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Senate

State of Minnesota

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ARTICLE 1

HEALTH CARE; DEPARTMENT OF HUMAN SERVICES

Sections 1-7 include pretreatment coordination services in these sections involving withdrawal management programs and chemical treatment programs.

Section 1 (245F.03) specifies that chapter 245F does not apply when a withdrawal management program is providing pretreatment coordination services.

Section 2 (245G.02, subd. 2) specifies that chapter 245G does not apply when a chemical dependency licensed treatment facility is providing pretreatment coordination services.

Section 3 (245G.06, subd. 3) adds pretreatment coordination services to the services that must documented and reviewed weekly by a chemical dependency licensed facility as part of a client's treatment plan.

Section 4 (245G.11, subd. 7) specifies that county staff who conduct chemical use assessments are qualified to provide treatment coordination services if employed as of July 1, 2022 and county staff employed after July 1, 2022 are qualified to provide treatment coordination services if the county staff person completes the required classroom instruction.

Section 5 (254B.05, subd. 1) states that American Indian programs and counties are eligible vendors of peer support services and requires an alcohol and drug counselor to be available to recovery peers for ongoing consultation. Also specifies that nonresidential programs, withdrawal management programs, American Indian programs and counties are eligible vendors of pretreatment coordination services when the individual providing the service meets the required staffing credentials.

Section 6 (254B.05, subd. 4a) authorizes an enrolled provider to provide pretreatment coordination services to an individual before the individual's comprehensive assessment to facilitate access to a comprehensive assessment. Specifies that pretreatment coordination services must not exceed 36 units per eligibility determination. Requires the staff providing the services to meet the required staff qualifications. Specifies what is included in pretreatment coordination services.

Section 7 (254B.05, subd. 5) requires the commissioner to establish rates for treatment coordination services and for pretreatment coordination services.

Section 8 (256.01, subd. 28) authorizes the expansion of the Minnesota encounter alerting system to improve care and lower health care costs.

Section 9 (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 10 (256.042, subd. 4) clarifies that the opiate epidemic response advisory council must provide the legislature by March 1, of each year a description of their priorities and specific activities the council intends to address for the upcoming fiscal year based on projected funds available for grant distribution. It also specifies that the council determines the grant awards and funding amounts and the commissioner awards and administers the grants.

Section 11 (256.043, subd. 4) specifies that any funds received by the state as a result of a settlement agreement against a consulting firm working for an opioid manufacturer or wholesaler shall be counted towards the $250,000,000 amount that triggers the sunset of the opiate licensing fees and the opiate registration fee.

Section 12 (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 13 (256.9695, subd. 1) expands the period in which hospitals may appeal or correct the information that the commissioner uses to set the rates and the overall budget pool for inpatient hospital services from 12 months to 18 months.

Section 14 (256.983) expands the fraud and prevention investigation programs to include tribal agencies.

Section 15 (256B.055, subd. 6) expands medical assistance eligibility for pregnant women to include six months postpartum, effective July 1, 2022.

Section 16 (256B.056, subd. 10) makes a conforming change to the expansion of eligibility to six months postpartum by requiring a woman to update their income and asset information following the end of the six months.

Section 17 (256B.057, subd. 3) aligns eligibility asset limits for qualified Medicare beneficiaries to the federal limits.

Section 18 (256B.06, subd. 4) makes a conforming change to the expansion of eligibility to six months postpartum for non-citizens.

Sections 19-21 make changes to the Health Services Policy Committee.

> **Section 19 (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.
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> **Section 20 (256B.0625, subd. 3d)** changes the membership 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.
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> **Section 21 (256B.0625, subd. 3e)** makes conforming changes to the name change.

Section 22 (256B.0625, subd. 9) expands adult dental medical assistance coverage to include nonsurgical treatment for periodontal disease.

Section 23 (256B.0625, subd. 9c) requires the commissioner to develop uniform prior authorization criteria for dental services requiring prior authorization.

Section 24 (256B.0625, subd. 9d) requires the commissioner to develop a uniform credentialing process for dental providers.

Section 25 (256B.0625, subd. 13) authorizes prescription refills of 90 days for drugs included on a 90-day supply list published by the commissioner.

Section 26 (256B.0625, subd. 13c) specifies that the drug formulary committee does not expire.

Section 27 (256B.0625, subd. 13e) increases the dispensing fee for prescriptions dispensed under the fee for service system from $10.48 to $10.77. This section also requires the commissioner when conducting the cost of dispensing survey required to be conducted on all pharmacies every three years to measure a single statewide cost of dispensing for specialty prescription drugs and a single cost of dispensing for non-specialty prescription drugs.

Section 28 (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 consult with the commissioner of health to determine the implications the change may have on state public health policies and initiatives. 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 29 (256B.0625, subd. 13k) requires a pharmacy to be licensed by the board of pharmacy and located within the state to be an eligible dispensing provider under the medical assistance and MinnesotaCare programs.

Section 30 (256B.0625, subd. 67) states that medical assistance covers pretreatment coordination services effective January 1, 2022, or upon federal approval whichever is later.

Sections 31-33 make changes to the opioid prescribing program.

> **Section 31 (256B.0638, subd. 3)** changes the membership of the opiate epidemic response advisory council by adding two consumer members who are Minnesota residents and have used or are using opioids to manage chronic pain and adding a member representing the commissioner of health.
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> **Section 32 (256B.0638, subd. 5)** specifies that commissioner shall annually report to provider groups the sentinel measures of data showing individual provider's opioid prescribing patterns and then requires the provider groups to distribute data to the individual providers.
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> **Section 33 (256B.0638, subd. 6)** makes a corresponding change.

Section 34 (256B.0659, subd. 13) clarifies that a personal care assistant must clear a background study and meet provider training requirements and eliminates the requirement that the personal care attendant enroll with the department as a qualified professional.

Section 35 (256B.196, subdivision 2, paragraph (c)) ends Hennepin Healthcare's authority to use intergovernmental transfers to fund managed care passthroughs. These managed care passthroughs are in the process of being phased out. The phase-out schedule for Regions Hospital remains unchanged.

Section 36 (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.
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> **Subdivision 2** requires federal approval before implementation of any directed payment arrangement.
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> **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 6 requires 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 meets a federal requirements for such an arrangement by aligning with state quality goals for Hennepin Healthcare.

Section 37 (256B.69, subd. 6d) requires managed care plans and county-based purchasing plans to comply with section 256B.0625, subd. 13k (licensed in state pharmacies) for purposes of contracting with dispensing providers.

Section 38 (256B.69, subd. 6f) requires applicable fee schedules for covered dental services to be provided to individual dental providers upon request.

Section 39 (256B.6928, subdivision 5) clarifies that certain state-directed managed care expenditures are permitted under federal law.

Section 40 (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 41 (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.

Sections 42-44 make modifications to MinnesotaCare program to realign the program with federal requirements.

Section 42 (256L.01, subd. 5) clarifies that income means a household's projected annual income for the applicable year.

Section 43 (256L.04, subd. 7b) requires the commissioner to adjust the income limits annually on January 1, instead of July 1.

Section 44 (256L.05, subd. 3a) requires redetermination of eligibility to occur during the open enrollment period for qualified health plans.

Section 45 (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.

Section 46 (256L.15, subd. 5) establishes a tobacco use premium surcharge for tobacco users in MinnesotaCare that equals 10% of the enrollee's monthly premium effective January 1, 2023.

Section 47 (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 48 [Capitation payment delay] delays a portion of the medical assistance capitation payment to managed care plans and county-based purchasing plans due in May 2023 and May 2025 until July 2023 and July 2025, respectively.

Section 49 [Dental home demonstration project plan] requires the commissioner to develop a plan to implement a dental home demonstration project.

Section 50 [Federal Approval; extension of postpartum coverage] requires the commissioner of human services to seek federal approval to extend medic al assistance postpartum coverage.

Section 51 [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 52 [Proposed formulary committee] requires the commissioner of human services to submit to the legislature a proposed reorganization of the drug formulary committee to ensure adequate representation by consumers and health care professionals and to ensure public input.

Section 53 [Opiate epidemic response advisory council; initial membership term] specifies the date in which the terms of the initial members of the advisory council ends.

Section 54 [Direction to commissioner; directed payment application] requires the commissioner of human services to submit by July 31, 2022 the necessary materials seeking approval from to the Centers for Medicare and Medicaid Services for the state-directed managed care expenditures under section 256B.1973.

Section 55 [Directions to commissioner; screening tools; substance use disorder reform evaluation; substance use disorder reform education] requires the commissioner of human services to: develop tools for screening individual for pretreatment coordination services and a template to document the results; develop a tool to evaluate the effects of substance use disorder treatment reform proposals enacted during the 2019 and 2021 session; develop educational materials regarding the implementation of substance use disorder treatment reform proposals enacted during the 2019 and 2021 session.

Section 56 [Funding recommendations for pretreatment coordination services] requires the commissioner of human services to submit recommendations to the legislature for funding pretreatment coordination services if federal approval is not obtained.

Section 57 [Revisor instruction] requires the revisor to change the name of the health services policy committee to the health services advisory council.

Section 58 [Repealer] repeals section 16A.724, subd. 2 effective July 1, 2024, which requires an annual transfer from the health care access fund to the general fund.

ARTICLE 2

HEALTH DEPARTMENT

Sections 1-7 make changes to the health information exchange oversight program by aligning federal and national efforts.

> **Section 1 (62J.495, subd. 1)** removes obsolete language regarding the development of uniform standards.
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> **Section 2 (62J.495, subd. 2)** eliminates an annual report on the progress in implementing a statewide health information infrastructure.
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> **Section 3 (62J.495, subd. 3)** eliminates the state certified requirement for a health data intermediary.
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> **Section 4 (62J.495, subd. 4)** 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.
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> **Section 5 (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.
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> **Section 6 (62J.4981)** removes references to health data intermediaries and changes references to health information exchange organizations.
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> **Section 7 (62J.4982)** changes references from health information exchange service provider to health information exchange service organization.

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 (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.
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> **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.
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> **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 10 (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.

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

Section 16 (144.125, subd. 1) increases the newborn screening fee from $135 to $177 per specimen.

Section 17 (145.125, subd. 2) requires the newborn screening to include a test for congenital human herpesvirus cytomegalovirus (CMV).

Section 18 (144.1461) requires the commissioner to develop and ensure that doula services, training and education are tailored to meet the needs of the groups with the most significant maternal and infant mortality and morbidity disparities.

Section 19 (144.1481, subd.1) adds a licensed dentist to the rural health advisory committee.

Sections 20-22 and 24 describe the changes to requirements for reporting birth records for safe place newborns received by a hospital.

> **Section 20 (144.216, subd. 3)** requires a hospital that receives a safe place newborn to report the birth to the office of vital records within five days after receiving the newborn and requires the state registrar to register the information in accordance with the rules regarding infants of unknown parentage.
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> **Section 21 (144.216, subd.4)** specifies that the birth record of the safe place newborn is confidential data on individuals and information regarding the birth record and birth certificate issued from the birth record shall only be disclosed to the responsible social service agency or pursuant to court order. This section also specifies that if the newborn was born in a hospital and the child's record of birth was registered the office of vital records shall replace the original birth record registered.
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> **Section 22 (144.218, subd. 6)** states that if a hospital receives a safe place newborn and the child's record of birth was registered, the hospital must report to the Office of Vital Records and identify the child's birth record. The state registrar is required to issues a replacement birth record that is free from any information that identifies a parent. Specifies that the prior vital record is confidential data on individuals and shall not be disclosed except under a court order.

Section 23 (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 24 (144.226, subd. 1) waives the fee for processing a request for a replacement birth record involving a safe place newborn.

Section 25 (144.551, subd. 1) exempts form the hospital moratorium a project to add 45 licensed beds at regions hospital, with no further public interest review required.

Section 26 (145.32, subd.1) permits a hospital upon request to destroy medical records of a patient who is a minor when the patient reaches the age of majority or seven years whichever occurs last.

Section 27 (145.4161) establishes licensure for abortion facilities.

Subdivision 1 defines the following terms: abortion facility; accrediting or membership organization; and commissioner.

Subd. 2, paragraph (a) requires abortion facilities to be licensed by the commissioner of health by July 1, 2022.

Paragraph (b) specifies that the license is not transferrable or assignable and is subject to suspension or revocation for failure to comply with this section.

Paragraph (c) requires each facility to be licensed if a single entity maintains more than one facility on different premises.

Paragraph (d) requires an abortion facility to be accredited or be a member of an accrediting or membership organization or obtain accreditation or membership within six months of the date of the licensure application. If a facility loses accreditation or membership, the facility must notify the commissioner.

Paragraph (e) states that the commissioner, attorney general, a county attorney, or a woman upon whom an abortion was performed or attempted to be performed at an unlicensed facility may seek an injunction in district court against the unlicensed facility.

Paragraph (f) states that sanctions provided in this section do not restrict other available sanctions.

Subd. 3 authorizes the commissioner to issue a temporary license for facilities that plan to begin operations on or after July 1, 2022. the temporary license is valid for a period of six months.

Subd. 4 specifies the information that must be included in the application for licensure.

Subd. 5 requires the commissioner of health to inspect the facility before the initial licensure and at least once every two years. The commissioner is not required to provide notice prior to an inspection.

Subd. 6 specifies the grounds under which the commissioner may refuse to grant or renew or suspend or revoke a license. The licensee is entitled to a notice and hearing and a new license may be issued after an inspection of the facility has been conducted.

Subd. 7 specifies the amount of the licensure fees.

Subd. 8 requires a license to be renewed every two years. A temporary license may be renewed for one additional six-month period.

Subd. 9 requires that the health records maintained by the facility comply with the Minnesota Health Records Act.

Subd. 10 provides for severability if any provision is found to be unconstitutional. Section 2 appropriates funds from the state government special revenue fund to the commissioner of health for licensure activities.

Section 28 (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 29 (145.902) includes in the definition a "safe place" for purposes of safe place for newborns the hospital where the newborn was born. Requires a hospital that receives a safe place newborn, and it is known that the child's record of birth was registered because the newborn was born in that hospital to report the birth to the Office of Vital Records within five days after receiving the newborn and to identify the child's birth record. The state registrar is then required to register the information in accordance with the rules regarding infants of unknown parentage.

Section 30 (145A.145) codifies the current nurse family partnership programs.

Sections 31-34 make modifications to the asbestos abatement program.

Section 31 (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 32 (326.75, subd. 1) increases the annual license fee for a license to perform asbestos relate work from $100 to $105.

Section 33 (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 34 (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.

ARTICLE 3

HEALTH OCCUPATION AND HEALTH RELATED LICENSING BOARDS

Sections 1-12 make various policy modifications to the training, education, registration and certification of personnel regulated by the Emergency Medical Services Regulatory Board.

Section 1 (144E.001, subd. 16) defines "primary instructor" for the purposes of emergency medical care certification and registration courses.

Section 2 (144E.27) makes technical and conforming changes, except subdivision 3 requires an emergency medical responder to successfully complete a course in cardiopulmonary resuscitation prior to the Board renewing an EMR's registration. It also specifies that a United States Department of Transportation emergency medical responder course is sufficient meets the education requirements for registration by the Board as an EMR.

Section 3 (144E.28, subd. 1) specifies that an individual must obtain an appropriate National Registry of Emergency Medical Technicians certification to be eligible for certification by the Board as an EMT, AEMT, or paramedic.

Section 4 (144E.28, subd. 3) makes technical changes.

Section 5 (144E.28, subd. 7) modifies the requirements for an applicant seeking renewal of EMT or AEMT Board certification. An applicant must either maintain National Registry of Emergency Medical Technicians certification if the applicant was initially certified after April 1, 2021 or maintain Minnesota certification by completing the required hours of continuing education as determined in the National Continued Competency Program of the National Registry of Emergency Medical Technicians if the applicant was Board certified prior to April 1, 2021.

Section 6 (144E.28, subd. 8) reduces from four to two the number of years that may elapse for an expired Board certification as an EMT or AEMT to be reinstated.

Section 7 (144E.282) modifies the qualifications for a primary instructor.

Section 8 (144E.285, subd. 1) subjects education programs for EMR to the same general standards as education programs for EMT, AEMT and paramedic, and makes technical and conforming changes.

Section 9 (144E.285, subd. 1a) specifies the minimum requirements for an EMR education program.

Section 10 (144E.285, subd. 1b) specifies the minimum requirements for an EMT education program.

Section 11 (144E.285, subd. 2) makes conforming changes to the statute governing the minimum requirements for an AEMT and paramedic education program and eliminates an exception for a paramedic education program operated by an advanced life support ambulance service.

Section 12 (144E.285, subd. 4) modifies the requirements for Board reapproval of education programs by requiring a site visit and requiring education programs for EMTs and paramedics to maintain accreditation with the CAAHEP.

Sections 13-17 make changes to the doula registry by permitting the commissioner of health to designate doula certification organizations.

Section 13 (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 14 (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 15 (148.996, subd .4) clarifies that registry renewal is dependent on the doula meeting the registry requirements.

Section 16 (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 17 (148.9965) establishes the designation process for the commissioner when designating doula certification organizations.

Sections 18-22 create a separate license for medical gas manufacturers, medical gas wholesalers, and medical gas dispensers.

Section 18 (151.01, subd. 29) modifies the definition for medical gas.

Section 19 (151.01, subd. 29a) adds a definition for medical gas manufacturer.

Section 20 (151.01, subd. 29b) adds a definition for medical gas wholesaler.

Section 21 (151.01, subd. 29c) adds a definition for medical gas dispenser.

Section 22 (151.191) creates a separate license and license requirements for medical gas manufacturers, medical gas wholesalers, and medical gas dispensers.

Section 23 [Revisor instruction] requires the revisor of statutes to relocate to a more appropriate place statutory language related to community EMTs.

Section 24 [Repealer] repeals requirements for EMR education programs because EMR education program requirements are incorporated into the requirements for other emergency medical care education programs.

ARTICLE 4

PRESCRIPTION DRUGS AND OPIATES

Section 1 (16A.151, subd. 2) clarifies that any money received by the state from a settlement agreement involving a consulting firm working for an opiate manufacturer or wholesaler 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 (62J.85) creates incentives to drug manufacturers to use the importation pathway created under federal regulations for certain prescription drug products that meet the federal importation guidelines.

Section 3 (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 4-6 decrease the licensure fees for medical gas manufacturers and wholesalers from $5260 to $260.

> **Section 4 (151.065, subd. 1)** decreases the applications fee for medical gas manufacturers and wholesalers.
>
> **Section 5 (151.065, subd. 3)** decreases the renewal licensure fees for medic al gas manufacturers and wholesalers.
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> **Section 6 (151.065, subd. 7)** makes a corresponding change to conform to the change in fees.

Section 7 (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.

Sections 8-11 make modifications to the drug repository program.

> **Section 8 (151.555, subd. 1)** includes over the counter drugs to the drug repository program.
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> **Section 9 (151.555, subd. 7)** removes the requirement that donated drugs be immediately inspected upon receipt and kept separately until inspected and reduces the numbers of years that the repository must keep a record of the donated drugs destroyed from five years to two years.
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> **Section 10 (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.
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> **Section 11 (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.

Section 12 (256.043, subd.3) extends the appropriations from the opiate epidemic response fund for the results first evaluations and for the ECHO projects.

Section 13 [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 5

HEALTH COVERAGE AND TRANSPARENCY

Sections 1-2 and 5 require health care providers to establish a Medicare percent that the provider will accept as payment in full.

> **Section 1 (62J.701)** specifies that the Medicare percent requirement does not apply to the prepaid medical assistance program or MinnesotaCare.
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> **Section 2 (62J.72, subd. 3)** requires a health care provider to include in a bill to a patient the Medicare allowable fee for service payment rate if the service is covered by Medicare and the provider's Medicare percent.
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> **Section 5 [62J.825] subdivision 1** defines Medicare percent as the percentage of the Medicare allowable payment rate that a provider accepts as payment in full for services covered by Medicare and for services not covered by Medicare, a dollar amount the provider is willing to accept as payment in full.
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>> **Subd. 2** requires a health care provider to establish a Medicare percent that the provider will accept as payment in full for services provided by that provider for services that are not covered by a patient's health plan or for patients who are not insured. Requires the provider to provide notice to patients and the public of the provider's Medicare percent.

Sections 3-4 (82J.81, subd. 1, 1a) modify the time in which a provider or health plan company must provide to a consumer a good faith estimate of the amount the provider has agreed to accept for payment by the consumer's the health plan company or the average allowable reimbursement the provider accepts as payment from third party payers for services specified by the consumer.

Section 6 [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.

Section 7 [62Q.524] requires a HPC to include in the summary of benefits and coverage a statement indicating whether funds from a patient assistance program will be applied by the HPC to an enrollee's deductible requirement.

ARTICLE 6

DHS LICENSING AND BACKGROUND STUDIES

Sections 1, 3, 22-24, and 33-35 modify provisions relating to initiation of background studies by 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 3 (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 22 [245C.03, subdivision 14] 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.

Section 23 [245C.03, 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.

Section 24 [245C.03, 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.

Section 33 [245C.10, subdivision 18] 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 34 [245C.10, subdivision 19] directs the commissioner to set a fee of up to $51 for background studies initiated by the Professional Educators Licensing Standards Board.

Section 35 [245C.10, subdivision 20] directs the commissioner to set a fee of up to $51 for background studies initiated by the Board of School Administrators.

Section 2 [119B.27] directs the governor to appoint two ombudspersons for child care providers to serve a two-year term and carry out duties, including advocating on behalf of a child care provider to address all areas of concern to providing 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 complains, 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 providing child care, 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 have been previously employed by the department of human services or as a county licensor. 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 and 30 modify background study requirements for individuals with licenses from a health-related licensing board.

> **Section 4 (144.057, subdivision 1)** states that the commissioner of human services is not required to conduct a background study on any individual who is working in a facility licensed by the commissioner of health and who has a valid license issued by a health-related licensing board and has completed a background check as part of receiving the license.
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> **Section 30 (245C.08, subdivision 1)** makes conforming changes.

Sections 5-7 [245A.02, subdivisions 23-25] clarify the statutory definitions of "family or group family child care program," "special family child care program," and "nonresidential family child care program."

Section 8 [245A.03, subdivision 10] increases from 14 to 16 the maximum licensed capacity of group family child care providers. Paragraphs (b) to (d) supersede and modifu the child to adult caregiver ratios and age distribution restrictions for group family child care providers provisions in Minnesota Rules. Instead of setting an explicit limit on the number of school-age children, under school-age children, toddlers, and infants, the revised ratios define the total capacity for a provider, the total number of children under school age (under five years old), and the total number of infants. Accordingly, a provider may serve any combination of children under five years old up to the permitted maximum, provided that they do not exceed the permitted number of infants. Conforming changes reflecting these ratio changes appear in sections 12 to 14.

Sections 9 and 43-44 modify provisions governing the opening of a new chemical dependency treatment program.

> **Sections 9 and 43 (245A.043, subdivision 3, paragraph (b); 245F.04, subdivision 2),** delete from the provisions relating to transferring ownership of an existing treatment program or applying for a new treatment program, statutory references to the administrative rules (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.
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> **Section 44 (245G.03, subdivision 2, paragraph (b))** requires 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 to the commissioner of human services, for consideration when determining whether to grant a license to the proposed program.

Sections 10-11, 18, 26-28, 31, 36-41, 47, and 53 modify provisions relating to licensed family foster setting background study requirements. All sections are effective July 1, 2022, except that section 31 is effective July 1, 2021, section 47 is effective July 1, 2023, and sections 26 and 27 would be effective by operation of law on July 1, 2021, since they do not specify an effective date.

> **Section 10 (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 11 (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 18 [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 26-27 (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 28 (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 31 (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 36 (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 37 [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 38 (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 39-40 (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 41 [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 47 (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 53 (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.

Sections 12-13 amend the effect of an administrative law judge decision relating to the license of a family or group family day care provider.

Section 12 (245A.08, subdivision 4) requires an administrative law judge to issue a final binding decision, rather than a recommendation to the commissioner of human services, following a hearing relating to the license of a family or group family day care provider. The decision may be appealed for judicial review in a district court.

Section 13 (245A.08, subdivision 5) makes a technical conforming change to the requirements for the commissioner to provide notice of a final order on a matter relating to licensed family or group family day care, because the commissioner would no longer issue such final orders.

Section 14 (section 245A.14, subdivision 1) increases from 14 to 16 the number of children that may be services by a group family day care in single-family residential home for the purposes of the purposes of zoning and other land use regulations.

Sections 15-16 modify the statutes governing licensure of special family child care homes to distinguish between family child care providers that operate in a residence and family child care providers that operate in a non-residential setting.

Section 15 (245A.14, subdivision 4) modifies the existing statute governing licensure of special family child care homes to have "special family child care" refer only to programs operated outside of the license holder's home, in a dwelling other than the license holder's own residence. The statute retains the provision authorizing the commissioner to grant a variance for a primary provider of care to be licensed according to the provisions that apply to nonprofit agencies or programs operated in a commercial space.

Section 16 [245A.141] establishes a new section of law that reproduces the provider types removed from 245A.14, subdivision 4, as "nonresidential family child care programs." The text is copied from the existing language in 245A.14, subdivision 4. The new title is meant to distinguish a "special family child care" program from these "nonresidential family child care" programs. The text is identical to the existing language in 245A.14, subdivision 4, that is deleted according to section 15, except that the commissioner may approve up to 4

licenses at a single location pursuant to 245A.141, subdivision 2. The current statute permits approval of two or more licenses.

Section 17 (245A.16, subdivision 1) makes a technical conforming change to update a cross-reference and incorporate the increased maximum family child care license capacity of 16 children. Paragraph (j) requires county agencies to forward all communications from DHS regarding family child care to all family child care providers in the county, with or without labeled comments by the county agency.

Section 19 (245A.50, subdivision 1a) adds a definition to the family child care training statute for an "adult assistant," meaning an adult who assists in caring for children exclusively under the direct supervision of the license holder, who is prohibited from serving as a second adult caregiver, and who has the same training requirements as helpers.

Section 20 (245A.50, subdivision 7) authorizes child care training instructors who are also family child care providers to count up to two hours of training instruction toward the 16-hour annual training requirement for family child care providers.

Sections 21, 26, 29, and 42 require the commissioner of human services to contract with up to three vendors to collect fingerprints for background studies.

> **Section 21 (245C.02, subdivision 4a)** modifies the definition of an authorized fingerprint collection vendor to mean one of up to three qualified organizations under contract with the commissioner of human services to provide to collect fingerprints for background studies.
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> **Section 26 (245C.05, subdivision 2c, paragraph (c), clause (3))** makes conforming changes.
>
> **Section 29 (245C.05, subdivision 5)** makes conforming changes.
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> **Section 42 (245C.32, subdivision 1)** makes corresponding changes.

Sections 25, 32, and 46 modify background study provisions relating to early intensive developmental and behavioral intervention (EIDBI) providers.

> **Section 25 [245C.03, subdivision 17]** requires the commissioner of human services to conduct 245C background studies when a study is initiated by an EIDBI provider.
>
> **Section 32 [245C.10, subdivision 17]** requires the commissioner of human services to collect a fee not to exceed $20 for each 245C background study initiated by an EIDBI provider.
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> **Section 46 [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 45 [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 48 (466.03, subdivision 6d) corrects a cross-reference and adds a paragraph establishing that for purposes of municipal tort liability, the act of granting a licensing variance does not constitute "actual knowledge" of a failure to meet licensing standards that resulted in a dangerous condition that foreseeably threatened a plaintiff.

Sections 49-50 (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 180 days (as opposed to 60 days) following the end of the peacetime public health emergency related to COVID-19.

Section 51 (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, as well as any other aspect of family child care training as requested by a committee member, a member of the public, or the commissioner or commissioner's designee.

The advisory committee's membership consists of eight family child care providers, with four from greater Minnesota and four from the metropolitan area, and up to seven individuals who have expertise in child development, instructional design, or training delivery. The speaker of the house and the majority leader of the senate each appoint two of each type of child care provider, as well as up to two of the seven individuals with expertise. Each of the remaining three members with expertise will be appointed by the Minnesota Association of Child Care Professionals, the Minnesota Child Care Provider Network, and the Greater Minnesota Partnership. 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 to the relevant legislative committees on any recommendations issued by the advisory committee.

Section 52 (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 11, 2022, and a final report by December 16, 2022.

Section 54 (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 55 (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 work groups developed to create plans to implement Family Child Care Task Force recommendations.

Section 56 (Direction to the Commissioner of Human Services; 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 57 (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 58 (Direction to the Commissioner of Human Services; Family Child Care License Applicant Orientation Training) directs the commissioner of human services to develop and implement orientation training by July 1, 2022, for family child care license applicants to receive the same fundamental information about the statutes and rules governing family child care licensure.

Section 59 (Direction to commissioner of human services; on-site background study fingerprinting) requires the commissioner of human services to contract with a qualified vendor to conduct on site fingerprinting beginning August 1, 2021 and extending until the date of expiration for the executive order (VC23) modifying certain background study requirements at locations of employers with 50 or more staff with outstanding background studies, including studies that have been delayed due to the COVID pandemic.

Sections 60-63 direct the commissioner of human services to allocate funds from the federal child care and development block grant.

> **Section 60** allocates $1,170,000 in fiscal year 2022 for the family child care regulation modernization project contract.
>
> **Section 61** allocates $4,000,000 in fiscal years 2023 and 2024 for the family child care one-stop assistance network proposal to be recommended by the commissioner in the 2022 legislative session.
>
> **Section 62** allocates $1,000,000 in fiscal years 2023 and 2024 for the family child care license applicant orientation training to be implemented by the commissioner by July 1, 2022.

Section 63 allocates $50,000 in fiscal year 2022 for the modifications to expand the family child care provider “Frequently Asked Questions” website.

Section 64 (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 7

MINNESOTA HEALTH AND EDUCATION FACILITIES AUTHORITY

Article 7 expands the authority and scope of the Minnesota Higher Education Facilities Authority (MHEFA) by allowing the MHEFA to provide financing to health care organizations and changes the name of the authority to the Minnesota *Health and* Education Facilities Authority. The MHEFA is a small state agency that was established in 1971. Under current law, the MHEFA provides an alternative method for higher education institutions in the state to finance or refinance capital construction projects by issuing tax exempt revenue bonds. MHEFA does not receive any general fund dollars or any legislative appropriations, and the proposed amendments in this article do not change the funding for MHEFA.

Sections 1-2 (3.732, subdivision 1; 10A.01, subdivision 35) are conforming changes modifying the agency name to the Minnesota Health and Education Facilities Authority.

Section 3 (136A.25) changes the agency name to the Minnesota *Health* and Education Facilities (the MHEFA acronym is retained).

Section 4 (136A.26, subd. 1) expands the membership of the board to include one additional member appointed by the Governor who is a trustee, director, officer, or employee of a health care organization.

Subdivision 1b is a new subdivision adding an advisory, nonvoting member to the board who is the chief executive officer of a Minnesota nonprofit health care association.

Subdivision 2 provides that the membership terms, compensation, removal, and vacancy related to the member under subdivision 1b is governed by Minnesota Statutes, section 15.0575.

Section 5 (136A.27) amends the policy statement for the organization to include that health care organizations within the state be provided with appropriate and additional means to establish, acquire, construct, improve, and expand health care facilities in furtherance of their purpose.

Section 6 (136A.28) defines the following new terms and modifies existing terms: “affiliate,” “project,” “health care organization,” “education facility,” “health care facility,” and “participating institution.”

Section 7 (136A.29, subd. 1) is a conforming change; incorporates “health care organization”.

Section 8 (136A.29, subd. 3) specifies that employees of the authority shall participate in the state managerial plan.

Section 9 (136A.29, subd. 6) requires a project involving a health care facility to comply with all applicable requirements in state law related to construction or modifications of facilities.

Sections 10-11 (136A.29, subd. 9; 136A.29, subd. 10) section 10 increases the bond limit from $1,300,000,000 to $4,000,000,000 and section 11 modifies the purposes of issuing bonds to include for health care facility projects.

Sections 12-15 (136A.29, subd. 14, 19-21) are technical conforming modifications.

Section 16 (136A.29, subd. 22) clarifies that when the MHEFA charges and apportions among institutions its administrative costs and expenses incurred, it may do so in the manner as the MHEFA in its judgment deems appropriate.

Section 17 (136A.29, subd. 24) authorizes MHEFA to determine whether an entity is an affiliate, as defined in section 4, subdivision 1a.

Sections 18-19 (136A.32, subd. 4; 136A.33) are technical conforming amendments.

Section 20 (136A.34, subd. 3) modifies a provision related to investing bond proceeds by permitting investment is certain mutual funds whose investment portfolio consists solely of direct obligations of the United States of America.

Sections 21 (136A.34, subd. 4) modifies a provision related to investing bond proceeds by eliminating the restriction that all deposits be time deposits.

Section 22 (136A.36) permits the authority to establish rates, rents, fees and other changes for projects involving a health care facility that differ from the rates, rents, fees and other changes the authority has established for projects involving educational facilities.

Sections 23-24 (136A.38; 136A.41) are technical modifications.

Section 25 (136A.42) requires the MHEFA to submit to the Minnesota Historical Society and the Legislative Reference Library an annual report on the authority's activities in the previous year, including all financial activities.

Sections 26-27 (136F.67, subd. 1; **354B.20, subd. 7)** are conforming changes modifying the agency name to the Minnesota Health and Education Facilities Authority.

Section 28 requires the Revisor of Statutes to recode the provisions of the bill in new chapter 16F.

Section 29 repeals a law allowing the MHEFA and the OHE to enter into a mutual agreement so MHEFA staff may also be members of the OHE staff.

ARTICLE 8

TELEHEALTH

Article 8 modifies coverage for services and consultations delivered through telehealth under private health plan coverage and public health care coverage, modifies telehealth coverage by including the delivery of health care services and consultations when using interactive audio and visual or audio only communication when the patient and health care provider are in different locations, and makes conforming changes in a number of statutes consistent with these modifications.

Section 1 (62A.673) rewrites the current telehealth coverage statute by changing the terminology form 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 transfer; 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 or audio only 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 patient if the communication is a scheduled appointment and the standard of care for that particular service can be met through the use of audio only communication, and specifies that telehealth does not include communication between health care providers or a healthcare provider and patient that consists solely of an email or fax.

- 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 particular 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 particular service.

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 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.

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 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) permits a psychiatric provider as a member of an assertive community treatment (ACT) team to use telehealth with necessary to ensure the continuation of psychiatric and medication services availability for clients and to maintain requirements for psychiatric care staffing levels.

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 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 transfer.

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 a subdivision that outlines the requirements for proved targeted case management services by 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 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. 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.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 18 (256B.094, subd. 6) 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 19 (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 20 (256B.0947, subd. 6) specifies intensive nonresidential rehabilitative mental health services provided by a psychiatric provide may be provided through telehealth when necessary to prevent disruption in client services or to maintain the required psychiatric staffing levels.

Section 21 (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 22 [Extension of COVID human services program modification] extends until June 30, 2023, the commissioner of human services modifications and waivers that involve expanding access to telemedicine services; allowing telemedicine alternatives to school linked mental health services; allowing the use of phone or video for targeted case management visits; extending telemedicine in health care, mental health and substance use disorder settings; and permitting comprehensive assessments to be completed by telephone or video communication and allowing the counselor, recovery peer or treatment coordinator to provide treatment services from their home by telephone or video communications to a client in their home.

Section 23 [Expanding telehealth delivery options] requires the commissioner of human services to study the viability of the use of audio only communication as a permitted option for the delivery of services delivered through telehealth and report any recommendations to the legislature by December 15, 2022.

Section 24 [Study of telehealth] requires the commissioner of health in consultation with the commissioner of human services, to study the impact of telehealth payment methodologies and delivery expansion on the coverage and provision of services delivered through telehealth under public health care programs and under private health insurance and submit the report findings to the legislature by February 15, 2024.

Section 25 [Task force on public-private telepresence strategy] establishes a task force to:

(1) explore opportunities for improving health care service delivery through the use of a common interoperable person-centered telepresence platform;

(2) review and coordinate state and local innovation initiatives and investments designed to leverage telepresence connectivity and collaborations;

(3) determine standards for a single interoperable telepresence platform;

(4) determine statewide capabilities for a single interoperable telepresence platform;

(5) identify barriers to providing telepresence technology;

(6) identify and make recommendations for governance that assures person-centered responsiveness;

(7) identify how the business model can be innovated to provide incentive for ongoing innovation;

(8) identify criteria for suggested deliverables;

(9) identify sustainable financial support for a single telepresence platform; and

(10) identify the benefits to partners in the private sector, state, political subdivisions, tribal governments, and constituents in using a common person-centered telepresence platform for delivering behavioral services.

Requires the task force to provide a report to the legislature by January 15, 2022.

Section 26 (Revisor Instruction) instructs the revisor to substitute the term "telemedicine" with "telehealth" and to correct necessary cross references.

Section 27 (Repealer) repeals the current telemedicine statutes that are being replaced by the new telehealth section in 62A.673, and repeals section 256B.0924, subd. 4a (targeted case management through interactive video).

ARTICLE 9

ECONOMIC SUPPORTS

Sections 1 and 30-33 implement methods to count and verity 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 30-33 (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 2-3 (252.27, subdivision 2a; 256B.14, subdivision 2) exempts parents of children utilizing the TEFRA option to access home and community-based waiver services from the rules governing parental contribution fees for those services.

Sections 4-8 [256D.051, subdivisions 20-24] align state SNAP employment and training program requirements with federal requirements.

Section 9 (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 10 (256E.34, subdivision 1) adds Tribal nations to the entities authorized to receive food shelf funding.

Sections 11-12, 15, and 17 modify MFIP and DWP provisions to permit applicants to submit application forms by phone or online.

> **Section 11 (256J.08, subdivision 21)** permits applicants for the Minnesota Family Investment Program (MFIP) to submit initial applications online or via telephone.
>
> **Section 12 (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 15 (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 17 (256J.95, subdivision 5) authorize 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.

Section 13 (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 14 (256J.35, paragraph (a)) increases the MFIP housing assistance benefit from $110 to $150 per month.

Section 16 (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.

> **Sections 18-29, 35, 37, and 39** modify provisions relating to the Northstar Care for Children program.
>
> **Sections 18 and 20 (256N.02, subdivision 16; 256N.22, subdivision 1)** clarify 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.

Section 19 (256N.02, subdivision 17) clarifies that a child identified as an "at-risk child (Level A)" only applies under adoption assistance.

Section 21 (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 22 (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 23-28 (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 29 [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 kindship agreement, or while seeking adoption of a child who qualifies as having special needs under the Northstar program.

Sections 35, 37, and 39 (259.22, subdivision 4; 259.35, subdivision 1; 259.73) update cross-references.

Section 34 (256P.06, subdivision 3) exempts unemployment insurance income obtained by young adults enrolled as students from being included as income for cash assistance eligibility.

Sections 36, 38, and 40-58 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 36 (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 38 (259.53, subdivision 4) makes technical clarifying changes regarding the timing of granting a petition for adoption.

Section 40 (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 41 (259.75, subdivision 6) revises the timing and circumstances under which the commissioner must review the state adoption exchange status of certain children.

Section 42 (259.75, subdivision 9) permits the commissioner to contract out the administration of the state adoption exchange.

Section 43 (259.83, subdivision 1a) updates cross-references to incorporate a reference to section 260C.212, subdivision 15.

Sections 44, 46-47 (259A.75, subdivisions 1, 3-4) make conforming changes to add tribal agencies to provisions regarding reimbursement of adoption placement services costs.

Section 45 (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 or adoption services.

Section 48 (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 49 (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 50 (260C.212, subdivision 2, paragraph (a)) clarifies that a related individual includes the legal parent, guardian, or custodian of a child's siblings.

Section 51 [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 52 (260C.219, subdivision 5) makes clarifying changes and updates a cross-reference.

Section 53 (260C.503, subdivision 2, paragraph (d), clause (1)) corrects a cross-reference.

Section 54 (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 55 (260C.605, subdivision 1, paragraph (d), clause (4)) corrects a cross-reference.

Section 56 (260C.607, subdivision 6, paragraph (f), clause (2)) corrects a cross-reference.

Section 57 (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 58 (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.

Section 59 (Grant to Minnesota Association for Volunteer Administration) requires the commissioner of human services to award a onetime grant to the Minnesota Association for Volunteer Administration to administer subgrants to under-resourced nonprofits in greater Minnesota to expand access to human services through increased volunteer activities. The

association is required to report to the legislature by December 15, 2023, on the outcomes of the subgrants and make recommendations for improving volunteer efforts statewide.

Section 60 allocates $73,000,00 in fiscal years 2022 and 2023 from funds received under the federal American Rescue plan act for the child care and development block grant for transfer to the commissioner of education for the early learning scholarship program. The commissioners must consult to ensure transferred funds are distributed to support priority groups in compliance with the federal regulations.

Sections 61-62 direct the commissioner of human services to allocate funds received under the federal American Rescue Plan Act for pandemic emergency assistance.

> **Section 61** allocates $10,000,000 in fiscal year 2022 for emergency assistance grants to families with children for rent or mortgage payments and arrears, utility bills and arrears, food, clothing, public transportation or vehicle repairs, and school-related equipment needs.
>
> **Section 62** allocates $4,327,000 to the MFIP consolidated fund.

Section 63 (Repealer) repeals statutes to implement the changes to SNAP employment and training and adoption policy modifications.

ARTICLE 10

CHILD CARE ASSISTANCE

Sections 1 and 4 (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 2 (119B.13, subdivision 1) adjusts the child care assistance program maximum subsidy rate to be calculated based on the 2021 provider rate survey, instead of the 2018 survey.

Section 3 (119B.13, subdivision 6) reduces 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. The new paragraph (g) prohibits the commissioner of human services from withholding a child care provider's CCAP authorization or a CCAP payment where the provider's alleged misconduct is the result of relying upon representations that the providers had been in compliance with program requirements.

Section 5 allocates $14,574,000 in fiscal years 2022, 2023, and 2024 from the federal child care and development block grant for the basic sliding fee child care assistance program.

ARTICLE 11

CHILD PROTECTION

Sections 1-3, 15-17, 19-28, and 35 update existing statutes relating to implementation of the Family First Prevention Act.

Sections 1-2 (245.4876, subdivision 3; 245.4882, subdivision 1) remove existing cross-references to administrative review of placement of a child for residential treatment.

Section 3 (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 15 (260C.007, subdivision 26c) adds a requirement for a county to contact a child's tribe to offer the tribe the option to designated 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 16 (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 17 (260C.157, subdivision 3) makes technical conforming and clarifying changes.

Section 19 (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 20 (260C.212, subdivision 13) makes technical conforming changes to include the federal definition of "commercial sexual exploitation."

Section 21 (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 22 (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 23 (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 24 (260C.706, paragraph (a), clause (1)) corrects a cross-reference.

Section 25 (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 26 (260C.71) clarifies and expands court approval requirements regarding a child's placement in a QRTP.

Section 27 (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 28 (260C.714) corrects a cross-reference.

Section 35 [260E.36, subdivision 1b] 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 4-10 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 4 [245A.02, subdivision 3c] adds a definition for the phrase "at risk of becoming a victim of sex trafficking or commercial sexual exploitation", the criteria for which the commissioner of human services shall establish.

Section 5 [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 6 [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 7 [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 8 [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 9 [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 10 [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 11 [245A.041, subdivision 6] 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 12 [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 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 8 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 9 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 13-14 (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.

Section 18 (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 July 1, 2022.

Sections 29-34 include 260D foster settings in the Family First Prevention Act requirements.

Section 29 (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 30-31 (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 32 (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 33 (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 34 (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 36 (Direction to the Commissioner; Initial Implementation of Court-Appointed Counsel in Child Protection Proceedings) directs the commissioner of human services to collect data from counties regrading use of court-appointed counsel in child protection proceedings, and to report on the data and efforts to assist counties with implementing the court-appointed counsel provisions, by July 1, 2022.

Section 37 (Direction to Commissioner of Human Services; Aftercare 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 38 (Direction to the Commissioner of Human Services; Costs to State, Counties, and Providers for Implementation of the Family First Preservation Services Act) directs the commissioner to contract with a vendor to study the fiscal impacts on the state, on counties, and on providers, of implementing the Family First proposals, and to submit a legislative report on the findings by June 30, 2023.

Section 39 (Direction to the Commissioner of Human Services; Ombudsperson for Families Reorganization Study) directs the commissioner to evaluate options for reorganizing the Office of Ombudsperson for Families into at least two separate options, and to develop a legislative proposal for introduction in the 2022 legislative session that would implement the reorganization.

Section 40 (Repealer) repeals statutes made unnecessary by Family First implementation.

ARTICLE 12

CHILD PROTECTION POLICY

Sections 1-2 modify provisions relating to child support noncooperation procedures.

Section 1 [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 2 [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.

Section 3 (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.

Sections 4-5 modify provisions relating to the parent education program for parties to family law proceedings.

Section 4 (518.157, subdivision 1) requires the district court to ensure that their website includes information on the parent education program.

Section 5 (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 though the use of private mediation.

Sections 6 and 18-23 remove interest charging requirements for child support judgments and specify that interest does not accrue on such judgments.

Section 6 (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 18 (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 19 (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 20 (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 21 (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 22 (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 23 (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 7-16 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 7 (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 8 (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 9 (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 10 (518A.35, subdivision 2) updates the basic support guideline table amounts and makes low-income adjustments. Effective January 1, 2023.

Section 11 (518A.39, subdivision 7) specifies that a decrease in child care support is effective the date the child care expenses terminate.

Section 12 [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 13 (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 14 (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 15 [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 16 (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 17 [518A.80] establishes procedures, standards, and criteria for transferring a postjudgment child support, custody, or parenting time action to a tribal court.

ARTICLE 13

BEHAVIORAL HEALTH

Section 1 (245.4889, subdivision 1) authorizes the commissioner of human services to award grants to fund evidence-informed interventions for youth who are at risk of developing a mood disorder or are experiencing an emerging mood disorder.

Sections 2-4 and 8 modify provisions relating to certified community behavioral health clinics (CCBHCs).

Section 2 (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 3 (245.735, subdivision 5) makes a conforming change to incorporate a reference to state requirements for CCBHCs.

Section 4 [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 8 (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 (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 ad for children.

Section 6 [254B.17] establishes a school-linked substance abuse grant program, for licensed substance use disorder treatment providers or licensed alcohol and drug counselors to identify and treat substance use disorder of students in secondary school settings. Grant recipients must provide data to the commissioner to evaluate the effectiveness of the grant program.

Section 7 (256B.0624, subdivision 7, paragraph (c)) 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.

Sections 9-14 modify provisions relating to the federal substance use disorder medical assistance demonstration project. Sections 13 and 14 become effective only upon federal approval.

Section 9 (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 June 30, 2025 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. The commissioner is also directed to seek the necessary federal authority to allow participating providers who need additional time to comply with increased quality standards to receive the demonstration participation reimbursement rates through at least July 1, 2022.

Section 10 (256B.0759, subdivision 4) permits participating providers to receive an increased payment rate of 30% or 35%, 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, are 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 suspend payments to the provider until the provider achieves compliance.

Section 11 [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 12 [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 13 [256B.0759, subdivision 8] authorizes the commissioner to seek federal approval to extend the demonstration project to accommodate the delayed enrollment date.

Section 14 [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 cause by participation in the demonstration project.

Sections 15-18 modify provisions relating to MA coverage of intensive nonresidential rehabilitative services.

Sections 15-16 (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 17 (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 18 (256B.0947, subdivision 6, paragraph (e)) makes a technical clarifying change to clarify that the treatment team must complete each client's treatment plan.

Section 19 (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 20 (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.

Section 21 (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 22 (Emerging Mood Disorder Grant Program; Authorized Uses of Grant Funds) clarifies that emerging mood disorder grant program funds may be used for intensive treatment and support, provider outreach, training, and guidance, ensuring access to services, and evaluating the efficacy of services provided.

Section 23 (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 24 (Direction to the Commissioner; Substance Use Disorder Treatment Paperwork Reduction) directs the commissioner of human services to consult with stakeholders to develop, asses, 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 25 (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 26 (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 mange the compulsive gambling treatment program.

Section 27 (Direction to the Commissioner of Human Services; SUD Demonstration Project Enrollment Report) requires the commissioner of human services to submit a report to the legislature following each budget forecast, beginning in November 2021, on the number of providers enrolled in the substance use disorder demonstration project, the amount of federal financial participation that corresponds to the enrollment, and the amount of federal financial participation that exceeds what was projected in the November 2021 forecast.

Section 28 (Direction to the Commissioner; SUD Treatment Rate Restructure Contract) directs the commissioner to contract with a qualified vendor to conduct rate modeling and develop frameworks for all substance use disorder treatment rates. The commissioner must issue a request for proposal for the vendor's work by January 1, 2022, and the commissioner must report to the legislature on the results of the vendor's work by January 15, 2023.

Section 29 (Direction to the Commissioner; SUD Technical Assistance Centers) directs the commissioner of human services to establish technical assistance centers by March 1, 2022, that will help providers enroll and meet the standards of the federal substance use disorder demonstration project.

Sections 30-33 direct the commissioner of human services to allocate funds from the federal community mental health services block grant.

> **Section 30** allocates $400,000 annually for children's mental health grants for emerging mood disorder programs.
>
> **Section 31** allocates $1,500,000 annually for children's mental health grants for first episode of psychosis grants, and an additional $200,000 annually to the four existing first episode of psychosis programs that receive grant funding.

Section 32 allocates $2,350,000 annually for adult mental health initiative grants.

Section 33 allocates $2,500,000 annually for school-linked mental health grants.

Sections 34-37 direct the commissioner of human services to allocate funds from the federal substance abuse prevention and treatment block grant.

Section 34 allocates $1,500,000 annually for school-linked substance abuse grants.

Section 35 allocates $250,000 in fiscal year 2022 for a grant to Anoka County for the substance use disorder treatment pathfinder companion pilot project.

Section 36 allocates $3,500,000 annually for grants to be awarded according to the recommendations of the Opioid Epidemic Response Advisory Council.

Section 37 allocates $2,000,000 annually for grants to community recovery organizations to provide community-based peer recovery support services that are not otherwise eligible for reimbursement.

Section 38 (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 39 (Repealer) repeals sections of statute that are out of date, relating to the federal substance use disorder demonstration project.

ARTICLE 14

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 $10 million dollar.

Section 4 (245A.03, subdivision 7) 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 5 (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 6 [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 7 [256.4772] 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 8 (256B.0653, subdivision 8) provides an annual inflation adjustment to the medical assistance service rates for home health agency services.

Section 9 (256B.0654, subdivision 5) provides an annual inflation adjustment to the medical assistance service rates for home care nursing services.

Section 10 (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 11 (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.

Section 12 (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 13 (256B.0911, subdivision 6) makes technical and clarifying changes to the existing statutory language governing payments to lead agencies for long-term care consultation services and strikes obsolete language from a payment methodology that was superseded by subsequent legislation.

Section 14 (256B.0911, subdivision 6b, paragraph (a)) freezes at fiscal year 2019 levels the appropriation for reimbursement to lead agencies for long-term care consultation services.

Paragraph (b) requires counties and tribes to collect data sufficient for the commissioner to develop and propose a capitated reimbursement method for long-term care consultation services to beginning in fiscal year 2026.

Section 15 (256B.092, subdivision 1b, paragraph (a), clause (7)) requires a coordinated service and support plan for an individual on a disability waiver to clearly indicate the monetary resources available to meet the assessed needs and preferences of the individual.

Section 16 to 19 (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 20 (256B.19, clause (5)) establishes a 10 percent county share for the cost of services provided to an individual 18 or older but younger than 27 residing in an ICF/DD of any size for more than 90 days. Under current law, a 10 percent county share only applies to services provided in an ICF/DD with 7 or more beds.

> **Clause (6)** establishes a 10 percent county share for the cost of the following services provided to an individual 18 or older but younger than 27: community residential services; corporate foster care services; and customized living services or 24-hour customized living services.

Section 21 (256B.49, subdivision 23) modifies the requirements a leased setting must meet to qualify as a community-living setting for the purposes of the disability waivers by permitting an indefinite number of two-year extensions of cosigned lease agreements.

Section 22 (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.

Sections 23 to 33 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 77** repeals the policy language enacted in 2020.

> **Section 23 (256B.4905, subdivision 1a)** defines “informed choice” and “HCBS” for the purposes of Minnesota Statutes, section 256B.4905.
>
> **Section 24 (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.
>
> **Section 25 (256B.4905, subdivision 3a)** requires the commissioner of human services and lead agencies to implement the policy of the state regarding informed choices and an informed decision-making process and specifies required features of an informed decision-making process.
>
> **Section 26 (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)
>
> **Section 27 (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)

Section 28 (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)

Section 29 (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).

Section 30 (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).

Section 31 (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).

Section 32 (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.

Section 33 (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 34 (256B.4914, subdivision 2, paragraph (p), clause (3), item (ii)) modifies the definition of a unit of service for the purposes of individualized home supports with training to include the option of a daily unit of service.

Section 35 (256B.4914, subdivision 5, paragraph (a), clause (14)) modifies the base wage for employment exploration services staff to equal the existing base wage for employment development services staff.

Paragraph (e) establishes component values for remotely delivered day support services and prevocational services at levels equal to the values for those services when delivered in person.

Paragraph (h) establishes component values for remotely delivered unit-based services with programming at levels equal to the values for those services when delivered in person.

Paragraph (j) establishes component values for remotely delivered unit-based services without programming at levels equal to the values for those services when delivered in person.

Paragraph (n) applies existing inflation adjustments for services delivered in person to services delivered remotely.

Paragraphs (o) and (p)contain conforming changes to cross-references.

Section 36 (256B.4914, subdivision 6, paragraph d) requires the commissioner to modify the customized living tool for recipients on the BI or CADI waiver to: (1) incorporate the customized living rate floor under section 256S.205; (2) prevent more than 24-hours of authorized services in a

day; and (3) establish acuity-based input limits for service rate calculations. Also, strikes obsolete language and incorporates duplicative language from paragraph (g).

Section 37 (256B.4914, subdivision 7) applies the new component values for the purposes of determining the rates for remotely delivered day support services and prevocational services to ensure that the rates are the same as for those services when delivered in person.

Section 38 (256B.4914, subdivision 8) applies the new component values for the purposes of determining the rates for remotely delivered unit-based services with programming to ensure that the rates are the same as for those services when delivered in person.

> **Clause (14)** increases from two to three the number of waiver participants who may share individualized home support with training services.

Section 39 (256B.4914, subdivision 9) applies the new component values for the purposes of determining the rates for remotely delivered unit-based services without programming to ensure that the rates are the same as for those services when delivered in person.

Section 40 (256B.5012, subdivision 18) effective for fiscal year 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 41 (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 42 (256B.5013, subdivision 6) makes a conforming change to the duties of the commissioner of human services.

Section 43 (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 44 (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.

Section 45 (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 46 (256B.85, subdivision 27) 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 requires service providers to submit requested cost data at least once every three years.

Section 47 (256B.85, subdivision 28) 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.

Section 48 (256I.04, subdivision 3) creates exceptions to the moratorium on the development of new housing support beds eligible for a supplemental services rate for a provider in Olmsted County and a provider in Blue Earth County.

Section 49 (256I.05, subdivision 1a) provides tribes the option to access the cost-neutral housing support lump-sum allocations currently available only to counties.

Section 50 (256I.05, subdivision 1c) makes technical and conforming changes, and permits an agency to increase by $100 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 51 (256I.05, subdivision 1q) establishes a housing support supplemental services rate for a provider in Olmsted County equal to the existing statutory maximums.

Section 52 (256I.05, subdivision 1s) establishes a housing support supplemental services rate for a provider in Douglas County equal to the existing statutory maximums.

Section 53 (256I.05, subdivision 1t) establishes a housing support supplemental services rate exceeding the statutory maximum for a provider in Winona County.

Section 54 (256I.05, subdivision 1u) establishes a housing support supplemental services rate for a provider in Blue Earth County equal to the existing statutory maximums.

Section 55 (256I.05, subdivision 1v) establishes a housing support supplemental services rate exceeding the statutory maximum for a provider in Steele County.

Section 56 (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 57 (256I.05, subdivision 11) provides tribes the option to access the cost-neutral housing support lump-sum allocations currently available only to counties.

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

Section 59 (256S.203) makes conforming changes to the statutes governing capitation payments and managed care payments for elderly waiver payments.

Section 60 (256S.205) establishes a rate floor of $119 per resident per day for certain facilities with an elderly waiver census of 80 percent or more and providing 24-hour customized living services.

Section 61 (Laws 2019, First Special Session chapter 9, article 5, section 86, subdivision 1, as amended by Laws 2020, First Special Session chapter 2, article 3, section 2, subdivision 1) amends the Disability Waiver Reconfiguration authorizing language to include in the intent of the project that a reconfigured waiver program must assess any racial or geographical disparities and institutional bias and take steps to address them.

Section 62 (Parenting with a disability; Pilot project) requires the commissioner to establish up to three two-year competitive grants to personal care service provider agencies to develop and deliver a grant funded supportive parenting service to assist with parenting tasks parents who have disabilities and are receiving PCA services. Grant funds may also by used by grantees to purchase adaptive parenting equipment at the request of families receiving supportive parenting services.

Section 63 (Direction to the commissioner; Study of supportive parenting services) requires the commissioner to study the parenting with a disability pilot project funded through a state-funded grant for supportive parenting services and develop a proposal and legislative language to add supportive parenting services as a covered medical assistance service.

Section 64 (Direction to the commissioner of human services; Plan for addressing effects on community of certain state-operated services) directs the commissioner to develop a plan to address MSOCS programs that are the location of repeated incidents that are disruptive to the communities in which the program is located.

Section 65 (Direction to the commissioner; Initial pace implementation funding) directs the commissioner to develop a proposal for a funding mechanism for the PACE program.

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 (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 68 (Direction to the commissioner; Long-term care consultation service rates) requires the commissioner to develop a proposal to reimburse lead agencies on a capitated basis for long-term care consultation services.

Section 69 (Housing support supplemental service rate reduction delay) delays by 3 months the rate reduction for housing stabilization services for providers who have made a good faith effort to become enrolled medical assistance providers.

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 (Directions to the commissioner of human services; Waiver growth limits) directs the commissioner to limit growth in the DD and CADI waiver to the equivalent of zero allocations per year, while providing for the return of individuals to the waivers after being off the waiver for no more than 90 and allowing exceptions to waiver growth for individuals exiting certain institutional settings.

Section 72 (Retainer payments for home and community-based service providers) establishes retainer payments in amounts to be determined by the commissioner to providers of most home and community-based services provided under the state Medicaid plan and the waiver programs.

> **Subdivision 1** requires the commissioner beginning July 1, 2021 to make 5 quarterly retainer payments to specified home and community-based service providers equal to a percentage to be determined by the commissioner of the providers medical assistance revenue for home and community-based services, including any revenue from managed care organizations.
>
> **Subdivision 2** defines “direct care professional,” “eligible recipient,” “eligible service,” “recipient,” and “total home and community-based service revenue from medical assistance.”
>
> **Subdivision 3** specifies the allowable uses of revenue from retainer payments and requires that at least 50 percent of such revenue be used for specified wages and benefits for direct care professionals.
>
> **Subdivision 4** requires an eligible recipient to request retainer payments.
>
> **Subdivisions 5 and 6** require an eligible recipient to attest and agree to various conditions on the receipt and use of retainer payments.
>
> **Subdivision 7** requires a recipient to prepare and make available to the commissioner and the recipient’s employed direct care professionals a distribution plan for the revenue from the retainer payments.
>
> **Subdivision 8** authorizes the commissioner to recoup retainer payments as over payments if a recipient uses revenue from retainer payments for an unallowable use.

Subdivision 9 specifies how the commissioner shall calculate the amount of each quarterly retainer payment based on submitted and paid service claims.

Section 73 (Direction to the commissioner; Personal care assistance service rate increases) provides a rate increase for personal care assistance services and community first services and supports to be determined by the commissioner based on the amount appropriated for this purpose.

Section 74 (Direction to the commissioner; Home care service rate increase) provides a rate increase for home health agency services and home care nursing services to be determined by the commissioner based on the amount appropriated for this purpose.

Section 75 (Direction to the commissioner; Elderly waiver rate increase) provides a rate increase for elderly waiver services to be determined by the commissioner based on the amount appropriated for this purpose.

Section 76 (Revisor instruction) requires the revisor of statutes to prepare, in collaboration with house research, senate council and DHS, legislation to recodify the DWRS rate statutes, and the long-term care consultation services and long-term care options counseling statutes.

Section 77 (Repealer) repeals the HCBS policy states passed in 2020 that are reframed and restated in this article and the State Quality Council.

ARTICLE 15

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 a 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 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 organization to the administration of CFSS.
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> **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.
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> **Section 59 (256B.85, subdivision 2)** makes various clarifying changes to definitions for the purposes of CFSS, including:
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> > **Paragraph (b)** modifies and clarifies the meaning of activities of daily living for the purposes of CFSS.
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> > **Paragraph (f)** clarifies that CFSS covers complex health-related interventions ordered by an advanced practice registered nurse or physician's assistance.
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> > **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)
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> **Section 60 (256B.85, subdivision 3)** clarifies eligibility for CFSS.
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> **Section 61 (256B.85, subdivision 4)** makes a technical change.
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> **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.
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> **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.
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> **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.
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> **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 requires 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 in 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 16

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 17

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 18

UNIFORM SERVICE STANDARDS; CONFORMING CHANGES

Sections 1-116 make conforming changes to incorporate mental health uniform service standards modifications.

ARTICLE 19

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 [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 3 (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 4 [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.

Section 5 (Child Care Facility Revitalization Grant Program) enacts a grant program to be administered by county human services agencies for child care providers to reopen a closed child care program facility, or to maintain or improve an operating child care program facility. Funds shall be distributed to counties proportionally based on population. Grant applicants must include a proposed plan and description for use of revitalization funds. If an applicant receives a grant but the child care program permanently closes within one year, the commissioner is authorized to recover

the grant funds. Maximum grant amounts are $15,000 to reopen a closed family child care site, $100,000 to reopen a closed child care center site, $7500 to repair or update an operating family child care program setting, and $50,000 to repair or update an operating child care center.

Section 6 (COVID-19 Public Health Support Funds for Child Care Programs) enacts a grant program to issue support funds for child care providers to afford additional costs necessary to operate in compliance with state and federal health guidelines. The grants shall be issued in three-month funding periods, utilizing designated fund amounts, with award amounts to be determined by the commissioner that are commensurate with the amount of funding made available for a three-month funding period. Award amounts shall not exceed $1200 for a family child care provider, $8500 for a licensed child care center, and $3000 for a certified child care center. 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. Providers who close permanently must report their closure, and grant funds may be recovered.

Section 7 (Direction to the Commissioner of Human Services; Parent Aware Validation Study) directs the commissioner to contract with a third party to evaluate whether the Parent Aware program's standards, indicators, and other measures are effectively measuring program quality and educational outcomes. The report on the findings is due to the legislature by February 1, 2024.

Section 8 (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 9 (Working Group; Affordable High Quality Child Care and Early Education for All Families) requires the commissioner to establish a working group, in coordination with the Minnesota Children's Cabinet, that will meet as necessary to develop a long-term plan that would maximize the affordability, quality, and staff qualifications and diversity of child care and early education programs, regardless of location or setting, by January 1, 2031. The working group must submit an interim report to the legislature on the working group's preliminary findings by July 1, 2022, and a final report on the working group's recommendations and implementation proposals by February 1, 2023.

Section 10 (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.

Sections 11-14 direct the commissioner of human services to allocate funds from the federal child care and development block grant.

> **Section 11** allocates up to $500,000 in fiscal year 2022 for the affordable high quality child care and early education for all families working group.
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> **Section 12** allocates $750,000 in fiscal years 2022 and 2023 for grants to nonprofits to provide jobs skills training, career counseling, and job placement assistance for economically challenged individuals to begin a career in child care. The commissioner shall report to the legislature on the results of this program by January 1, 2024.
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> **Section 13** allocates $4,500,000 in fiscal years 2022 and 2023 for the "Jerry Relph Family Supports and Improvement Plan," which would issue grants to counties beginning October 1, 2021, to coordinate a two-year voluntary information-sharing program for county agencies, providers, and families who receive child care assistance and are eligible for other assistance programs, to better understand the needs of the families that diminish access to or effectiveness of the assistance programs. The commissioner shall distribute grant awards based on the number of children enrolled in CCAP in a county, and shall provide an interim and final report on the results of the program to the legislature by February 1, 2023 and 2024, respectively.
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> **Section 14** allocates $375,000 in fiscal year 2022 and 2023 for the REETAIN grant program.

Sections 15-18 direct the commissioner of human services to allocate funds from the federal child care stabilization fund.

> **Section 15** allocates $10,000,000 in fiscal years 2022 and 2023 for grants to communities to increase the supply of child care providers. At least 60% of the grants must be awarded to communities outside the metro area, and recipients are required to obtain a 50% match of either cash or in-kind contributions. The grants must be used to implement projects to reduce the child care shortage in the state, which includes starting or expanding businesses, provider training, facility modification or required licensing improvements. Communities that have a demonstrated shortage of child care are given priority. All grant recipients must report on the results of their grant awards within one year of receipt.
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> **Section 16** allocates $3,000,000 in fiscal year 2022 for a competitive grant to a nonprofit organization to operate a business training program for child care providers that will help expand access to child care services in underserved areas of the state. The commissioner must report the outcomes and recommendations for replication of this training initiative throughout the state, by December 15, 2023.
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> **Section 17** allocates $252,000,000 in fiscal year 2022 for the public health support funds for child care programs, with the amount distributed in decreasing amounts among three-month funding periods from June 2021 until May 2023. Up to $2,000,000 is reserved for administrative costs.

Section 18 allocates $50,000,000 in fiscal year 2022 for the child care facility revitalization grant program. Up to $1,500,000 is reserved for administrative costs.