Paragraph (b) specifies the conditions under which an individual qualifies for services during the day, and thus for reimbursement for those services under paragraph (a).

Section 48 (256B.69, subdivision 5a, paragraph (d), clause (2)) requires each managed care plan to submit annually to the commissioner of human services and the legislature a report documenting the impact of any PCA or CFSS rate increase on rates paid by the plan to PCA or CFSS provider agencies.

Section 49 (256B.85, subdivision 2, paragraph (a)) is a conforming change extending the applicability of the definitions for the statutory section governing the community first services and supports (CFSS) program to the statutory section governing rates for PCA services and CFSS.

> **Paragraph (o)** modifies the definition of instrumental activities of daily living" for the purposes of CFSS to include traveling with a participant to medical appointments; modifies the meaning to traveling for this purposes of this definition to mean both accompanying the participant in the participant's chosen mode of transportation or driving the participant.

Section 50 (256B.85, subdivision 7a) reduces from 12 to 10 the required hours of service for which a person must qualify in order for the community first services and supports provided to the person to qualify for the existing enhanced CFSS service rate; specifies that any statutory change to participant eligibility for an enhanced CFSS rate does not constitute a change in the terms or conditions of employment of individual providers and is not subject to collective bargaining requirements related to individual providers.

Section 51 (256B.85, section 11, paragraph (h)) requires CFSS provider agencies to ensure that any support worker driving a participant has a valid driver's license and the vehicle used is licensed and insured.

Section 52 [256B.85, subdivision 12c] establishes documentation requirements under the CFSS program for travel time.

Section 53 (256B.85, subdivision 14, paragraph (b), clause (10)) requires CFSS participants using the self-direct budget model to ensure that any support worker driving a participant has a valid driver's license and the vehicle used is licensed and insured.

Section 54 (256B.85, subdivision 16) reduces from 12 to 10 the required hours of service for which a person must qualify in order for the community first services and supports provided to the person to qualify for the existing enhanced CFSS service rate.

Section 55 [256B.851] establishes a fee schedule rate methodology for personal care assistance (PCA) services and community first services and supports (CFSS).

> **Subdivision 1** specifies the services that are covered by the new rate methodology.
>
> **Subdivision 2** provides definitions, in addition to the applicable definitions from section 256B.85, that apply to this statutory section.
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> **Subdivision 3** establishes an initial base wage for all the covered services.
>
> **Subdivision 4** establishes a competitive wage factor, which when applied to the base wage index, will increase the base wage by the percentage indicated. For PCAs and support workers, the competitive wage factor is 4.7 percent.

Subdivision 5, paragraph (a) establishes the standard component values for nonwage costs associated with providing PCA services and CFSS.

Paragraph (b) establishes an implementation factor, which reduces the framework rates for PCA and CFSS by nearly 25 percent.

Subdivision 6 describes the calculation to establish the hourly framework rate, apply the implementation factor, and establish a 15-minute unit rate.

Subdivision 7 requires that any future rate adjustments required to enable participant-employers and provider agencies to meet the terms and conditions of any collective bargaining agreement must be applied as changes to the value of component factors in the framework and not as rate-on-rate increases or after framework adjustments.

Subdivision 8 requires service providers to submit requested cost data at least once every three years; authorizes the commissioner to withhold payments if the requested data is not submitted within the statutorily established timelines; requires the commissioner to conduct random data validations of submitted data to ensure its accuracy; and requires the commissioner to develop and implement a process for providing training and technical assistance to providers to support compliance with the cost reporting requirements.

Subdivision 9 requires the commissioner to conduct on-going evaluations of whether the rates for PCA and CFSS appropriately address the costs of providing the services, requires the commissioner to make recommendations to the legislature on service rates based on the commissioner's evaluation; and specifies that the commissioner shall publish every two years an evaluation with recommendations of the costs and the rates for providing PCA and CFSS services.

Subdivision 10 requires the commissioner to access and publish a biennial report on the long-term impact of the rate methodology implementation on staff providing services with rates determined under this section, including but not limited to measuring changes in wages, benefits provided, hours worked, and retention.

Subdivision 11 clarifies that a change in the framework rates for PCA services or CFSS does not constitute a change in a term or condition for individual providers and is not subject to the state's obligation to meet and negotiate with the exclusive representative of individual providers.

Section 56 (256I.05, subdivision 1c) makes technical and conforming changes, and permits an agency beginning July 1, 2022, to increase by $50 per month the housing support rates paid on behalf of individuals residing in unlicensed, uncertified, or unregistered supportive housing establishments when the individual has an approved habitability inspection and an individual lease agreement.

Section 57 (256I.05, subdivision 2a, paragraph (a)) is a restatement of existing law deleted from paragraph (d) of section 256I.05, subdivision 1c related to absence days from supportive housing.

Paragraph (b) creates a new extended absence day limit of 92 days per year for individuals who are absent from a housing support setting because they are admitted to certain facilities.

Paragraph (c) creates a new exception process for individuals who exceed the new extended absence day limit.

Section 58 (256I.06, subdivision 8) is a conforming change.

Section 59 (256S.18, subdivision 7) makes clarifying changes to an existing elderly waiver monthly case mix budget caps exception for enhanced PCA service and CFSS rates.

Section 60 (256S.20, subdivision 1) modifies customized living provider requirements by (1) permitting newly licensed assisted living facilities to provide customized living and (2) limiting the settings in which comprehensive home care providers may provide customized living to certain assisted living exempt settings that meet the setting requirements under the BI and CADI waivers and comply with new consumer protection provisions in 325F.722.

Section 61 (256S.203) makes conforming changes to the statutes governing capitation payments and managed care payments for elderly waiver payments.

Section 62 (256S.205) establishes a rate floor of $119 per resident per day beginning July 1, 2022 for certain facilities with an elderly waiver census of 80 percent or more and providing 24-hour customized living services.

Section 63 (256S.21) deletes obsolete language.

Section 64 (256S.2101, subdivision 1) makes conforming changes.

Subdivision 2 modifies the elderly waiver rate framework phase-in percentages beginning January 1, 2022, for specified services under the elderly waiver, alternative care, and essential community supports. The result is an approximately three percent increase in rates for these services.

Section 65 [325F.722] establishes consumer protection provisions related to settings that are not licensed assisted living facilities, but in which customized living services are being provided. Much of the language in this new statutory section is drawn from language relating to housing with services establishments in Chapter 144D, which is set to expire on August 1, 2021. In effect, this section of the act preserves these consumer protections for people receiving customized living services while residing in settings that are currently housing with services establishments but will be exempt from assisted living licensure beginning August 1, 2021.

Section 66 (Direction to the commissioner; Customized living report) requires the commissioner to study the prevalence of customized living services being offered in unlicensed settings supplanting the provision of services in settings that must be licensed when providing similar services under the BI or CADI waiver. Based on the study the commissioner must submit to the legislature a report with recommendations related to continuing the enrollment moratorium on customized living settings and licensing existing customized living settings.

Section 67 (Personal care assistance enhanced rate for persons who use consumer-directed community supports) requires the commissioner of human services beginning January 1, 2022, to increase by 7.5 percent the annual budget of CDCS participants who would be eligible for an enhanced PCA services or enhanced CFSS rate.

Section 68 (**Direction to the commissioner of human services; Direct care services during short-term acute hospital visits)** requires the commissioner to develop a medical assistance covered service to provide direct care services to patients admitted to an acute care hospital and submit to the legislature draft language to implement such a service.

Section 69 (Direction to the commissioner; Study of supportive parenting services) requires the commissioner to submit to the legislature by February 15, 2023, a report containing the commissioner's recommendations regarding developing and providing supportive parenting services and providing adaptive parenting equipment to parents with disabilities and disabling conditions under Medicaid state plan or waiver authorities.

Section 70 (Personal care assistance compensation for services provided by a parent or spouse) resumes temporary funding for the provision of PCA services by parents of a minor and spouses.

Section 71 (Direction to the commissioner; provider standards for customized living services in designated settings) requires the commissioner, in consultation with stakeholders, to review policies and provider standards for customized living services provided in settings that are not licensed assisted living facilities. The commissioner may make recommendations to the legislature based on this review regarding appropriate regulatory oversight and payment policies for customized living services delivered in these unlicensed settings.

Section 72 (Rate increase for direct support services workforce) Paragraph (a) requires the commissioner of human services to increase direct support services reimbursement rates, individual budgets, grants, or allocations by specified percentages effective October 1, 2021, or upon federal approval, whichever is later, if the labor agreement between the state and SEIU Healthcare Minnesota is approved.

Paragraphs (b) and (c) list the programs to which the rate changes apply.

Section 73 (Waiver reimagine phase II) Paragraph (a) requires the commissioner of human services to implement no sooner than July 1, 2024, a two-home and community-based services waiver program structure that serves persons who are determined by a certified assessor to require the levels of care provided in a nursing home, hospital, neurobehavioral hospital, or an intermediate care facility for persons with developmental disabilities.

Paragraph (b) requires the commissioner to implement no sooner than July 1, 2024, an individualized budget methodology that serves persons who are determined by a certified assessor to require the levels of care provided in a nursing home, hospital, neurobehavioral hospital, or an intermediate care facility for persons with developmental disabilities.

Paragraph (c) allows the commissioner to seek all federal authority necessary to implement this section.

Section 74 (Rate increase for certain home care services) increases payment rates for home health services, home care nursing services, and respiratory therapy by five percent effective January 1, 2022.

Section 75 (Direction to the commissioner; Waiver reimagine and informed choice stakeholder consultation) requires the commissioner of human services to (1) consult with and seek input and assistance from stakeholders concerning potential adjustments to the streamlined service menu from waiver reimagine phase I and to the existing rate exemption criteria and process; (2) to consult with and seek input and assistance from stakeholders concerning the development and implementation of waiver reimagine phase II, including criteria and a process for individualized budget exemptions and supporting and expanding informed choice and informed decision making; (3) establish a Waiver Reimagine Advisory Committee; (4) submit to the legislature prior to seeking federal approval for waiver reimagine phase II a report on plans for waiver reimagine phase II and other related modifications to the waiver programs; (5) establish a process to assist people who use waiver services and lead agencies transition to a two-waiver system with an individual budget methodology; (6) develop an online support planning tool for people using disability waiver services that allows access to the total budget available to the person, the services for which they are eligible, and the services they have chosen and used; and (7) develop and implement a curriculum and training plan to ensure all lead agency assessors and case managers have the knowledge and skills necessary to comply with informed decision making for people who used home and community-based disability waivers.

Section 76 (Direction to the commissioner of human services; residential support services criteria report) requires the commissioner to collect data on the implementation of residential support services criteria and submit to the legislature an analysis and recommendations regarding the impact of the criteria on utilization of nonprovider controlled setting.

Section 77 (Self-directed worker contract ratification) ratifies the labor agreement between the state of Minnesota and SEIU Healthcare Minnesota that was submitted to the Legislative Coordinating Commission on March 1, 2021.

Section 78 (Revisor instruction) requires the revisor of statutes to modify a section headnote consistent with the repeal of the subdivision of the section regarding the state quality council.

Section 79 (Repealer, paragraph (a)) repeals no sooner than July 1, 2024, and upon implementation of waiver reimagine phase II various provisions related to the disability waivers that will be rendered obsolete, including provisions governing distribution of waiver funds, waiting list data reporting, and excess and underspending provisions.

Paragraph (b) repeals the HCBS policy states passed in 2020 that are reframed and restated in this article and the State Quality Council.

Paragraph (c) repeals a provision regarding the setting in which customized living must be provided that is rendered obsolete with the repeal of chapter 144D on August 1, 2021.

Paragraph (d) repeals the state quality council and related provisions.

Paragraph (e) repeals the DT&H DWRS transition grants.

ARTICLE 14

MISCELLANEOUS

Sections 1-2 and 8-14 establish the Office of the Ombudsperson for American Indian Families in its own section of statute, instead of being included in the statutes establishing the Office of Ombudsperson for Families.

Sections 1-2 [3.9215; 3.9216] create new statutes to establish the Office of Ombudsperson for American Indian Families and the American Indian Community-Specific Board, replicating the terms, functions, and provisions in the existing statute governing the Office of Ombudsperson for Families.

Sections 8-12 (257.0755, subdivision 1; 257.076, subdivisions 3, 5; 257.0768, subdivisions 1, 6; 257.0769) make conforming changes.

Section 13 (257.0769) specifies the amounts to be appropriated annually from the special account for the Office of the Ombudsperson for Families as follows: $23,000 for the Office of Ombudsperson for American Indian Families, and $69,000 for the ombudspersons within the Office of Ombudsperson for Families.

Section 14 (Transfer of Money) requires the Office of the Ombudsperson for Families to transfer by the end of fiscal year 2021to the Office of the Ombudsperson for American Indian Families any remaining money designated for use by the Ombudsperson for American Indian Families.

Section 3 [119B.195] establishes the Retaining Early Educators Through Attaining Incentives Now (REETAIN) grant program, which would issue grant awards through a nonprofit to child care and early education workers who agree to remain working in those fields for the next year. Grant amounts are to be determined by the commissioner, and the commissioner is required to report to the legislature on the results of the grant program by January 1 each year.

Section 4 (124D.142) updates the statute governing the quality rating and improvement system (knows as Parent Aware) to eliminate outdated language, specify that participation in the system is voluntary, and to establish the purposes, specifications, evaluation criteria, and reporting requirements relating to an evaluation of the Parent Aware program. The evaluation findings and recommendations for program changes are to be reported to the legislature by December 31, 2024.

Section 5 (136A.128, subdivision 2) increases the award amounts under the TEACH grant program and includes public prekindergarten employees as eligible award recipients.

Section 6 (136A.128, subdivision 4) increases from five percent to ten percent the percentage of the TEACH grant amount permitted to be used for administration.

Section 7 (256.041) updates, eliminates outdated language, and makes clarifying changes to the statute governing the Cultural and Ethnic Communities Leadership Council.

Section 15 (Grants to Expand Access to Child Care for Children with Disabilities) establishes a two-year grant program for the commissioner of human services to award grants to counties or tribes that partner with family child care providers or child care centers who would use grant funding to develop, improve, or expand their child care setting to enable the provider to care for children with disabilities in the same space as children without disabilities.

Grant recipients and partner child care providers would identify onetime and ongoing expenses that would enable the partner provider to develop an inclusive child care setting by making modifications to the space, training or hiring additional staff, or funding the cost of services or equipment for the children with disabilities.

Grant recipients would report to the commissioner every six months, and at the end of the grant period, the commissioner will report to the legislature on the process and outcomes of the program, as well as how inclusive child care settings could be expanded statewide.

Section 16 (Direction to Commissioner of Human Services; Family Child Care Shared Services Innovation Grants) directs the commissioner to establish a grant program that would test strategies for family child care providers to share services in order to achieve economies of scale. The commissioner is required to report on the results of the program to the relevant legislative committees.

Section 17 (Direction to Commissioner of Human Services; Foster Family Recruitment and Licensing Technology Request for Information) directs the commissioner to issue a request for information to identify available technology to support foster family recruitment and training through an online portal. The commissioner must report to the legislature by January 15, 2022, on the results of the request for information.

Section 18 (Working Group; Affordable, High-Quality Child Care and Early Education for All Families) requires the governor to establish a working group, in coordination with the Minnesota Children's Cabinet, that will meet as necessary to develop strategies that would maximize the affordability, access, quality, and staff qualifications and diversity of child care and early education programs, to be implemented beginning in July 2025 and finishing by no later than July 2031. The working group includes 15 voting members and 22 non-voting members. The working group must convene by December 1, 2021, and must submit an interim report to the governor and legislature on the working group's preliminary findings by December 15, 2022, and a final report on the working group's recommendations and implementation proposals by February 1, 2023.

Section 19 (Direction to Commissioner of Human Services; Family Supports and Improvement Program Recommendations) directs the commissioner to collaborate with the children's cabinet to engage with relevant state and local agencies to develop recommendations for implementing a voluntary, family-focused information-sharing program that would improve the effectiveness of public assistance programs for which families are eligible or currently enrolled. The commissioner shall report to the legislature on the results of the program by January 15, 2023.

Section 20 (Report on Participation in Early Childhood Programs by Children in Foster Care) requires an interim and final report by the commissioner of human services on participation in early care and education programs, including head start programs, special education programs, early learning scholarship programs, school readiness programs, voluntary prekindergarten, and child care assistance programs, by children under age 6 who have experienced foster care. The reports must include the rates of participation, demographic information, and recommendations to provide annual data, to facilitate participation in early childhood programs, and to measure early childhood well-being for children who have experienced foster care. The reports must also include an implementation plan and identify barriers to early care and education programs.

Section 21 (Child Care Stabilization Grants) enacts a noncompetitive grant program to issue support funds to support the stability of child care providers during and after the COVID-19 public health emergency. To receive funds, a program must attest and agree in writing that the program has been operating during each funding period, and that the program intends to remain operating for the duration of the funding period, with exceptions given for health and safety service disruptions or planned temporary closures. Grant recipients must use at least 70% of the grant awards for increased pay or benefits to employees or other workers. Providers who fail to comply with grant program requirements are subject to award recoupment for up to six years of the conclusion of the grant program. The commissioner shall determine grant award amounts based on the full-time

equivalent number of staff who regularly care for children in the program. Awards will be issued until June 30, 2023, with the award amounts being reduced each month beginning July 1, 2022, so that the final month's award amount is no more than 50% of the amounts awarded in September 2021. The commissioner may increase an award amount to a program that the commissioner determines to be in extreme financial hardship. Authorized uses of grant funds include personnel costs, family co-payment or tuition payment relief, rent, purchasing or updating equipment and supplies related to health and safety practices, purchasing goods and services necessary to maintain or resume child care services, providing mental health supports, or providing reimbursement for losses incurred during the COVID-19 public health emergency for activities in this list that took place between January 31, 2020, and the date of the provider's application for a stabilization grant.

Section 22 (Direction to the Children's Cabinet; Early Childhood Governance Report) requires the children's cabinet to submit a report to the governor and the legislature by February 1, 2022, that recommends how to govern early childhood programs, including whether the programs should be governed under a single state agency or a new Department of Early Childhood. The children's cabinet must engage with the public to provide input.

Section 23 (Direction to Commissioner of Human Services; Federal Fund and Child Care and Development Block Grant Allocations) directs the commissioner of human services to allocate amounts from the federal fund and the federal child care and development block grant (CCDBG) fund in fiscal year 2022.

Paragraph (a) allocates $1,435,000 from the CCDBG for the Parent Aware program evaluation and equity report.

Paragraph (b) allocates $499,000 from the CCDBG for the Ombudsperson for Family Child Care Providers.

Paragraph (c) allocates $858,000 from the CCDBG for transfer to the commissioner of MMB for the affordable high-quality child care and early education for all families working group.

Paragraph (d) allocates $200,000 from the CCDBG for transfer to the commissioner of MMB to complete the early childhood governance report.

Paragraph (e) allocates $150,000 from the CCDBG to develop recommendations for implementing a family supports and improvement program.

Paragraph (f) allocates $1,000,000 from the CCDBG for the REETAIN grant program.

Paragraph (g) allocates $2,000,000 from the CCDBG for the TEACH grant program.

Paragraph (h) allocates $304,398,000 from the federal fund for child care stabilization grants, and sets aside up to $5,000,000 for administration of the grants.

Paragraph (i) allocates $200,000 from the federal fund for the family child care provider shared services pilot program.

Paragraph (j) allocates $290,000 from the CCDBG for the report on participation in early care and education programs by children in foster care.

Paragraph (k) allocates $3,500,000 from the CCDBG for administration of the CCDBG allocations included throughout this omnibus bill.

Paragraph (l) specifies that the allocations in this section are available until June 30, 2025.

Section 24 (Revisor Instruction) instructs the revisor to renumber the statute establishing the

TEACH grant program from chapter 136A to chapter 119B, and to make necessary conforming changes.

ARTICLE 16

HOME AND COMMUNITY-BASED SERVICES; SPECIAL TIME-LIMITED FUNDING PROVISIONS

Section 1 (256.478) modifies the name of the existing grant program from the home and community-based services transition grants to the transition to community initiative; specifies requirements and allowable uses of grants funds; and expands the eligibility requirements to receive services funded by the grants.

Section 2 (Laws 2021, chapter 30, article 12, section 5) modifies the expiration date of the Governor's Council on an Age-friendly Minnesota by extending to until June 30, 2024.

Section 3 (Grants for Technology for HCBS Recipients) establish a time-limited grant program to assist HCBS participants gain access to remote service delivery and telehealth.

Section 4 (Development of Individual HCBS Portal for Recipients) describes the funding available for the commissioner of human services to develop and implement an online support planning tool for HCBS waiver participants.

Section 5 (Housing Transitional Costs) describes funding for two housing transition programs to assist individuals transitioning to community settings with one-time costs associated with such a transition.

Section 6 (Transition to Community Initiative) describes additional time-limited funding for the existing transition to community initiative.

Section 7 (Lead Agency Process Mapping) describes funding available to the commissioner to assist lead agencies, such as counties and tribes, to analyze their procedures and business practices with respect to administrating home and community-based services.

Section 8 (Age-Friendly Minnesota) describes funding available for age-friendly community grants and technical assistance grants.

Section 9 (Continuity of Care for Students with Behavioral Health and Disability Support Needs) describes funding available for the commissioner to consult with stakeholders regarding improving continuity of care for students with behavioral health and disability support needs.

Section 10 (Provider Capacity Grants for Rural and Underserved Communities) describes funding available for grants to providers of home and community-based services who serve rural and underserved communities in an effort to strengthen the state's infrastructure for HCBS.

Section 11 (Expand Mobile Crisis) describes additional time-limited funding available for an existing grant program for adult mobile crisis services.

Section 12 (Psychiatric Residential Treatment Facility and Child and Adolescent Mobile Transition Unit) describes time-limited funding available for the creation of children's mental health transition and support teams to facilitate the transition of children and adolescents from certain treatment setting to the community.

Section 13 (Reducing Reliance on Children's Congregate-Care Settings) describes funding for an analysis by the commissioner of the utilization and efficacy of current residential and psychiatric residential treatment facility treatment options for children under the state Medicaid program.

Section 14 (Task Force on Eliminating Subminimum Wages) establishes a task force to plan and make recommendations to phase out the payment of subminimum wages to people with disabilities and establishes a time-limited provider reinvention grant program to facilitate HCBS providers and other employers swift away from paying subminimum wages and toward integrated competitive employment.

Section 15 (Moving to Independence: Subminimum Wage Phase-Out) describes the funding available for the provider reinvention grant program.

Section 16 (Research on Access to Long-Term Care Services and Financing) describes one-time funding for an actuarial research study of public and private financing options for long-term services and supports reform to increase access to HCBS across the state.

Section 17 (Additional Funding for Respite Services and Studies) describes funding available to strengthen access to respite services and caregiver support to enhance HCBS for older adults.

Section 18 (Medical Assistance Outpatient and Behavioral Health Service Rates Study) describes funding available for an analysis of current rate setting methodology for various services under medical assistance and MinnesotaCare.

Section 19 (Centers for Independent Living HCBS Access Grant) describes additional time-limited funding available to the eight Minnesota Centers for Independent Living.

Section 20 (HCBS Workforce Development Grant) describes time-limited funding available to attract and retain direct care works, particularly direct care workers earning less than 200 percent of federal poverty.

Section 21 (Direction to Commissioner; Stakeholder Engagement for Spending Plan) requires the commissioner to engage with stakeholders prior to submitting the state's initial HCBS spending plan for federal approval.

Section 22 is the default effective date for the article.