Senate Counsel, Research, and Fiscal Analysis

Tom Bottern, Director

Minnesota Senate Building
95 University Ave. W. Suite 3300
ST. PAUL, MN 55155-1800
(651) 296-4791
www.senate.mn/scrfa

Senate

State of Minnesota

H.F. No. 2128 – Omnibus Health and Human Services Policy and Finance Bill – The Conference Committee Report

Author: Senator Michelle R. Benson

Prepared by: Katie Cavanor, Senate Counsel (651/296-3801)
Patrick Hauswald, Senate Counsel (651/296-5079)
Liam Monahan, Legislative Analyst (651/296-1791)

Date: May 16, 2021

ARTICLE 1
DHS HEALTH CARE PROGRAMS

Section 1 (256.01, subd. 42) paragraph (a) specifies that for any mandated report that does not include a specific expiration date the expiration dates specified in this subdivision apply.

> **Paragraph (b)** any report mandate enacted before January 1, 2021, shall expire on January 1, 2023, if the report is required annually and shall expire on January 1, 2024, if the report is required biennially or less frequently.
>
> **Paragraph (c)** any report mandate enacted on or after January 1, 2021, expires three years after the date of enactment if the report is required annually and expires five years after the date of enactment if the report is required biennially or less frequently.
>
> **Paragraph (d)** requires the commissioner to submit a list to the legislature by February 15 of each year beginning February 15, 2022, of all reports set to expire during the following calendar year.

Section 2 (256.969, subd.2b) allows the commissioner, when rebasing inpatient hospital payment rates, to combine claims from two consecutive years if claims volume for a single year falls below the threshold needed for a statistically valid sample. Prohibits the use of years in which claims volume is reduced or altered due to a pandemic or public health emergency if the base year includes more than one year.

Section 3 (256.969, subdivision 2f) requires the commissioner to reduce by 99 percent the disproportionate share hospital (DSH) payments received by Hennepin Healthcare, and replace Hennepin Healthcare's lost DSH revenue with an alternative inpatient payment rate of comparable value.

Section 4 (256.969, subd.9) modifies the provisions governing disproportionate share hospital (DSH) payments, by: (1) basing the DSH adjustment for providing transplant services on all MA

payments including managed care, not just fee-for-service payment; (2) clarifying an existing DSH payment for a hospital (HCMC) with an MA utilization rate at least 2.5 standard deviations above the statewide mean by adding the requirement that this hospital must be a level one trauma center; and (3) specifying that the MA utilization rate and discharge thresholds used to determine eligibility for various DSH factors are to be measured using only one year, when a two-year base period is used.

Section 5 (256.9695, subd. 1) expands from 12 to 18 months the period during which hospitals may appeal or correct the information the commissioner uses to set the overall budget pool and rates for inpatient hospital services.

Section 6 (256.983) expands the fraud and prevention investigation programs to include tribal agencies.

Section 7 (256B.057, subd. 3) aligns eligibility asset limits for qualified Medicare beneficiaries to the federal limits.

Sections 8-10 make changes to the Health Services Policy Committee.

Section 8 (256B.0625, subd. 3c) changes the name of the health services policy committee to the health services advisory council; adds as a duty of the committee to advise the commissioner on evidence-based decision making and health care benefit and coverage policies for Minnesota health care programs. Makes other minor changes and strikes obsolete language.

Section 9 (256B.0625, subd. 3d) changes the membership of the committee by reducing the number of licensed physicians from seven to six; adding an additional voting member of the committee who is a health care or mental health professional actively engaged in Minnesota in the treatment of persons with mental illness; and adding another consumer as a voting member. It also clarifies that no member of the committee shall be employed by the state of Minnesota except for the medical director and what constitutes a quorum.

Section 10 (256B.0625, subd. 3e) makes conforming changes to the name change.

Section 11 (256B.0625, subd. 30) for purposes of rebasing encounter rates for federally qualified health centers (FQHCs) and rural health clinics, prohibits the use of years in which costs or claims volume is reduced or altered due to a pandemic, disease, or other public health emergency, when the base year includes more than one year. Allows the commissioner to use Medicare cost reports of a year unaffected by pandemic, disease, or other public health emergency, or the previous two consecutive years, inflated to the base year.

Sections 12-14 make changes to the opioid prescribing program.

Section 12 (256B.0638, subd. 3) adds to the opioid prescribing workgroup two consumer members who are Minnesota residents and who have used or are using opioids to manage chronic pain. Also adds a representative of the Minnesota Department of Health as a nonvoting member.

Section 13 (256B.0638, subd. 5) modifies the procedure used to report opioid prescriber data, by requiring the commissioner to report to provider groups data on individual prescribers' prescribing patterns and requiring provider groups to distribute this data to prescribers.

Section 14 (256B.0638, subd. 6) allows the commissioner to share with provider groups data on prescribers' prescribing patterns.

Section 15 (256B.0659, subd. 13) eliminates a requirement that DHS enroll qualified professionals who work for personal care assistance provider agencies. Requires qualified professionals to meet provider training requirements and strikes outdated language.

Section 16 (256B.196, subdivision 2, paragraph (c)) ends Hennepin Healthcare's authority to use intergovernmental transfers to fund managed care passthroughs. These managed care pass-throughs are in the process of being phased out. The phase-out schedule for Regions Hospital remains unchanged.

Section 17 (256B.1973) requires, with federal approval, the Commissioner of Human Services to direct certain managed care organization expenditures to Hennepin Healthcare through an arrangement known as a state-directed fee schedule.

> **Subdivision 1** defines "billing professional," "health plan," and "high medical assistance utilization" for the purposes of this section.
>
> **Subdivision 2** requires federal approval before implementation of any directed payment arrangement.
>
> **Subdivision 3** defines providers who may participate in a directed payment arrangement. Currently, only Hennepin Healthcare meets the definition.
>
> **Subdivision 4** permits a nonstate government entity, such as Hennepin Healthcare, to make voluntary intergovernmental transfers to maximize the value of allowable directed payments.
>
> **Subdivision 5 to 7** require health plans to submit claims data from Hennepin Healthcare to the commissioner; requires the commissioner to determine a fee schedule for services provided by Hennepin Healthcare to the MA population to maximize allowable directed payments; requires the commissioner to increase capitation rates to health plans to account for the fee schedule; and requires the health plans to reimburse Hennepin Healthcare according to the fee schedule.
>
> **Subdivision 8** requires that the directed payment arrangement and state-directed fee schedule meet a federal requirement for such an arrangement by aligning with state quality goals for Hennepin Healthcare.

Section 18 (256B.6928, subdivision 5) clarifies that certain state-directed managed care expenditures are permitted under federal law.

Sections 19-21 make modifications to the MinnesotaCare program to realign the program with federal requirements.

> **Section 19 (256L.01, subd. 5)** clarifies that income means a household's projected annual income for the applicable year.
>
> **Section 20 (256L.04, subd. 7b)** requires the commissioner to adjust the income limits annually on January 1, instead of July 1.
>
> **Section 21 (256L.05, subd. 3a)** requires redetermination of eligibility to occur during the open enrollment period for qualified health plans.

Section 22 (295.53, subdivision 1) expands an existing exemption from the gross revenues subject to the hospital, surgical center, or health care provider taxes to include the state-directed managed care expenditures authorized under the new directed payment arrangement under section 256B.1973.

Section 23 [Direction to Commissioner of Human Services; Funding for Recuperative Care] requires the Commissioner of Human Services to develop an MA reimbursable recuperative care service to serve individuals with chronic conditions who lack a permanent residence at the time of discharge. Provides that the section is contingent on the receipt of nonstate funding.

Section 24 [Revisor Instruction] requires the revisor to change the name of the health services policy committee to the Health Services Advisory Council.

ARTICLE 2
DEPARTMENT OF HUMAN SERVICES
LICENSING AND BACKGROUND STUDIES

Section 1 (245A.043, subdivision 3, paragraph (b)) deletes from the provisions relating to transferring ownership of an existing treatment program, statutory references to the administrative rules requiring an assessment of the need for a new chemical dependency treatment or rehabilitation program.

Section 2 (245F.04, subdivision 2) deletes from the provisions relating to applying for a new treatment program, statutory references to the administrative rules requiring an assessment of the need for a new chemical dependency treatment or rehabilitation program.

Sections 3-4 (245G.03, subdivision 2, paragraph (b); 254B.03, subdivision 2, paragraphs (d)-(e)) require an applicant for substance use disorder treatment program licensure must give at least 60 days' notice of their intent to open a new program to the county human services director. The notice must include a description of the proposed program, the proposed target population, and a copy of the program's abuse prevention plan. The county human services director is authorized to support or oppose the new program in writing with supporting documentation to the Commissioner of Human Services, for consideration when determining whether to grant a license to the proposed program.

Section 5 (Repealer) repeals the administrative rules relating to (1) requiring an assessment of the need for a new chemical dependency treatment or rehabilitation program, as well as the corresponding documentation requirements, and (2) requiring a county board to submit a statement to the commissioner in support or opposition to the need for the new program.

ARTICLE 3
HEALTH DEPARTMENT

Sections 1-4 make changes to the health information exchange oversight program by aligning federal and national efforts.

Section 1 (62J.495, subd. 3) eliminates the state-certified requirement for a health data intermediary.

Section 2 (62J.498) removes reference to federal legislation and the definition of a state-certified health data intermediary. Authorizes the commissioner to require information be provided as needed from health information exchange services providers.

Section 3 (62J.4981) removes references to health data intermediaries and changes references to health information exchange organizations.

Section 4 (62J.4982) changes references from health information exchange service provider to health information exchange service organization.

Sections 5-7 (62J.84, subdivisions 3, 4, and 5) extend the date to January 1, 2022, in which drug manufacturers must begin reporting to the Commissioner of Health certain drug prices increases under the prescription drug price transparency act.

Section 8 (62J.84, subd. 6) permits the commissioner to reference drug price data from other sources to meet the reporting requirements under the prescription drug price transparency act.

Section 9 (62J.84, subd. 9) extends the due date for the initial annual report that the commissioner must submit to the legislature on the prescription drug transparency act from January 15, 2022, to May 15, 2022.

Section10 (144.05. subd. 7, paragraph (a)) specifies that for any mandated report that does not include a specific expiration date the expiration dates described in this subdivision apply.

> **Paragraph (b)** establishes that any report mandate enacted before January 1, 2021, shall expire on January 1, 2023, if the report is required annually and shall expire on January 1, 2024, if the report is required biennially or less frequently.
>
> **Paragraph (c)** establishes that any report mandate enacted on or after January 1, 2021, expires three years after the date of enactment if the report is required annually and expires five years after the date of enactment if the report is required biennially or less frequently.
>
> **Paragraph (d)** requires the commissioner to submit a list to the legislature by February 15 of each year beginning February 15, 2022, of all reports set to expire during the following calendar year.

Sections 11-15 (144.1205) make changes to the fee structure for radioactive material and special nuclear material licenses.

Section 16 (144.1481, subd.1) adds a licensed dentist to the rural Health Advisory Committee.

Section 17 (144.1911, subd.6) adds general surgery as an eligible primary care residency grant recipient in the international medical graduate primary residency grant program.

Section 18 (144.223) removes race as information collected from marriage license applications.

Section 19 (144.225, subd.7) modifies the list of individuals authorized to request a certified birth or death certificate by removing from the list the party responsible for filing the vital record and clarifying that an attorney must be representing the subject of the vital record or one of the authorized individuals listed.

Section 20 (144G.84) amends requirements for access to outdoor space for residents of assisted living facilities with dementia care, to require existing housing with services establishments that obtain an assisted living facility license to provide residents with regular access to outdoor space, and to require a licensee with new construction or a new licensee to provide regular access to secured outdoor space on the premises of the facility.

Section 21 (145.87) requires the commissioner to award grants to community health boards, nonprofit organizations, and Tribal nations for home visiting programs serving pregnant women and families with young children.

Section 22 (145.893, subd.1) changes a term used, from vouchers to food benefits, in a subdivision authorizing eligible individuals to receive benefits to purchase nutritional supplements under WIC.

Section 23 (145.894) allows local health agencies to issue WIC food benefits three times per month, instead of twice per month as permitted under current law. Strikes obsolete language and changes the term vouchers to food benefits.

Section 24 (145.897) specifies that for purposes of determining the foods eligible for purchase under WIC, the federal Department of Agriculture, not the commissioner, determines allowable foods. This section also changes the term vouchers to food benefits and strikes language listing examples of allowable foods.

Section 25 (145.899) changes the term vouchers to food benefits in this section allowing WIC food benefits to be used to buy cost-neutral organic allowable foods.

Section 26 (145A.145) codifies the current nurse family partnership programs.

Section 27 (151.72, subd.2) modifies the labeling requirements for cannabinoid products to permit instead of the required information on the label, a scannable bar code or a QR code that links to the manufacturer's website.

Section 28-41 modify the medical cannabis program.

Section 28 (152.22, subd.5c) adds a definition of hemp processor to the medical cannabis statutes.

Section 29 (152.22, subd.6) permits the use of dried raw cannabis and permits smoking as a permissible delivery method. This section is effective the earlier of (1) March 1, 2022, or (2) a date by which rules on combustion of dried raw cannabis are in effect and independent laboratories can perform the required tests on dried raw cannabis.

Section 30 (152.22, subd.11) removes from the definition of registered designated caregiver the requirement that a health care practitioner identify a patient as needing assistance in administering or obtaining medical cannabis due to a disability. This section is effective the day following final enactment.

Section 31 (152.23) states that the medical cannabis statutes do not permit, or prevent the imposition of penalties for, combusting medical cannabis in any of the listed locations or where the smoke would be inhaled by a minor child. Tribal medical cannabis programs.

Section 32 (152.26) authorizes the commissioner to adopt or amend rules to implement the addition of dried raw cannabis as an allowable form of medical cannabis, allows the commissioner to adopt rules using the procedure to adopt exempt rules, and provides that the two-year limit on the effect of such rules does not apply to these rules. This section is effective the day following final enactment.

Section 33 (152.27, subd.2) permits the commissioner to remove qualifying medical conditions or delivery method under the same requirements as provided under this section for adding or modifying a qualifying condition or delivery method.

Section 34 (152.27, subd.3) removes the reference to having a health care practitioner determine, as part of the patient application, that the patient needs assistance in administering or obtaining medical cannabis due to a disability. This section is effective the day following final enactment.

Section 35 (152.27, subd.4) removes the requirement that a health care practitioner must certify that a patient is disabled and therefore needs assistance in administering or obtaining medical cannabis for the commissioner to register a designated caregiver for the patient. Allows a registered designated caregiver to be the caregiver for up to six patients at once (rather than one patient as in current law) and counts patients who live in the same residence as one patient. This section is effective the day following final enactment.

Section 36 (152.28, subd.1) deletes from the list of health care practitioner duties the duty of determining whether a patient is disabled and needs assistance administering or obtaining

medical cannabis due to that disability. This section is effective the day following final enactment.

Section 37 (152.29, subd.1) authorizes a medical cannabis manufacturer to acquire hemp products produced by a hemp processor licensed by the Commissioner of Agriculture under chapter 18K. Allows a manufacturer to manufacture or process hemp products into an allowable form of medical cannabis, and makes hemp products subject to the quality control, security, testing, and other requirements that apply to medical cannabis. Requires a manufacturer's operating documents to include procedures for the delivery and transportation of hemp products between hemp processors and manufacturers and requires a manufacturer to verify that a hemp processor is licensed under chapter 18K before acquiring hemp products from the processor.

Section 38 (152.29, subd.3) **paragraph (c)** permits pharmacist consultations to occur by telephone or other remote means, in addition to by videoconference. This paragraph also eliminates a requirement that the pharmacist consultation occur when the patient is at the distribution facility; and states that a pharmacist patient-specific dosage plan and is not modifying the dosage or product. This paragraph is effective the day following final enactment.

Paragraph (e) specifies that medical cannabis in dried raw cannabis form shall be distributed only to patients who are 21 years of age or older or to their caregivers. This paragraph is effective the earlier of (1) March 1, 2022, or (2) a date by which rules on combustion of dried raw cannabis are in effect and independent laboratories can perform the required tests of dried raw cannabis. Distribution to a recipient in a motor vehicle.

Section 39 (152.29) authorizes a manufacturer to distribute medical cannabis to a patient, registered designated caregiver, or other caregiver who is at the distribution facility but remains in a motor vehicle, provided the requirements in the subdivision are met regarding the distribution of medical cannabis and payment. This section is effective the day following final enactment.

Section 40 (152.29, subd.3c) exempts manufacturers from being required to grind medical cannabis plant root balls or to incorporate the root balls with other solid waste before transporting them to another location for disposal. This section is effective the day following final enactment.

Section 41 (152.31) authorizes the commissioner to execute data-sharing arrangements with the Commissioner of Agriculture to verify licensing, inspection, and compliance information related to hemp processors.

Section 42 (157.22) exempts from chapter 157 food served at a fellowship meal that is prepared at a faith-based organization so long as a certified food manager or volunteer trained in a food safety course trains the food preparation workers and permits the food that is prepared to be available for curbside pickup and for delivery to members of the organization or the community in which the organization serves.

Section 43 (256.98, subd.1) changes in this section the term vouchers to food benefits as it is used in referencing wrongfully obtaining WIC assistance.

Sections 44 - 47 make modifications to the asbestos abatement program.

Section 44 (326.71, subd.4) removes the exception to the definition of asbestos-related work of asbestos-containing material in single-family residences and buildings with no more than four dwelling units.

Section 45 (326.75, subd.1) increases the annual license fee for a license to perform asbestos relate work from $100 to $105.

Section 46 (326.75, subd.2) increases the certification fee to be certified as an asbestos worker or asbestos site supervisor from $50 to $52.50 and requires any individual who is required to be certified as an asbestos inspector, management planner, or project designer must pay a certification fee of $105.

Section 47 (326.75, subd.3) increases the project permit fee for asbestos-related work from one percent of the total costs of the asbestos-related work to two percent of the total costs.

Section 48 (Laws 2008, chapter 364, section 17) eliminates an annual transfer from the SGSR to the general fund to eliminate a portion of the projected negative balance in the SGSR.

Section 49 (Laws 2019, First Special Session chapter 9, article 14, section 3, as amended by Laws 2019, First Special Session chapter 12, section 6) reduces fiscal year 2021 appropriations to the Commissioner of Health. Some of the reductions help eliminate a portion of the projected negative balance in the SGSR and some of the reductions are related to modifications to the prescription drug price transparency act.

Section 50 (Laws 2020, Seventh Special Session chapter 1, article 6, section 12, subd.4) Corrects a cross-reference in a subdivision governing conversion of housing with services establishments from registration to assisted living facility licensure. This section is effective retroactively from December 17, 2020.

Section 51 [Direction to Modify Marriage License Applications] requires local registrars or a designee of the county board to delete from the county's marriage license application any requirement requiring the applicant to specify the applicant's race.

ARTICLE 4
HEALTH \-RELATED LICENSING BOARDS

Sections 1- 5 create a separate license for medical gas manufacturers, medical gas wholesalers, and medical gas dispensers.

Section 1 (151.01, subd.29) modifies the definition for medical gas.

Section 2 (151.01, subd.29a) adds a definition for medical gas manufacturer.

Section 3 (151.01, subd.29b) adds a definition for medical gas wholesaler.

Section 4 (151.01, subd.29c) adds a definition for medical gas dispenser.

Section 5 (151.191) creates a separate license and license requirements for medical gas manufacturers, medical gas wholesalers, and medical gas dispensers.

Section 6 [Repealer] repeals section 151.19, subd.3 (sale of federally restricted medical gases).

ARTICLE 5
PRESCRIPTION DRUGS

Section 1 (62W.11) prohibits pharmacy benefit managers and health carriers from restricting a pharmacy or pharmacist from discussing with an enrollee the pharmacy's acquisition cost for a prescription drug and the amount the pharmacy is being reimbursed by the pharmacy benefit manager or health carrier for the prescription drug. It also prohibits the pharmacy benefit manager from restricting a pharmacy or pharmacist from discussing with a health carrier the amount the pharmacy is being reimbursed for a drug by the pharmacy benefit manager or the pharmacy's acquisition cost for the drug.

Sections 2 - 5 make modifications to the drug repository program.

Section 2 (151.555, subd. 1) includes over-the-counter drugs to the drug repository program.

Section 3 (151.555, subd. 7) removes the requirement that donated drugs be immediately inspected upon receipt and kept separately until inspected and reduces the number of years that the repository must keep a record of the donated drugs destroyed from five years to two years.

Section 4 (151.555, subd. 11) reduces the number of years the repository must keep all records that are required to be maintained from five years to two years.

Section 5 (151.555, subd. 14) authorizes the central repository to enter into an agreement with another state that has established a drug repository or donation program to offer to the other state inventory that is not needed by a Minnesota resident and to accept inventory from the other state that could be distributed to a Minnesota resident.

ARTICLE 6
HEALTH INSURANCE

Section 1 [62Q.097] requires a health plan company (HPC) when it receives a clean application for provider credentialing, to upon request, affirm that the application was received and the date by which the HPC will make a determination on the application. The HPC must also within three business days inform the provider of the application's deficiencies if it is determined that the application is not a clean application. The HPC is also required to make a determination on a clean application within 45 days after receipt of the application unless there are substantive quality or safety concerns identified that require further investigation.

ARTICLE 7
TELEHEALTH

Sections 1-4 modify MFIP and DWP provisions to permit applicants to submit application forms by phone or online.

Section 1 (256J.08, subdivision 21) permits applicants for the Minnesota Family Investment Program (MFIP) to submit initial applications online or via telephone.

Section 2 (256J.09, subdivision 3) makes conforming changes; requires county agencies to inform applicants for MFIP submitting an initial application online or via telephone that the county agency must receive the applicant's signed written application within 30 days of

submitting the initial application; and permits applicant interviews to be conducted by telephone.

Section 3 (256J.45, subdivision 1) removes the requirement that when the county agency provides an orientation to an MFIP caregiver of a minor child, that the orientation be done face-to-face.

Section 4 (256J.95, subdivision 5) authorizes assistance to begin on the date that an applicant for the Diversionary Work Program (DWP) submits an initial application online or via telephone and requires county agencies to inform applicants submitting an initial application online or via telephone that the county agency must receive the applicant's signed written application within 30 days of submitting the initial application.

ARTICLE 8
ECONOMIC SUPPORTS

Section 1 (256E.34, subdivision 1) adds Tribal nations to the group of entities that are authorized to receive food shelf funding.

Section 2 (256J.30, subdivision 8) permits county agencies to make required contact of the caregiver of a minor child in writing or by phone upon receipt of an incomplete monthly MFIP household report form. Under current law, the county agency must return the incomplete MFIP household report form.

Section 3 (256J.626, subdivision 1) clarifies that tribes that administer MFIP eligibility are authorized to use emergency funds for all authorized purposes, whereas tribes that do not administer MFIP eligibility may use emergency for some authorized purposes, and clarifies that payments from the MFIP consolidated fund to support a caregiver are not included in a family's available income for eligibility purposes.

ARTICLE 9
CHILD PROTECTION

Section 1 (256N.02, subdivision 16) clarifies that to be eligible for Northstar kinship assistance, custody cannot be transferred to a child's parent or to a shared custody arrangement with the child's parent. Also clarifies that the definition of "relative" does not include a child's parent.

Section 2 (256N.02, subdivision 17) clarifies that a child identified as an "at-risk child (Level A)" only applies under adoption assistance.

Section 3 (256N.22, subdivision 1) clarifies that to be eligible for Northstar kinship assistance, custody cannot be transferred to a child's parent or to a shared custody arrangement with the child's parent. Also clarifies that the definition of "relative" does not include a child's parent.

Section 4 (256N.23, subdivision 2, paragraph (b), clauses (3) and (5)) permits parental consent of a child receiving kinship assistance to satisfy one portion of adoption assistance eligibility, and corrects a cross-reference.

Section 5 (256N.23, subdivision 6) adds an exception to the prohibition on providing adoption assistance to a child's legal custodian or guardian who is adopting the child, to permit assistance payments to relatives who are receiving kinship assistance benefits on behalf of the child.

Sections 6-11 (256N.24, subdivisions 1, 8, 11, 12, 14; 256N.25, subdivision 1) make technical changes to clarify when Northstar adoption assistance or Northstar kinship assistance applies.

Section 12 [256N.25, subdivision 1a] requires the commissioner to reimburse relative custodians and adoptive parents up to $2,000 for reasonable and necessary costs incurred while seeking permanent custody of a child with a Northstar kinship agreement, or while seeking adoption of a child who qualifies as having special needs under the Northstar program.

Sections 13, 14, and 15 (259.22, subdivision 4; 259.35, subdivision 1; 259.73) update cross-references relating to the changes to the Northstar program.

ARTICLE 10
CHILD PROTECTION POLICY

Sections 1, 26-28, 30, 32, 35-36, 43-48, and 58 update existing statutes relating to implementation of the Family First Prevention Act.

Section 1 (245.4885, subdivision 1) makes technical revisions to clarify that the services and functions in the statute are to be provided for a child. Paragraph (d) also indicates that the validated tool to determine an appropriate level of care under the Children's Mental Health Act may also be the tool used to conduct an assessment following a recommendation from the juvenile screening team for placing the child in a QRTP.

Section 26 (260C.007, subdivision 26c) adds a requirement for a county to contact a child's tribe to offer the tribe the option to designate a trained culturally competent professional or licensed clinician, under certain conditions, to act as the "qualified individual" for purposes of child safety and placement procedures.

Section 27 (260C.007, subdivision 31) incorporates victims of sexual exploitation, as defined in federal law, into the definition for "sexually exploited youth" for purposes of child safety and placement.

Section 28 (260C.157, subdivision 3) makes technical conforming and clarifying changes.

Section 30 (260C.212, subdivision 1a) makes technical clarifying changes and requires the agency placing a child in a QRTP to file with the court its report seeking court approval of the placement in addition to the out-of-home placement plan.

Section 32 (260C.212, subdivision 13) makes technical conforming changes to include the federal definition of "commercial sexual exploitation."

Section 35 (260C.4412, paragraph (c)) exempts lead county contracts from establishing variable foster care maintenance payments to cover the listed items for licensed foster care settings. Instead, the maintenance payments must align with the existing, definite basic monthly rates for Northstar Care for Children.

Section 36 (260C.452) revises the Successful Transition to Adulthood provisions.

Subdivision 1 adds a definition for "youth" that identifies the potential circumstances under which a youth from age 14 to 23 could qualify for services under this statute. It also describes the areas in which the available services are meant to address needs.

Subdivision 1a identifies which case management services are available to a qualifying youth under the statute.

Subdivision 2 requires development of an independent living plan for youth 14 and older who are receiving support under this section of law, regardless of placement status.

Subdivision 4 makes conforming and clarifying changes.

Subdivision 5 establishes the content and timing of notice requirements for youth 18 or older that leave foster care, to inform the youth of the date upon which services shall end, and any available appeal rights.

Section 43 (260C.704) clarifies the responsible social service agency's duties in distributing an assessment completed by a qualified individual, and in planning a placement for a child in a QRTP or a less restrictive setting.

Section 44 (260C.706, paragraph (a), clause (1)) corrects a cross-reference.

Section 45 (260C.708) makes technical clarifying changes, and requires that evidence of a family and permanency team's involvement in the placement assessment and the family and permanency team's placement preferences be included in an out-of-home placement plan.

Section 46 (260C.71) clarifies and expands court approval requirements regarding a child's placement in a QRTP.

Section 47 (260C.712) incorporates additional statutory references in chapter 260D that incorporate review requirements for QRTP placements, and clarifies that the responsible social services agency must submit evidence of the compelling reasons for placing a child in an out-of-state QRTP at each placement review hearing.

Section 48 (260C.714) corrects a cross-reference.

Section 58 [260E.36, subdivision 1a] requires training regarding sex trafficking and sexual exploitation of children and youth, for all child protection social workers and social services staff with child protection duties.

Sections 2-8 add definitions to the human services licensing chapter, chapter 245A, to incorporate terms used frequently in the sections of law implementing the Family First Prevention Act.

Section 2 [245A.02, subdivision 3c] adds a definition for the phrase "at risk of becoming a victim of sex trafficking or commercial sexual exploitation," to the criteria for which the Commissioner of Human Services shall establish.

Section 3 [245A.02, subdivision 4a] adds a definition for the phrase "children's residential facility" to mean a residential program licensed under chapter 245A or chapter 241**.**

Section 4 [245A.02, subdivision 6e] adds a definition for "foster family setting" to incorporate the existing meaning in Minnesota Rules, as well as settings licensed by the Commissioner of Human Services or the Commissioner of Corrections.

Section 5 [245A.02, subdivision 6f] adds a definition for "foster residence setting" to incorporate the existing meaning in Minnesota Rules, as well as settings licensed by the Commissioner of Human Services or the Commissioner of Corrections.

Section 6 [245A.02, subdivision 18a] adds a definition for "trauma" to mean an event, series of events, or circumstances experienced as physically or emotionally harmful or life-threatening and has lasting adverse effects on the individual's well-being. It also includes cumulative emotional or psychological harm of group traumatic experiences transmitted across generations often associated with racial and ethnic population groups that have suffered major intergenerational losses. This definition only applies for purposes of Families First program certification under section 245A.25.

Section 7 [245A.02, subdivision 23] adds a definition for "victim of sex trafficking or commercial sexual exploitation" to mean a sex trafficking victim under Minnesota law or a

victim of commercial sexual exploitation under federal law. This definition only applies for purposes of Families First program certification under section 245A.25.

Section 8 [245A.02, subdivision 24] adds a definition for "youth" to mean a "child" as defined in section 260C.007, subdivision 4, including individuals under 21 who continue to live in foster care past the age of 18. This definition only applies for purposes of Families First program certification under section 245A.25.

Section 9 [245A.041, subdivision 5] requires children's residential facilities and foster residence settings to document the first date that a person subject to a background study begins working in that setting.

Section 10 [245A.25] establishes the parameters for a program to be certified to receive Title IV-E funding under the Families First Prevention Act.

Subdivision 1 defines the scope of Family First certification for a children's residential facility or child foster residence setting as one of three types of programs: (1) a QRTP, (2) a residential setting specializing in serving youth who have been or at risk of becoming victims of sex trafficking or commercial sexual exploitation, or (3) a residential setting specializing in prenatal, postpartum, or parenting support for youth. Certification is not available to a foster family setting in which the license holder resides in the foster home, or to a children's residential facility licensed as a detention setting or secure program. Certifications for foster residence settings may only be issued by the Commissioner of Human Services, not a delegated agency.

Subdivision 2 repeats the three types of certification available, and requires an applicant to submit a request for certification on a form and in a manner prescribed by the Commissioner of Human Services. The commissioner's certification decision is final and not subject to appeal.

Subdivision 3 requires programs certified as QRTPs or as a setting specializing in serving youth victims of sex trafficking or commercial sexual exploitation to provide services according to a trauma-informed model of care, as defined in paragraph (b).

The program must have a process for identifying signs and symptoms of trauma and must address needs related to trauma, as defined in paragraph (c). **Paragraph (d)** requires the listed principles of trauma-informed care to be incorporated into a program's services. **Paragraph (e)** lists additional specific forms of trauma-based treatment for QRTPs to include in its treatment model.

Paragraph (f) establishes requirements for the provider's physical, social, and emotional environment. **Paragraph (g)** requires the program to have policies and procedures describing the listed aspects of the program.

Paragraph (h) requires training for each staff member on trauma-informed care and the impacts of each youth's culture, race, gender, and sexual orientation on the youth's behavioral health and traumatic experiences, prior to any direct contact with a youth. The training must be repeated annually.

Subdivision 4 establishes specific programming, staffing, accreditation, service standards, and documentation requirements for programs to be certified as QRTPs.

Subdivision 5 establishes specific programming, service delivery, documentation, and staff training requirements for programs to be certified as settings specializing in serving youth

victims of sex trafficking or commercial sexual exploitation.

Subdivision 6 establishes specific programming, service delivery, and documentation requirements for programs to be certified as a setting specializing in prenatal, postpartum, or parenting supports for youth.

Subdivision 7 establishes specific programming, service delivery, and documentation requirements for programs to be certified as a supervised independent living setting for youth who are 18 years of age or older.

Subdivision 8 authorizes the Commissioner of Human Services to monitor, inspect, and review a DHS-licensed program's compliance with the certification requirements to receive federal Title IV-E funding under this section. The commissioner may issue correction orders for noncompliance.

The Commissioner of Human Services may also review the compliance of a DOC-licensed program biennially and may issue correction orders for noncompliance. A correction order must state the conditions that constitute a violation, the specific law or rule violated, and the time allowed to correct the violation. A DOC-licensed program may request reconsideration in writing within 20 days of receiving the correction order. The commissioner's decision on reconsideration is final and not subject to appeal.

Subdivision 9 authorizes the Commissioner of Human Services to decertify a program for failure to comply with the certification requirements in this section. The decertification may be reconsidered upon written request from the license holder. The commissioner's decision regarding a reconsideration of a decertification is final and not subject to appeal.

Subdivision 10 permits the Commissioner of Human Services to grant variances to this section's requirements that do not affect youth health and safety or compliance with federal Title IV-E funding requirements, so long as the variance procedures in section 245A.04, subdivision 9, are satisfied.

Sections 11-12 (256.01, subdivision 14b; 256.0112, subdivision 6) authorize tribes to enter into lead contracts within and across reservation boundaries in the same manner as counties enter into lead contracts within and across county lines.

Sections 13-14 modify provisions relating to child support noncooperation procedures.

Section 13 [256.741, subdivision 12a] permits an individual to appeal a determination or redetermination of whether good cause existed to excuse the individual's noncooperation with a child support agency.

Section 14 [256.741, subdivision 12b] permits notice of an individual's noncooperation with a child support agency to be sent to the relevant public assistance agencies when the time that an individual may appeal a good cause determination has expired.

Sections 15-25, 29, 31, 33-34, and 37-42 modify policy provisions relating to adoption procedures, reimbursement of adoption placement services costs for tribal agencies, and requirements to complete a social and medical history for children in out-of-home placement.

Section 15 (249.241, paragraph (c)) clarifies that an individual in extended foster care may consent to their own adoption so long as a court finds the individual is competent to give such consent.

Section 16 (259.53, subdivision 4) makes technical clarifying changes regarding the timing of granting a petition for adoption.

Section 17 (259.75, subdivision 5) adds language requiring a child's adoption exchange

registration to be withdrawn when a child is no longer under the guardianship of the commissioner and is no longer seeking an adoptive home.

Section 18 (259.75, subdivision 6) revises the timing and circumstances under which the commissioner must review the state adoption exchange status of certain children.

Section 19 (259.75, subdivision 9) permits the commissioner to contract out the administration of the state adoption exchange.

Section 20 (259.83, subdivision 1a) updates cross-references to incorporate a reference to section 260C.212, subdivision 15.

Sections 21, 23-24 (259A.75, subdivisions 1, 3-4) make conforming changes to add tribal agencies to provisions regarding reimbursement of adoption placement services costs.

Section 22 (259A.75, subdivision 2) updates a cross-reference and eliminates the requirement for a child under guardianship of the commissioner to have a fully executed adoption placement agreement to be eligible for adoption services.

Section 25 (260C.007, subdivision 22a) makes technical clarifying changes to cross-references and includes tribally licensed or approved programs to those in which a child may be co-located in foster care with a parent in treatment.

Section 29 (260C.212, subdivision 1, paragraph (d)) clarifies that the responsible agency must provide a child with a copy of their social and medical history under certain circumstances.

Section 31 (260C.212, subdivision 2, paragraph (a)) clarifies that a related individual includes the legal parent, guardian, or custodian of a child's siblings.

Section 33 [260C.212, subdivision 15] establishes the procedures, timing, and content requirements for responsible social services agencies to complete a social and medical history for each child in out-of-home placement.

Section 34 (260C.219, subdivision 5) makes clarifying changes and updates a cross-reference.

Section 37 (260C.503, subdivision 2, paragraph (d), clause (1)) corrects a cross-reference.

Section 38 (260C.515, subdivision 3, clause (8)) permits a court to terminate parental rights in the circumstance where a prospective adoptive parent that has consented to adopt a child is not going to adopt the child.

Section 39 (260C.605, subdivision 1, paragraph (d), clause (4)) corrects a cross-reference.

Section 40 (260C.607, subdivision 6, paragraph (f), clause (2)) corrects a cross-reference.

Section 41 (260C.609) makes a conforming change to delete text that has been moved to a new statute regarding social and medical history, and clarifies the circumstances under which a prospective adoptive parent shall receive a copy of a child's social and medical history, and under which the social and medical history must be submitted to DHS or a court.

Section 42 (260C.615) corrects a cross-reference and clarifies the commissioner's duties to review and process adoption placement agreements and to supervise duties delegated to responsible social services agencies regarding children under guardianship of the commissioner.

Sections 49-54 include 260D foster settings in the Family First Prevention Act requirements.

Section 49 (260D.01, paragraph (c), paragraph (f)) incorporates references to the statutory sections governing placement of a child in a QRTP, including the provisions governing the responsible social service agency's consultation with a child's parent during assembly of the family and permanency team.

Sections 50-51 (260D.05; 260D.06, subdivision 2) incorporate the requirements for the responsible social services agency to submit evidence to the court for a child placed in a QRTP.

Section 52 (260D.07, paragraph (c)) includes in the materials required to be submitted with a petition for permanency review regarding a child in voluntary foster care for treatment, any evidence submitted to a court for a matter regarding a child placed in a QRTP.

Section 53 (260D.08, paragraph (b)) requires a court to annually review evidence submitted to a court for a child placed in a QRTP, as part of an annual permanency review for a child in voluntary foster care for treatment.

Section 54 (260D.14) replaces the term "child" with "youth" and clarifies a cross-reference to the section providing foster care benefits to youth 18 years of age or older.

Section 55 (260E.20, subdivision 2) permits face-to-face contact in response to a report alleging sexual abuse or substantial child endangerment to be postponed for up to five calendar days, if: 1) the child is residing in a location that is confirmed to restrict contact with the alleged offender; or 2) the local welfare agency is pursuing a court order for the child's caregiver to produce the child for an interview under section 260E.22, subdivision 5.

Section 56 (260E.31, subd. 1) exempts a health care professional from reporting a pregnant woman's drug use if the professional is providing or collaborating with other professionals to provide prenatal care, postpartum care, or other health care services. Specifies that if the woman does not continue to receive regular prenatal or postpartum care, the professional is required to report the drug usage after attempting to contact the woman.

Section 57 [260E.33, subdivision 6a] requires an administrative law judge to inform a maltreated child's parent, legal custodian, or guardian of the right to file a written statement and the right to attend and participate in the hearing in a contested case hearing appealing a licensing sanction or disqualification related to a maltreatment determination, and describes related notice requirements, requirements for the written statement, and procedures for providing the address of a parent, legal custodian, or guardian.

Sections 59-60 modify provisions relating to the parent education program for parties to family law proceedings.

Section 59 (518.157, subdivision 1) requires the district court to ensure that their website includes information on the parent education program.

Section 60 (518.157, subdivision 3) authorizes parties who have not agreed to custody or parenting time to take online classes to meet the minimum eight hours required for the parenting education program. Parties must complete the class before the initial case management conference, unless otherwise ordered by the court. The court must provide notice to the parties regarding their option to resolve disagreements through the use of private mediation.

Sections 61 and 73-78 remove interest charging requirements for child support judgments and specify that interest does not accrue on such judgments.

Section 61 (518.68, subdivision 2) removes interest charging language; removes paragraph (k), stating that the public authority may suspend or resume interest charging on child support judgments under certain conditions, from child support judgment notice requirements. Removes statement that interest begins to accrue on child support payments when the amount due is greater than the support due, from judgments for unpaid support notice requirement. Requires notice in judgments for unpaid maintenance, stating that the public authority is not responsible for calculating interest on a judgment for unpaid spousal maintenance; provides exception for collecting interest on unpaid spousal maintenance in IV-D cases. Effective August 1, 2022.

Section 73 (548.091, subdivision 1a) removes language regarding interest accrual on child support judgments. Specifies that interest does not accrue on judgments for child support, confinement and pregnancy expenses, or genetic testing fees. Effective August 1, 2022.

Section 74 (548.091, subdivision 2a) specifies that a child support judgment entered and docketed is not subject to interest charging or accrual. Effective August 1, 2022.

Section 75 (548.091, subdivision 3b) specifies that a child support judgment renewal only includes unpaid interest accrued prior to August 1, 2022, the effective date of this section.

Section 76 (548.091, subdivision 9) specifies that the child support or maintenance payoff statement from the public authority must state that the public authority does not calculate accrued interest and that an interest balance may be owed. Effective August 1, 2022.

Section 77 (548.091, subdivision 10) adds language specifying that the lien release requirement applies to child support amounts due. Specifies that the public authority is not responsible for satisfaction of judgments for unpaid maintenance. Effective August 1, 2022.

Section 78 (549.09, subdivision 1) exempts child support judgments from family court action interest accrual provisions. Specifies that interest does not accrue on child support judgments. Effective August 1, 2022.

Sections 62-71 modify provisions related to child support guidelines, deductions, and calculations; child care support obligations; adjustments due to increased income; and reporting arrears to consumer reporting agencies.

Section 62 (518A.29, paragraph (g)) removes deduction of court-ordered child support payments from other periodic payments received by a party for purposes of determining gross income, effective January 1, 2023.

Section 63 (518A.33) specifies that court-ordered child support payments for a nonjoint child are to be deducted from the payor's gross income. Requires a deduction to be calculated when a parent is legally responsible for a nonjoint child and that parent is not obligated to pay court-ordered basic child support for the nonjoint child to the other parent or legal guardian. Specifies that this deduction is calculated using the basic support guideline table and the gross income of the parent for whom the deduction is being calculated, minus other deductions and up to six eligible nonjoint children. Modifies the deduction for nonjoint children from 50 percent to 75 percent of the guideline amount. Effective January 1, 2023.

Section 64 (518A.35, subdivision 1) specifies the support obligation determination for when a support order is sought in an action involving only one parent. Increases maximum combined parental income for the presumed basic child support obligations from $15,000 to $20,000 per month. Effective January 1, 2023.

Section 65 (518A.35, subdivision 2) updates the basic support guideline table amounts and makes low-income adjustments. Effective January 1, 2023.

Section 66 (518A.39, subdivision 7) specifies that a decrease in child care support is effective the date the child care expenses terminate.

Section 67 [518A.40, subdivision 3a] requires the obligee to give the child care provider the name and address of the obligor, and to give the obligor the contact information of the child care provider. Requires the obligee to provide the obligor with verification from the child care provider indicating child care expenses for the previous year, by February 1 of each year. Requires the obligee to inform the obligor of changes to child care, and allows the obligor to request the verification from the provider if the obligee fails to provide it. Requires the obligee to notify the obligor and the public authority when the obligee is no longer incurring child care expenses.

Section 68 (518A.40, subdivision 4) specifies that, in cases where child care expenses have ended, parties may modify the order. Allows parties to contact the public authority about filing a stipulation to modify or terminate the child care support amount, when the public authority is providing child support services.

Section 69 (518A.42) Subd. 1. Ability to pay. Modifies the calculation of the obligor's income available for support by subtracting the self-support reserve from parental income for determining support (PICS) instead of gross income.

Subd. 2. Minimum basic support amount. Modifies provisions related to minimum basic support amounts for certain numbers of children; increases maximum to six or more children. Removes provision specifying that the minimum amounts do not apply if an obligor receives no income and completely lacks the ability to earn an income.

Subd. 3. Exception. Specifies that the minimum basic support amount does not apply if the obligor's basic support amount is reduced below the minimum due to the parenting expense adjustment. This section is effective January 1, 2023.

Section 70 [518A.43, subdivision 1b] allows the court to deviate from the presumptive child support obligation in a modification when the only change in circumstances is an increase in the custodial parent's income and: 1) the basic support increases; 2) the parties' combined gross income is $6,000 or less; or 3) the obligor's income is $2,000 or less. Effective January 1, 2023.

Section 71 (518A.685) makes public authority reporting of child support arrears to a consumer reporting agency optional, not required. Adds option for obligor to enter into a written and approved payment agreement for child support arrears to prevent reporting of arrears to a consumer reporting agency. Effective January 1, 2023.

Section 72 [518A.80] establishes procedures, standards, and criteria for transferring a postjudgment child support, custody, or parenting time action to a tribal court.

Section 79 (Direction to Commissioner of Human Services; Qualified Residential Treatment Transition Supports) directs the commissioner to consult with stakeholders and develop policy guidance by December 31, 2022, for providing aftercare supports to children who are transitioning from a QRTP to reunification with the child's family or a less restrictive setting, as part of Family First implementation.

Section 80 (Revisor Instruction) instructs the Revisor to insert a headnote in chapter 260C relating to placement of children in QRTPs.

ARTICLE 11
BEHAVIORAL HEALTH

Sections 1-4 modify provisions relating to certified community behavioral health clinics (CCBHCs).

Section 1 (245.735, subdivision 3) clarifies that the commissioner must establish a state CCBHC certification process that satisfies all federal requirements, without service area limits based on geographic area or region, and follows consultation with CCBHC stakeholders.

Section 2 (245.735, subdivision 5) makes a conforming change to incorporate a reference to state requirements for CCBHCs.

Section 3 [245.735, subdivision 6] authorizes the commissioner to operate a CCBHC federal demonstration project, if federal funding for the project remains available. To the extent possible, the commissioner shall align the standards for the federal demonstration project with the CCBHC standards for MA reimbursement.

Section 4 (256B.0625, subdivision 5m) establishes a per-visit prospective payment system that uses a provider-specific rate, limits payment to one payment per day per MA enrollee, establishes new provider rates that are similar to existing rates for other similar providers, rebases rates once every three years and one year following a rate change, and permits a provider to request a rate adjustment. Paragraph (e) directs the commissioner to implement a quality incentive payment program for CCBHCs, that would give a CCBHC an additional payment upon meeting certain measures for performance, if the CCBHC has been enrolled for at least a year. Paragraph (f) establishes the timing for submission and payment of claims to managed care plans, based upon the date of billed service and whether the managed care plan has complied with federal requirements for payment to CCBHCs.

Section 5 (297E.02, subdivision 3) requires the Commissioner of Human Services to issue to the state problem gambling affiliate a monthly statement of the amounts deposited for the compulsive gambling treatment program and for the grant to the state problem gambling affiliate, and to issue to the legislature an annual reconciliation of the amounts deposited.

Section 6 (Direction to the Commissioners of Health and Human Services; Compulsive Gambling Programming and Funding) requires the Commissioner of Human Services to consult with the Commissioner of Health and report to the legislature by September 1, 2022, on whether the revenue appropriated to DHS for a grant for compulsive gambling programming is more properly appropriated to and managed by a different agency, and on whether DHS should continue to manage the compulsive gambling treatment program.

Section 7 (Revisor Instruction) instructs the Revisor of Statutes to replace “excellence in mental health demonstration project” with “certified community behavioral health clinic services” in the headnote of section 245.735.

Section 8 (Repealer) repeals sections of statute that are out of date, relating to the federal Excellence in Mental Health demonstration project.

ARTICLE 12
DISABILITY SERVICES AND CONTINUING CARE FOR OLDER ADULTS

Section 1 (256.9741, subdivision 1) modifies the definition of "long-term care facility" in the statutes governing the authority and duties of the ombudsman of long-term care to grant the ombudsman jurisdiction over certain unlicensed settings in which home care services are arranged or provided by the setting.

Section 2 (256B.0911, subdivision 3a) permits an individual who was receiving HCBS waiver services prior to a temporary admission to an institutional setting of 121 days or fewer to return to the waiver without an assessment, provided all other eligibility criteria are met.

Section 3 (256I.05, subdivision 1a) provides tribes the option to access the cost-neutral housing support lump-sum allocations currently available only to counties.

Section 4 (256I.05, subdivision 11) provides tribes the option to access the cost-neutral housing support lump-sum allocations currently available only to counties.

Section 5 (Governor's Council on an Age-Friendly Minnesota) specifies duties of the Governor's Council on an Age-Friendly Minnesota and extends the council until October 1, 2022.

Section 6 (Revisor instruction) requires the revisor of statutes to prepare, in collaboration with House Research; Senate Counsel, Research and Fiscal Analysis; and DHS, to renumber portions of the DWRS rate statutes prior to publication of the 2021 supplement, and to propose draft legislation to recodify the long-term care consultation services and long-term care options counseling statutes.

ARTICLE 13
COMMUNITY SUPPORTS POLICY

Section 1 (245.4874, subdivision 1) authorizes the Commissioner of Human Services to access private data on individuals related to an individual child's mental health screening for the purposes of program evaluation and improvement.

Section 2 (245.697, subdivision 1) modifies membership on the State Advisory Council on Mental Health to include a representative of the Minnesota Department of Health, of the American Indian Mental Health Advisory Council, and of a consumer-run mental health advocacy group.

Section 3 (252.43) clarifies that determinations of need are required for all-day services for adults with disabilities, except when a day service provider changes name or ownership.

Sections 4 to 47 updates statutes governing public guardianships (chapter 252A) for persons with developmental disabilities to reflect changes made to guardianship law (chapter 524) in Laws 2020, chapter 86, article 1, including modernizing terminology and requiring before imposing public guardianship that less restrictive alternatives to public guardianship be attempted and determined to be insufficient to meet the person's needs.

Section 48 (254B.03, subdivision 2) clarifies which services are eligible for payments from the behavioral health fund.

Sections 49 to 53 (256B.051) renames "housing support services" as "housing stabilization services" to prevent confusion between this medical assistance service and the state-funded housing support program under chapter 256I.

Section 52 (256B.051, subdivision 6) requires housing stabilization service providers to complete annual vulnerable adult training.

Section 54 (256B.051, subdivision 8) specifies the requirements for documenting the provision of housing stabilization services.

Section 55 (256B.0947, subdivision 6) clarifies that a treatment team must complete an individual treatment plan for intensive nonresidential rehabilitative mental health services.

Section 56 (256B.4912, subdivision 13) aligns the statutory disability waiver transportation standards for a driver and a vehicle with the federally approved waiver plans.

Sections 57 to 81 make various clarifications and modifications to CFSS policy prior to its rolling implementation beginning in the fall of 2021.

Section 57 (256B.69, subdivision 5a) extends the current requirements regarding administration of the PCA program by managed care organizations to the administration of CFSS.

Section 58 (256B.85, subdivision 1) clarifies that services and supports purchased under CFSS are not home care services for the purposes of Department of Health licensing.

Section 59 (256B.85, subdivision 2) makes various clarifying changes to definitions for the purposes of CFSS, including:

> **Paragraph (b)** modifies and clarifies the meaning of activities of daily living for the purposes of CFSS.
>
> **Paragraph (f)** clarifies that CFSS covers complex health-related interventions ordered by an advanced practice registered nurse or physician's assistant.
>
> **Paragraph (u)** strikes language related to the definition of "participant's representative." Expanded and clarifying language is proposed in section 75 (256B.85, subdivision 14a)

Section 60 (256B.85, subdivision 3) clarifies eligibility for CFSS.

Section 61 (256B.85, subdivision 4) makes a technical change.

Section 62 (256B.85, subdivision 5) clarifies the notice requirements following a long-term care consultation assessment and clarifies the process for authorizing temporary CFSS without an assessment.

Section 63 (256B.85, subdivision 6) makes clarifying and technical changes and specifies that a CFSS service delivery plan must describe the units of service or dollar amount available to a CFSS participant.

Section 64 (256B.85, subdivision 7) modifies restrictions on the wages for support workers who are the parent, stepparent, legal guardian, or spouse of the participant.

Section 65 (256B.85, subdivision 8) clarifies the conditions under which a participant qualifies for additional units of service for level I behaviors.

Section 66 (256B.85, subdivision 8a) establishes alternative authorization procedures for CFSS for temporary provision of CFSS, emergency provision of CFSS, temporary higher level of need for a current participant, reinstated MA eligibility, agency error, a third-party payer denies or adjusts payment, or temporary disenrollment from a managed care plan.

Section 67 (256B.85, subdivision 9) clarifies that CFSS does not cover services (1) provided in a foster care setting unless the setting is the licensee's primary residence; (2) services that are the contractual obligation of a foster care provider; (3) certain assistance with instrumental activities of daily living provided to children; and (4) services provided in certain institutional settings.

Section 68 (256B.85, subdivision 10) clarifies CFSS agency-provider and FMS provider qualifications and duties.

Section 69 (256B.85, subdivision 11) requires an agency provider to make a reasonable effort to fulfill a participant's request for the participant's preferred support worker.

Section 70 (256B.85, subdivision 11b) establishes timelines for agency providers to complete an evaluation of support workers' competency through direct observation; documentation requirements related to support worker orientation and instruction for performing health-related tasks; and requirements related to developing support worker training and development plans.

Section 71 (256B.85, subdivision 12) clarifies CFSS agency-provider enrollment requirements, including by applying the existing fidelity bond coverage amount to each provider location.

Section 72 (256B.85, subdivision 12b) extends from 10 to 30 the number of days' notice a CFSS provider-agency must give a participant before terminating services.

Section 73 (256B.85, subdivision 13) requires participants using the budget model who share CFSS services or who are the joint employer of a single support worker to use the same FMS provider.

Section 74 (256B.85, subdivision 13a) requires a FMS provider to give a participant 30 days' notice before terminating FMS services.

Section 75 (256B.85, subdivision 14a) specifies when a participant's representative is required for a participant to receive CFSS, the requirements for participant representatives, the requirements of a written agreement between a participant representation and an agency-provider or FMS provider; the requirements for delegating a participant's representative's duties to another adult, and the circumstances under which a lead agency may disqualify an individual as serving as a participant representative.

Section 76 (256B.85, subdivision 15) clarifies that support worker timesheets must be submitted at least once per month.

Section 77 (256B.85, subdivision 17a) specifies the surety bond requirements for consultation service providers; and requires consultation service providers to report maltreatment of vulnerable adults and minors.

Section 78 (256B.85, subdivision 18a) specifies the required qualifications of individuals providing worker training and development services and clarifies the limit on covered worker training and development services.

Section 79 (256B.85, subdivision 20b) specifies that a participant has a right to be told before services begin of any agreements for shared services.

Section 80 (256B.85, subdivision 23) clarifies the potential consequences of a provider-agency, FMS provider, or consultation services provider denying the commissioner access to the provider's offices and records when the commissioner is investigating possible overpayments.

Section 81 (256B.85, subdivision 23a) clarifies that existing sanctions for agency providers and FMS service providers also apply to consultation service providers.

Section 82 (256L.03, subdivision 1) clarifies the CFSS and housing stabilization services are not covered services under MinnesotaCare.

Section 83 (Revisor Instruction) requires the revisor of statutes to change where appropriate the term "consolidated chemical dependency treatment fund" to the term "behavioral health fund;" the term "housing support services" to "housing stabilization services;" and the term "group residential housing" to "housing support."

Section 84 (Repealer) repeals statutory language related to determinations of need for day services

and related appeals; repeals the definitions of public conservator and conservatee, and related definitions, from the public guardianship statute to conform with updated language elsewhere in the article.

ARTICLE 14
MISCELLANEOUS

Section 1 [62A.082] prohibits a health plan or group health plan that provides coverage for anatomical gifts, organ transplants, or related treatment and services from discriminating against an enrollee with a disability by denying coverage based on the disability; denying eligibility to enroll, or to renew coverage solely to avoid the requirements of this section; penalizing or reducing reimbursement to a provider, or inducing the provider to provide care in a manner inconsistent with this section; or reducing or limiting coverage benefits because of the enrollee's disability.

Section 2 [363A.50] prohibits a covered entity from discriminating against a qualified individual by deeming the individual ineligible to receive an anatomical gift or organ transplant; denying medical or related transplantation services; refusing to refer the individual to a transplant center or other related specialist for evaluation or for the receipt of a gift or organ transplant; refusing to place an individual on an organ transplant waiting list or placing the individual on a lower priority position; or declining insurance coverage for any procedure associated with the receipt of the gift or transplant.

ARTICLE 15
MENTAL HEALTH UNIFORM SERVICE STANDARDS

Sections 1-19 modify mental health statutes in order to achieve a uniform service standards framework, including a unified licensing framework for mental health services, common standards that apply to all mental health care programs, the start of a transition of residential crisis stabilization (RCS) and intensive residential treatment services (IRTS) to the new common standards beginning July 1, 2022, a consolidated list of mental health services covered by medical assistance, and requirements for the Commissioner of Human Services to consult with stakeholders to continue to develop recommendations for a single comprehensive mental health licensing structure.

ARTICLE 16
CRISIS RESPONSE SERVICES

Sections 1-5 modify provisions relating to crisis response services as part of the mental health uniform service standards proposal, by combining crisis standards for adults and children to eliminate unintentional differences and clarifying how mobile crisis teams can work with family members and other third parties calling on behalf of someone in need of crisis assistance.

ARTICLE 17
UNIFORM SERVICE STANDARDS; CONFORMING CHANGES

Sections 1-114 make conforming changes to incorporate mental health uniform service standards modifications.

ARTICLE 18
FORECAST ADJUSTMENTS

Sections 1-3 modify the fiscal year 2021 appropriations to the Department of Human Services for

the forecasted programs administered by the department to account for changes in projected spending as reflected in the most recent state budget forecast.

ARTICLE 19
EFFECTIVE DATES

Section 1 establishes an effective date of July 1, 2021, for all sections in this act, unless another effective date is specified.