NAMI Minnesota
2020 Minnesota Legislative Session
Summary of New Laws Affecting
Children and Adults with Mental Illnesses and Their Families

Children's Mental Health

Children's Mobile Crisis Teams: Allows children's mobile crisis teams to provide services in an emergency room or urgent care, just like adult crisis teams. (SS Chapter 2, Article 2)

Foster Child Phone Call: When a child enters foster care or moves to a new foster care home, the county must try to set up a phone call between the foster parent or facility and the child's parent or legal guardian. The goal of this call is to build a connection between the child's family and the foster parent or facility, including sharing important information about the child's needs and interests, so that the child can successfully transition to foster care, reduce the risk of trauma, and improve the quality of the child's care. This call should happen as soon as possible, but no later than 72 hours after the child's placement. The county is not required to coordinate this phone call if it poses a danger to the mental or physical health of the child or foster parent. The county must document the steps taken to facilitate this phone call, as well as any reasons the phone call did not occur. DHS must issue guidance to the counties on how to implement this new law by August 1, 2020. (SS Chapter 2, Article 1)

Prenatal Alcohol Exposure Screening: A county must conduct a prenatal alcohol exposure screening for any child who enters foster care. This screening must happen as soon as possible but no later than 45 days after the child enters foster care. (SS Chapter 2, Article 1)

Psychiatric Residential Treatment Facilities (PRTFs): Allows for children and youth to obtain treatment at a PRTF on the recommendation of a mental health professional, without also requiring approval from the state medical review agent. The Commissioner of Human Services will provide oversight and review the admissions to a PRTF to ensure that eligibility criteria reflect state and federal standards. The Commissioner must also create and update a list of the children and youth who meet the criteria for the PRTF level of care but are waiting to get in. This list cannot be used to direct admission to a specific PRTF. Per diems will be set for each facility instead of one statewide rate. (SS Chapter 2, Article 2)

Residential Treatment under Family First: Implements the initial requirements of the Federal Family First legislation at the state level. The intent of the federal legislation is to prevent out-of-home placements of children when they can be supported in their family home and to dramatically reduce the number of children living in congregate care (residential treatment) centers. While the focus was on child protection, children with mental illnesses who need residential treatment are lumped in with children in need of child protection services.

When federal dollars are used (Title IVE) or county funds, the county social services agency gets to determine if a child needs residential treatment. Residential treatment (except for PRTFs) use these funds to pay for room and board so children with mental illnesses must go through the county. The county conducts a screening and then creates a juvenile screening team. While this happened in the past, there are changes to the process. The team members are decided by the county and can include social workers, people with expertise in the treatment of children/youth, the child's relatives, the child's foster care parent, and professionals who are a resource (such as teachers, medical or mental health providers and clergy). The team must consult with the family, the child if age 14 years or older, and the tribe. NAMI was able to include language that allows the parent or legal guardian to object to specific relatives or professionals being on the team.

A screening team is not required for placement in a (1) residential facility specializing in prenatal, postpartum, or parenting support; (2) a facility that specializes in supporting youth who are victims of sex trafficking or at risk of becoming sex trafficking victims; (3) supervised settings for youth over 18 to live independently; (4) a residential, family-based treatment for substance use disorders; or (5) placement due to an emotional crisis or mental health emergency.

Instead of referring to residential treatment, as we know it, the new language, as required by the federal law, only allows placement in what they are calling a qualified residential treatment program (QRTP). Requirements for QRTP include having a trauma-informed treatment model, nursing and other clinical staff who are available 24/7, and must be accredited by an independent nonprofit organization approved by the United States Department of Health and Human Services. A QRTP must also facilitate the participation of the child's family members if it is in the child's interest, facilitate outreach to family members including siblings, document this outreach family engagement, and provide both the child and the child's family with discharge planning and after-care services for at least six months after discharge.

There are no changes to the standards or criteria for determining if a child is eligible for residential treatment. In order to be eligible, it must still be found that this level of care is (1) necessary (2) appropriate for the child's individual treatment needs (3) cannot be effectively provided in the child's home and (4) provides a length of stay as short as possible consistent with the individual child's needs.

If the juvenile screening team recommends placement, then the county must conduct a relative search – this means reaching out to all the relatives of the child to see if they will take the child into their home instead of the child being placed into residential treatment. NAMI was able to include language that the child, parents and tribe would be consulted on the relative search to ensure that only people who would be qualified or have the best interests of the child in mind would be contacted.

Then the county uses a "qualified individual" who assesses the child. According to the new law, this is a person who is a trained culturally competent professional or licensed clinician,

including a mental health professional, who is not an employee of the county or a residential treatment center. This person assesses the child's needs and strengths, determines if the child's needs can be met by other relatives or a family foster home, develops a list of short and long term mental and behavioral health goals for the child, and works with the child's family and permanency team. This assessment can be shared with other members of the team including other relatives. NAMI was able to include language protecting the release of medical data unless the parent authorizes it, or it is allowed under the state data practices law.

A family and permanency team is then created, which looks exactly like the juvenile screening team (except that a child age 14 or older can select two people to be on the team). Their purpose is to create a permanency plan for the child to: reunify the child with their parents, place the child with other relatives, have someone adopt the child, or find a new legal guardian for the child. If the family disagrees with the placement recommendation of this qualified individual, that must be noted in the plan.

All of these plans are reviewed by the court, as they have always been. This includes ongoing review of the child's placement over time. If a child is in placement more than 12 consecutive months or 18 nonconsecutive months (six consecutive months for a child under 13), the head of the county social services agency must sign off on it and include the report to the court on why residential treatment should be continued to DHS.

Some might ask how this impacts the voluntary placement law, known as 260D that NAMI advocated for years ago. While no changes were made this year, it is not clear at all how it will be used in the future. Despite wanting to place a child voluntarily, parents of children with a mental illness will still need to go through the screening team, relative search and the family and permanency team.
NAMI has grave concerns about these changes. Due to our concerns, language was added that requires DHS to confer with us, Association of Minnesota Counties, Minnesota Association of County Social Service Administrators, Aspire MN, Minnesota's Tribal communities and other county and state agencies to make recommendations to the legislature regarding payment for the cost of care of residential treatment, especially for those children and families using the voluntary placement option under 260D.
(SS Chapter 2, Article 5)

Respite Care: Clarifies that a child is not required to have a case manager to be eligible for respite care. (SS Chapter 2, Article 5)

Youth ACT Teams: Youth Assertive Community Treatment (ACT) teams provide intensive community mental health services to youth between the ages of 16-20 with a serious mental illness. Family peer specialists can now serve on a Youth ACT team. Changes the provider contract requirements by switching to performance evaluation criteria instead of administrative and clinical contract standards. Aligns the treatment plan requirements for Youth ACT teams with Adult ACT teams and requires the treatment team to consult with parents or guardians when developing a treatment plan for clients under the age of 18. (SS Chapter 2, Article 2)

Civil Commitment

Civil Commitment: Comprehensive re-write of the civil commitment law, with key changes to definitions, transport and emergency holds, a new section on engagement services, resolving paperwork issues, and numerous other technical changes. Changes reflect our current mental health system. The standard for being civilly committed was **not** changed, and no substantive changes were made to the section around the commitment of people who are found by the court to be mentally ill and dangerous.

The definition of community-based services was expanded to include the wide array such as crisis, ACT teams, and Medicaid waivers. Person first language is used and instead of referring to "person who is mentally ill' it reads "person who poses a risk of harm due to a mental illness." Regional treatment centers no longer exist and so it was changed to state operated treatment programs.

The previous language used the term "treatment facility" to interchangeably refer to community-based treatment, treatment at a residential facility or hospital, or state-operated treatment programs. The new language makes clear which type of program is being referenced.

The legislation replaces court-ordered early intervention with a new language on engagement in treatment. The language on early intervention was not used because the process took so long that a potential candidate met the criteria for civil commitment before the early intervention process could be finished. The goal of engagement in treatment is to provide services and supports early on to prevent commitment or going to jail. In order to be eligible for engagement services, the person must be at least 18 years old, have a mental illness, and either (1) be exhibiting the signs of a serious mental illness; or (2) have a history of failing to adhere with treatment for their mental illness that has been a key factor in the past for a hospitalization or incarceration, and the person is now showing the symptoms that may lead to hospitalization, incarceration, or court-ordered treatment.

Families and others can contact pre-petition screening at the county and ask for help. Engagement services include assertive attempts to engage the individual in mental health treatment, engaging the person's support network including education on means restriction, and meeting the person's immediate needs for food, housing, medication, income, disability verification and treatment for medical conditions. Engagement services must consider a person's personal preferences and can last for up to 90 days. Services end if the person meets the criteria for civil commitment or if the person agrees to voluntary treatment. When an individual agrees to voluntary treatment, the engagement team must facilitate the referral to an appropriate mental health provider including help obtaining insurance. Engagement staff can be county staff or through a contracted agency. They can include but are not limited to members of a mobile crisis teams, certified peer specialists, and homeless outreach workers. Counties are not required to offer engagement in treatment services.

Another key set of changes were around the transport holds and emergency holds. Both sections were re-written to increase clarity. A transport hold is ordered by a police or health officer to have someone involuntarily transported to a hospital for assessment due to being a danger to self or others. An emergency hold is ordered by an examiner, for the purpose of conducting a more thorough evaluation to see if the person will seek treatment voluntarily or if the person needs to be civilly committed. It cannot last more than 72 hours (excluding weekends and holidays).

The first key change in this part of law was expanding the definition of health officer to include any mental health professional, as well as a mental health practitioner working on a mobile crisis team under the supervision of mental health professional. It also clarified that a transport hold issued by a health officer or examiner is sufficient authority for a police officer to transport the person with a mental illness to the hospital. This legislation also clarifies that protected transportation can be used for a transport hold if this service is available. Finally, the legislation states that someone taken to a hospital under a transport hold must be assessed by an examiner as soon as possible and within 12 hours of the person's arrival. The transport hold ends when the person agrees to treatment voluntarily, an emergency hold is initiated, the examiner decided not to issue an emergency hold, or 12 hours after the person's arrival.

An examiner can now be any mental health professional – in the past it was a physician, psychologist, an APRN or a physician assistant. Examiners can initiate a 72- hour hold, however, only court examiners (physician or psychologist with a doctoral degree) can participate in the legal process around civil commitment.

The new law also recognizes the importance of health care or psychiatric directives and limits the definition of "interested person' to people who have a specific interest in the welfare of the person. There is a preference for doing in-person interviews in court hearings.

There can clearly be a dual commitment between the commissioner of human services and a community-based program or treatment facility. The community program or treatment facility can also agree to a provisional discharge.

Under Jarvis orders (involuntary medication), the medical practitioner (now broader than just a physician) can continue a medication the person was previously on when the person lacks capacity to consent through the hearing date or until the court issues an order. If someone in jail has a Jarvis order, it can be carried out if the jail has the appropriate medical staff.

Commitments do not end if a county worker forgets to file the paperwork at 30, 60 or 90 days. The court will notify the county and have them submit the paperwork. As part of these reviews, a statement from the patient will be included.

NAMI Minnesota will be re-writing the civil commitment booklet to reflect these changes if members or supporters are interested in learning more. (SS Chapter 2, Article 6)

Criminal Justice/Juvenile Justice/Legal Issues

Diversion: For the Yellow Line and similar projects, changes the term for the service provided from "post-arrest community-based service care coordination" to "officer-involved community-based care coordination." Also expands the type of providers which can provide these services to include tribal organizations, Licensed Alcohol and Drug Counselors, and peer support specialists. (SS Chapter 2, Article 2)

Feminine Hygiene Products in Prison: Requires the Department of Corrections to provide feminine hygiene products to individuals housed in state correctional facilities for female residents. Requires the commissioner of corrections to implement a process for making a reasonable number of feminine hygiene products available to residents. (Chapter 110)

Guardianship and Conservatorship: Updates guardianship and conservatorship laws. A major initiative is to offer supported decision making or appointing a health care agent instead of guardianship. This means the person identifies one or more individuals that will help them understand the nature and consequences of potential personal or financial decisions. The court will also look at what less restrictive means have been used and why they were not sufficient to meet the person's needs.

Instead of calling people "wards" they will be called "person subject to guardianship" or "person subject to conservatorship." The list of "interested persons" is expanded to include adult stepchildren of a living spouse and tribal leadership for American Indian children. Someone who is considered an "interested person" can now opt out of receiving notices.

The person's rights are expanded to include consideration of cultural practices, participating in decisions about their lives, and looking at employment and employment supports. If the guardian limits communications in any way, that must be reported to the court and the person under guardianship (or the person who isn't being allowed to communicate with them) can petition the court to allow communication. The guardian can establish an ABLE account but may not administer it. The guardian has the duty and power to help the individual with court proceedings such as restraining orders, orders for protection, housing court, etc.

The law also limits guardianship for people under age 30 to 72 months. For people over 30, the guardianship can be for an indefinite period.

Interested persons (such as family) must be notified of changes to where the person lives (including nursing homes, etc.), an unexpected change to their health, involvement with police or EMTs, and death. (Chapter 86)

Harassment Crimes: Aligns Minnesota law with federal law by requiring intent for harassment crimes and makes harassment a crime if it causes substantial emotional distress. "Substantial emotional distress" is defined as "mental distress, mental suffering, or

mental anguish as demonstrated by a victim's response to an act including but not limited to seeking psychotherapy as defined in section 604.20, losing sleep or appetite, being diagnosed with a mental-health condition, experiencing suicidal ideation, or having difficulty concentrating on tasks resulting in a loss of productivity." (Chapter 96)

Police Reform: Protects the privacy of first responders who participate in peer counseling and critical incident stress management sessions. A counselor may not share information gathered in a session with a third party unless there is a safety risk or permission is given. This allows first responders to seek help without fear that sensitive information disclosed for mental health reasons will be used against them in an investigation or negatively impact their career.

Creates legislative intent about use of force that peace officers must exercise special care when interacting with people with physical, mental health, developmental, or intellectual disabilities as they may not be able to understand or comply with commands. Prohibits the use of deadly force if a person poses a threat to themselves, but no one else.

Creates the Ensuring Police Excellence and Improving Community Relations Advisory Council. The 15-member council includes five law enforcement representatives, four members appointed by the legislature, and six community members including a member appointed by NAMI Minnesota. The council will meet at least quarterly, assist the POST Board in regulating peace officers and offering citizen involvement, and provide an annual report to the legislature with recommendations for improvement. (2nd SS, Chapter 1)

Police Training: Requires six hours of the 16 hours on continuing education be on mental illness crisis training for all peace officers every three-year licensure cycle. This includes using scenario-based training and covering the following topics:

- techniques for relating to individuals with mental illnesses and the individuals' families;
- techniques for crisis de-escalation;
- techniques for relating to diverse communities and education on mental illness diversity;
- mental illnesses and the criminal justice system;
- community resources and supports for individuals experiencing a mental illness crisis and for the individuals' families;
- psychotropic medications and the medications' side effects;
- co-occurring mental illnesses and substance use disorders;
- suicide prevention;
- mental illnesses and disorders and the symptoms;
- training on children and families of individuals with mental illnesses to enable officers to respond appropriately to others who are present during a mental illness crisis.

Requires the Peace Officers Standards and Training (POST) Board to consult with DHS and mental health stakeholders to create a list of approved courses and training providers and to share the list with law enforcement agencies across the state. Requires law enforcement agencies to document the training officers receive and submit it to the POST Board. This

includes who the provider of the training was, evaluations of the training and an explanation of expenditure of funds.

The POST Board must include an evaluation of the effectiveness of the training in reducing the use of force against people in a mental health crisis in their annual compliance report. Appropriates $145,000 in fiscal year 2021 for mental illness crisis training and $137,000 every year after that. The law also requires four hours of training on autism with similar standards and documentation but adds preservice training. (2nd SS, Chapter 1)

Prisons: Allows health care decisions to be made by the Commissioner of Corrections when someone is placed outside the facility on conditional medical release and the person cannot make the decision and no one else is documented to make the decision (the Commissioner can already do this when the person is in the prison). If a person has 90 days or less on their term, they can be placed in a county jail or detention center for the rest of their term. (Chapter 71)

Youth Intervention Grants: Exempts youth intervention grant recipients from the local match requirement for 2020 if the grant was awarded before March 13th, 2020, or if the youth intervention program was closed or severely impacted by the COVID-19 pandemic peacetime emergency. Youth Intervention Grants are awarded by the MN Office of Justice Programs to offer early intervention and services including emergency shelter, counseling, juvenile justice diversion, and more. (Chapter 110)

Early Childhood, Education and Special Education

Individualized Education Programs: Allows a functional assessment to be conducted as a stand-alone assessment. Students on an IEP can participate in a district's "prevention" program that provides additional academic or behavioral support even if the student's IEP does not list the student needing help in that area, as long as it doesn't increase the costs to the program or displace a student who needs it and does not have an IEP. (SS Chapter 8, Article 4)

Mental Health Training for Teachers: Requires all Minnesota teachers to receive training in suicide prevention and the key warning signs of mental illnesses in children. When teacher licensing moved to having four tiers, only Tier 3 and Tier 4 teachers were required to have this training as part of their licensure renewal. The initial training must include understanding the key warning signs of early-onset mental illness in children and adolescents. In future renewal periods, training must cover more in-depth training in student mental illness and trauma, accommodations for students with mental illnesses, the role of parents in addressing student mental health, Fetal Alcohol Spectrum Disorders (FASD), autism, de-escalation, requirements governing restrictive procedures, and other similar topics. (SS Chapter 8, Article 2)

Students in Foster Care: A student in foster care must remain in their current school unless it is not in their best interest. If they must go to a new school, they must be enrolled within seven days. (SS Chapter 2, Article 1)

Student Discipline in Preschool and Prekindergarten: Prohibits the suspension or expulsion of young students participating in early childhood education, school readiness, school readiness plus, voluntary prekindergarten, Head Start, or other school-based preschools or prekindergarten programs, unless all other resources have been exhausted and there is an ongoing safety risk to the child or others. Efforts to avoid suspension and expulsions must include at least one of the following: (1) collaborating with the pupil's family or guardian, child mental health consultant or provider, education specialist, or other community-based support; (2) creating a plan alongside a parent or guardian that details the steps and support necessary for the student to fully participate in the early learning program; (3) providing a referral for needed support services, including parenting education, home visits, and other supportive education interventions. If appropriate, this can include an evaluation for the student's eligibility for special education. (SS Chapter 8, Article 5)

Vaping Awareness: Requires public schools to provide vaping prevention education at least once to students in grades six through eight. Schools are encouraged to use evidence-based vaping prevention for students in grades 9 through 12, as well as to use a peer-to-peer education program as a part of vaping prevention work. (SS Chapter 8, Article 3)

Health Care

Alec Smith Insulin Affordability Act: Creates a process for Minnesotans with an urgent need for insulin to access this medication through MNsure. In order to be eligible for this program, the individual must be a resident of Minnesota, not currently enrolled in MinnesotaCare or Medical Assistance, not be enrolled in a prescription drug program that places a cap on cost-sharing for insulin of $75 or less for a thirty day supply, and has not received an emergency supply of insulin in the last 12 months. There is an exception to the 12 month requirement if the individual is in the process of applying for Medical Assistance or MinnesotaCare and has not yet been approved, or the individual has been found ineligible for a manufacturers' patient assistance program. After accessing the emergency supply of insulin, the pharmacist must provide the recipient with an information sheet on options for accessing affordable insulin and a list of navigators who can help the person access ongoing coverage for insulin. (Chapter 73)

Nicotine Replacement Medications and Opiate Antagonists: A pharmacist is now authorized to prescribe nicotine replacement medications and opiate antagonists approved by the Food and Drug Administration (FDA) if they have taken training specifically developed for these medications offered by a college of pharmacy or a continuing education provider accredited by the Accreditation Council of Pharmacy Education. (Chapter 115)

Policies Due to COVID-19: Pays for COVID-19 testing and diagnosis for people who are uninsured. Allows the Department of Health to grant temporary waivers for the programs under its supervision for the duration of the public health emergency, including nursing homes, certain residential programs for people with developmental disabilities, human services judges who make decisions about a range of issues including eligibility for public programs, and other areas. Prohibits a health carrier from denying reimbursement for treatment because it was provided via telemedicine. This chapter originally authorized the use of telehealth and phones, and the end date was extended during the first special session. (Chapter 74)

Prescription Drug Price Transparency: Requires a drug manufacturer to submit information to the Department of Health for any prescription drug that costs $100 or more for a 30 day supply or a course of treatment that lasts less than 30 days, as well as brand name drugs with a 10% increase over 12 months or 16% over a 24 month period, and a generic drug with a price increase of 50% or more over 12 months. This information must include the name of the drug and the price increase by percentage, the reasons for this price increase, any generic drugs that are available, the price of the prescription drug when it was first approved and the yearly price increases for the medication, and the direct costs for the manufacturer for the medication. A lot of detailed information about manufacturing costs, etc. is also required. Starting on October 1, 2021, prescription drug manufacturers must also report similar information for any medication with a price that exceeds the Medicare Part D specialty drug tier.

The information disclosed under this legislation must be made available to the public in an online platform. The Commissioner of Health must submit a yearly report documenting the effectiveness of these new reporting requirements to increase transparency, improve public understanding of pharmaceutical spending trends, and assist the state and other payers to control pharmaceutical drug costs. (Chapter 78)

Prior-Authorization: Creates new consumer protections around prior-authorization and utilization reviews. Starting on January 1, 2022, all prior-authorization requests must be responded to within five business days of receiving the request. If a health professional believes an expedited review is necessary, the request must be responded to within 48 hours. The utilization review organization must respond to an appeal within 15 days of receiving the appeal request.

The physician turning down a prior authorization request must have a same or similar specialty relevant to the request. This means that any prior authorizations for mental health treatment must be done by a physician specializing in mental health.

All utilization review organizations must submit their standards for making a prior-authorization, including the evidence-based clinical criteria, to all health plan companies they work with. The Health plans must make this information public.

A utilization review organization cannot revoke, limit, or restrict a prior authorization that has already been authorized, unless there is evidence of fraud or misinformation.

To promote continuity of care, there are two important changes. When someone has a new health plan, any treatments that have been prior-authorized must continue for at least the 60 days on the new plan. If a utilization review organization changes the coverage terms or the clinical criteria used to make a decision around authorizing a health care service, the change cannot go into effect until the next plan year for any enrollee who has already received prior-authorization approval for the service.

Starting on April 1, 2022, all health plans must post on their website relevant information about the use of prior authorizations for each of their insurance products. This must include the number of prior-authorization requests, the number of prior-authorization requests which were denied and the outcome of an appeal of this decision, the number of electronically submitted prior authorization request, and the reasons for prior-authorization denial broken down by the reason for the denial. Finally, the Commissioner of Health must submit a report on April 1, 2021 on compliance with this legislation for prescription drugs, including key indicators like the reasons electric and nonelectronic prior authorizations were denied and the anticipated effects on denials and turnaround times if all providers in Minnesota were required to submit their requests electronically. (Chapter 114)

Tobacco Use: Raises the age to legally possess tobacco to be 21 years or over, including e-cigarettes and any tobacco product designed for human consumption. Law enforcement and the courts are required to develop alternative civil penalties for possession. Prohibits anyone from possessing tobacco in a school, unless the tobacco is in the possession of an adult as part of a traditional Indian ceremony. (Chapter 88)

Housing/Homelessness

Emergency Housing: Appropriated $26.5 million for additional shelter space, vouchers for hotel rooms, purchasing cleaning supplies, hiring more staff to address homelessness and COVID-19. (Chapter 71)

Homeless Youth: Allows a minor living separately from their parent or legal guardian to consent to receive homeless youth services and services for sexually exploited youth. This does not impact a parent or legal guardian's custody of the minor. (SS Chapter, 2, Article 5)

Housing Rates: Appropriates $5.5 million to the Department of Human Services to increase the room and board rates by 15% for three months to maintain access for group housing. (Chapter 71)

Human Services

Child Protection: Updates the maltreatment of minors law. It includes a focus on multi-disciplinary teams, requiring agencies to notify each other (police, child welfare), updates to family assessments and more. (SS Chapter 2, Article 7)

Consumer Directed Community Supports: Makes several changes to the Consumer Directed Community Supports (CDCS) program for people on a Home and Community Based Services (HCBS) waiver program. CDCS offers additional flexibility and autonomy to people with a HCBS waiver, including self-directing their services and hiring and managing support workers. Key changes include requiring the Commissioner of Human Services to provide an up to 30% increase in funds for either increasing funding for employment opportunities, transitioning to a temporary residence due to an illness, or developing and implementing a positive behavior support plan. This funding can be used by people on CDCS program or people with a HCBS wavier who are using a licensed provider for these services.

Allow higher rates for people who are ready to be discharged from an institutional setting like the Anoka Metro Regional Treatment Center (AMRTC) or crisis beds but are having difficulty finding appropriate services under the current budget limits. Allows payments for certain shared services. (SS Chapter 2, Article 2)

Corporate Foster Care: Allows the Department of Human Services to continue issuing licenses for new adult foster care settings with five beds through December 31, 2020, as well as allowing existing providers to continue operating. (SS Chapter 2, Article 2)

Early Intensive Developmental and Behavioral Intervention Benefit (EIDBI): This program is for people who are on the Autism Spectrum Disorder or have a related condition. Makes minor wording changes and requires providers to ensure people are qualified to deliver treatment and receive training within six months. Providers must use modalities established by the commissioner. Allows services to be provided across multiple settings, individually or in a group. Providers can be located in a border state. (SS Chapter 2, Article 5)

Home and Community Based Services: Creates new standards for Home and Community Based Services. This includes defining sexual violence and requiring staff to be trained on how to minimize the risk of sexual violence including concepts of health relationships, consent, and bodily autonomy for people with disabilities. Providers must conduct initial treatment planning before providing 45 days of service or within 60 days of service initiation, whichever is shorter. Previously the standard was within 45 days of service initiation. The provider is now also required to engage in treatment planning with other people identified by the person who is receiving Home and Community Based Services or the person's legal representative. This initial treatment planning must now also include strategies to develop and maintain life-enriching skills, opportunities for community engagement with a focus on the preferences of the person obtaining services, opportunities to develop and strengthen personal relationships, and opportunities to seek competitive employment in the community. (SS Chapter 2, Article 2)

Adds policy statements that under the Developmental Disability and CADI Waivers, employment must be offered to all recipients, and there is the presumption that people with disabilities want to live independently in the community with proper services.

Finally, states that all adults with disabilities and families of children with disabilities can and want to use self-directed services and supports. (SS Chapter 2, Article 3)

Requires all people with a Home and Community Based Services (HCBS) waiver living in a corporate foster care setting (group home) to have their living arrangement reviewed at least once per year. The review involves the person, their legal representative, the case manager, and other people identified by the person or their legal representative to discuss options for transitioning out of the group home. This conversation must be documented and include any additional education or information necessary to make this decision. (SS Chapter 2, Article 4)

Human Services Waivers Due to COVID-19: Authorizes the Department of Human Services (DHS) to continue several waivers around the delivery of health and human services after the public health emergency due to COVID-19 is over.

The following waivers are allowed to continue under federal government timelines:

- CV 17: Preserves health care coverage under Medical Assistance and MinnesotaCare by allowing enrollees to continue coverage unless they specifically request to be taken off.
- CV18: Waives work requirements for able bodied adults without children to obtain food stamp or SNAP benefits.
- CV 20: Eliminates the cost-sharing requirements for COVID-19 diagnosis or treatment for Medical Assistance and MinnesotaCare enrollees. This includes copayments and deductibles.
- CV 37: Temporarily waives the requirement for food stamp recipients to verify their eligibility every 6 months. Also allows for counties and tribes to process new food stamp applications.
- CV 59: Extends the eligibility for the Refugee Cash Assistance (RCA) program between 8 to 18 months, with the benefit not going beyond September 30, 2020.
- CV 60: Extends the 60-month eligibility period for the federally funded Refugee Social Services Program, with additional months not going beyond September 30, 2020.

The legislation also extends these waivers through June 30, 2021 unless the federal government does not allow it:

- CV 15: Allows for phone and video visits to provide services under a Home and Community Based Services (HCBS) waiver.
- CV 16: Keeps telehealth as an option for people with health insurance through the Children's Health Insurance Program (CHIP), Medical Assistance, and MinnesotaCare to access needed health services including mental health. This includes expanding the definition of telemedicine to include phone calls and nonsecure platforms like skype, allowing the providers' first visit to be over the phone, allowing more than three telemedicine visits per week, and requiring managed care plans to follow these policies.

- CV 21: Expands ability for school-linked mental health and intermediate school district mental health programs to provide services via telemedicine. This includes using grant funds to expand telemedicine services, no longer requiring the first visit to be in person, waiving the three visit per week limit on telemedicine, and allowing for the use of telephone and other non-secured platforms like skype.
- CV 24: Waives the requirement for face-to-face visits for Minnesotans on Medical Assistance who receive targeted case management. This includes child welfare targeted case management, children's mental health targeted case management, adult mental health targeted case management, vulnerable adults, or adults with developmental disabilities (VA/DD) targeted case management, and relocation service coordination targeted case management.
- CV 27: Waives the limit on the number of days a housing support recipient can be absent from their residence. This will allow for people to return to their residence after hospitalization or quarantine due to the COVID-19 pandemic.
- CV 30: Allows additional mental health and substance use disorders to provide telemedicine via telephone or video visits. Eligible providers include licensed health care providers, mental health peer specialists, Adult Rehabilitative Mental Health Services (ARMHS), Children's Therapeutic Support Services (CTSS), and alcohol and drug counselors and other substance use disorder staff.
- CV 31: Allows counties to request not be held financially responsible for the increased charges when a patient no longer meets the criteria for care at the Anoka Metro Regional Treatment Center (AMRTC) and the Community Behavioral Health Hospitals (CBHHs), so long as the delay in discharge is due to challenges related to the COVID-19 pandemic.
- CV 38: Provides flexibility for housing support settings to safely provide services in group and individual settings during the pandemic, including moving people to another setting in order to isolate and keep people safe.
- CV 43: Modifies a previous waiver on Home and Community Based Services to further expand phone and video services for people living in their own homes in order to reduce social isolation and strengthen the health and safety of older adults and people with disabilities, particularly those who are used to daily contact in day service facilities.
- CV 44: Allows for the delivery of adult day services remotely or in-person to one individual at a time. Day treatment providers can use alternative strategies to provide wellness checks, socialization, activities, meal delivery, assistance with the activities of daily living, and individual support to family caregivers.
- CV 45: Modifies requirements for substance use disorder providers, including treatment delivery, telemedicine, personnel and training requirements, and other areas.
- CV 50: Modifies requirements for the Early Intensive Developmental and Behavioral Intervention (EIDBI) services for people with Autism Spectrum Disorder (ASD) and related conditions. Changes include expanding the use of phone and video

platforms, clarifying the limit on telemedicine visits, waiving the face-to-face requirement for EIDBI coordinated care conferences, and waving the requirement to update the individual treatment plan in order to extend EIDBI services.

- CV 53: Allows Personal Care Assistance (PCA) providers to provide in-person oversight via telephone or video platforms and increasing the number of hours an individual worker can work to 310 hours per month.
- CV 64: Modifies standards for mental health centers so that they can safely serve their clients. Waivers for treatment delivery, personnel, and documentation are retroactive to March 13th. This includes permitting alternative mental health professional supervision of clinical services at satellite locations; permitting an alternative process for case consultation meetings; and permitting mental health professionals to provide required client-specific supervisory contact by telephone or video communication instead of face-to-face supervision.

Finally, also allows for all other waivers and modifications sought by DHS due to the COVID-19 pandemic to continue for no more than 60 days after the conclusion of the public health emergency. This legislation also includes an appropriation to cover the cost of an extended absence for a resident of a housing supports program due to hospitalization or isolation for COVID-19. (SS Chapter 7)

MnChoices Assessment: The MnChoices assessment must provide information about all the options for services that would support someone to live independently or in a provider controlled setting, employment services, and options for self-directed services and supports, including self-funding options. There must be documentation that the individual was shown all available options for employment services, independent living, and self-directed supports and services. During reassessment, the person receiving services must be given these options again. Case Managers are also responsible for developing a person-centered coordinated service and support plan that reflects the full array of employment options, choices to live independently, and financial management services. (SS Chapter 2, Article 4)

Mental Health Care

Behavioral Health Homes: Clarifies that MinnesotaCare does not cover behavioral health homes. (Chapter 115)

Certified Community Behavioral Health Clinics (CCBHC): Removes the county share requirement for CCCBHC services. There is also language that authorizes the Commissioner of Human Services to seek federal approval for an updated rate methodology for CCBHCs, as well as policy language requiring managed care plans and county-based purchasing plans to pay the CCBHC prospective payment rate. (SS Chapter 2, Article 2)

Rural Mental Health: Appropriates $40,000 to the Commissioner of Agriculture to increase outreach to rural farmers and the agriculture community around mental health. This includes suicide prevention training, mental health awareness training for farm and

rural teens, and mental health forums in response to the COVID-19 pandemic. (Chapter 101)

State Operated Programs: People who have been provisionally discharged to a state operated community group home, shall, when included in their discharge plan, not have access to inherently dangerous instruments such as sharpened or metal knives, guns, incendiary material or devices, unless unsupervised access is approved by the individual, county case manager, and the individual's support team. There is also language regarding service termination from state operated waiver programs and requiring a 90-day notice and rescinding the notice if they cannot find a community provider. (SS Chapter 2, Article 5)

Substance Use Disorder

Opioid Epidemic Response Advisory Council: Allocates $2.713 million in grant awards for the 2021 fiscal year. The council awards $367,000 for the Commissioner of Health to distribute naloxone to all eight emergency service regions in the state, to rural and urban tribal entities and to fund syringe exchange programs should there be adequate capacity. The Steve Rummler HOPE Network was also awarded $367,000 to distribute naloxone to 30 targeted counties. The council awarded $412,000 for ECHO programs to provide online training and support for professionals to better engage people with an opioid use disorder. There is also $200,000 for the enhancement and expansion of care with a focus on peer supports for American Indians. Finally, the council awarded $1 million to increase access to Medication-Assisted Treatment (MAT). In the event there is less available funding in 2021, the decreases must be proportional to the awards made in this legislation. (Chapter 113)

Positive Screen: A person who screens positive for alcohol or substance misuse can access initial services without completing a comprehensive assessment. (SS Chapter 2, Article 5)

System Issues: A withdrawal management provider can admit someone if they meet the admission criteria. Clarifies information about conducting comprehensive assessments. (Chapter 74)

Withdrawal Management: Makes changes to withdrawal management programs by requiring a "licensed practitioner" instead of "medical director" and requiring an assessment summary for each patient. (SS Chapter 2, Article 5)

Workforce

Advanced Practice Registered Nurses: Changes were made throughout Minnesota laws regarding what Advance Practice Registered Nurses (APRN) can do. Pretty much wherever physicians are allowed or required to do things APRNs were included such as authorization for the use of restraints, advance directives, giving out medications in limited pharmacy areas, medication education services under ARMHS, NEMT certification, etc. (Chapter 115)

Physician Assistants: Changes the collaborative practice agreement for Physician Assistants (PAs). They must practice in a clinic or hospital for 2,080 hours working together with a physician to provide care. After that, once a year, the PA must have a practice agreement, describing what they can do, with a licensed physician within the same clinic, hospital, health system, or facility. The reviewing physician must also have knowledge of the PAs practice and ensure it is consistent with the practice agreement. A PA can only provide ongoing psychiatric treatment for children with emotional disturbances and adults with serious mental illnesses in collaboration with a licensed physician. This collaboration must be defined and include appropriate consultation or referral to psychiatry. (Chapter 115)

Social Workers: Changes were made to the licensing of social workers and the licensing board. At least five of the ten board members must be from a community of color or underrepresented community. Provides more specificity of the continuing education requirements. There are several other minor changes. (Chapter 79)

Other

Financial Exploitation of Vulnerable Adults: Requires banks or credit unions to delay or hold a transaction when they believe or the Commissioner of Commerce, a law enforcement agency, or prosecuting attorney's office believe the accountholder may have or will be financially exploited (Chapter 85)

Veterans: Provides $6.2 million to the Department of Veterans Affairs to provide financial assistance to any veteran or surviving spouse in need of assistance due to COVID-19 such as hospitalization, medical care, treatment, etc. (Chapter 71)

Workers Compensation: Provides workers compensation coverage for COVID-19 related health issue for people who are employed as first responders (police, fire, EMTs); state nurse or health care workers, state correctional or security counselors; health care providers, nurse or assistive employee in a heath care, home care or long term care setting with direct COVID-19 patient care units; and workers required to provide child care to first responders and health care workers. Note this does not include mental health workers. (Chapter 72)

Acronyms:

- ABLE – Achieving a Better Life Experience
- ACT = Assertive Community Treatment
- ARMHS = Adult Rehabilitative Mental Health Services
- AMRTC = Anoka Metro Regional Treatment Center
- APRN = Advanced Practice Registered Nurse
- ASD = Autism Spectrum Disorder
- CADI = Community Access for Disability Inclusion
- CBHH = Community Behavioral Health Hospital
- CCBHC – Certified Community Behavioral Health Clinic
- CDCS = Consumer Directed Community Supports

- Chapter = Chapter in Session Law
- CHIP = Children's Health Insurance Program
- CTSS = Children's Therapeutic Services and Supports
- DHS = Department of Human Services
- ECHO = Extension for Community Healthcare Outcomes
- EIDBI = Early Intensive Developmental and Behavioral Intervention
- EMT = Emergency Medical Technician
- FASD = Fetal Alcohol Spectrum Disorder
- FDA = Food and Drug Administration
- FY = Fiscal Year
- HCBS = Home and Community Based Services
- IEP = Individualized Education Program
- Jarvis = involuntary medication
- IRTS = Intensive Residential Treatment Services
- MA = Medical Assistance or Medicaid
- MAT = Medication-Assisted Treatment
- NEMT = Non-Emergency Medical Transportation
- PA = Physician Assistant
- PCA = Personal Care Assistance
- POST = Peace Officers Standards and Training
- PRTF = Psychiatric Residential Treatment Facility
- RCA = Refugee Cash Assistance
- SNAP = Supplemental Nutrition Assistance Program
- SS = Special Session
- QRTP = Qualified Residential Treatment Program

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