Despite the significant challenges of a fully remote legislative session, there were some significant wins for people with mental illnesses and their families. The 2021 legislative session began with a projected budget deficit, but relief from Congress took the pressure off the legislature and opened the door for new investments. After a long and contentious special session, the legislature and Governor Walz were able to reach a compromise that includes many proposals from NAMI Minnesota.

You can’t build a mental health system without a stable workforce. That’s why NAMI Minnesota collaborated with the Wilder Foundation to push for a comprehensive legislative package to expand the diversity of our mental health workforce and to make it more culturally informed. Key items included requiring continuing education for mental health professionals to become more culturally informed; increasing funding for the loan forgiveness for mental health professionals and expanding it to include Licensed Alcohol and Drug Counselors (LADCs); mandating geographic and cultural diversity on the mental health professional licensing boards; funding to expand the number of culturally diverse supervisors; creating a statewide task force, and more. It was exciting to accomplish so much in this area, but there is more to do, including requiring all private health plans to pay for treatment provided by clinical trainees and to explore alternative pathways to licensure for mental health professionals. (Rep. Vang/Sen. Utke)

NAMI Minnesota and Aspire Minnesota worked together to make sure that the provisions of the Federal Family First legislation wouldn’t force families seeking voluntary residential treatment for their child with a mental illness into the child protection system which would have required a relative search among other things. We engaged the Department of Human Services (DHS) and counties to reach a compromise and created a third path for these families that is outside the child protection system. Funds were allocated to pay for the loss of federal dollars. (Rep. Hanson /Sen. Nelson)

It was a busy and often contentious session in the public safety and judiciary committees as well. As policing was the prominent topic in public safety, we spent a lot of time educating legislators on the existing mobile crisis system in Minnesota and advocating to continue building this system to address mental health calls without police when possible. We testified and advocated in support of Travis’ Law named after Travis Jordan who was killed by police during a mental health crisis in 2018. Travis’ Law requires the 911 system to refer crisis calls to mental health crisis teams where available (Rep. Hanson J./Sen. Abeler). NAMI was also able to provide support for legislation to allow incarcerated pregnant women to be released and stay with their babies after birth (Rep. Becker-Finn/Sen. Kiffmeyer).
Other key bills NAMI took the lead on included:

- Allowing people to keep their CADI waiver if they receive residential or inpatient treatment for up to 121 days. Previously, someone would lose their CADI waiver after 30 days of inpatient or residential treatment and would have to go through the full assessment process to restore their waiver. (Rep. Hanson/Sen. Housley)
- Continuing funding for an online suicide prevention training for school staff. (Rep. Feist/Sen. Coleman)
- Expanding the eligibility for Youth ACT teams to children as young as eight and youth up to age 25. (Rep. Kotyza-Witthuhn/ Sen. Nelson)
- Creating a task force on sober homes. (Rep. Edelson/Sen. Housley)

NAMI Minnesota also provided information and language to amend bills:

- Making it harder for hospitals to close psychiatric beds. (Rep. Fischer/Sen. Marty)
- Ensuring that any mental health education that includes suicide prevention is evidence-based.
- Creating jail standards that took into account the needs of inmates in jails who have a mental illness. (Rep. Long/Sen. Latz)
- Ensuring that the 911 telecommunicator working group included a mental health crisis team providers and ensure that as we improve our emergency response system, mental health crises will receive the appropriate response from well-trained dispatchers. (Rep. Igo/Sen. Ingebrigtsen)
- Ensuring that crisis teams can work with families and that we have good discharge plans when leaving residential care. (Rep. Fischer/Sen. Abeler)

NAMI Minnesota also testified and supported bills that passed that will fund our smaller crisis homes in Greater Minnesota, fund mental health care for firefighters, Veterans’ treatment courts, digital well-being, billing Medical Assistance in schools for mental health services, non-exclusionary discipline, postpartum coverage to one-year, mental health awareness in colleges, banning the use of shackles on juveniles, and more. There were many bills we worked on that did not pass, but we will be back next year to advocate for them.

Thank you to all the NAMI members and supporters who made the 2021 legislative such a great success. We hope you find this summary helpful and are happy to answer any questions that you have.

### Adult Mental Health

**Adult Mental Health Grants:** Requires the Department of Human Services (DHS) to work with legislative staff to draft a law laying out the eligibility criteria, targeted populations, authorized funding uses, and outcomes for projects funded under this grant program. Currently the pilot projects can fund mental health crisis services, housing with supports for adults with serious mental illness; and projects for assistance in transitioning from homelessness (PATH program) along with a number of other services such as community support programs and peer support. (SS Chapter 7, Article 11)
Adult Mental Health Initiative: Requires DHS to submit a report on the new funding formula for Adult Mental Health Initiatives (before implementing it) by February 1, 2022. This report must include an updated funding formula, the rationale for this formula, and stakeholder feedback. Many counties are concerned about the new formula. Appropriates $3.5 million in FYs 22-23 and $1.75 million in FY 24 for these programs. (SS Chapter 7, Article 11)

Crisis Stabilization Services: Requires DHS to develop a statewide rate for crisis stabilization providers that serve no more than four adult residents in the facility. There are only a small number of crisis stabilization providers that serve just four people but they play an important role in meeting people’s needs in greater Minnesota. (SS Chapter 7, Article 11)

Children's Mental Health

First Episode Psychosis Grants: Provides criteria on how funding for first episode of psychosis programs can be used. It includes intensive treatment, medication management, psychoeducation, case management, employment supports, education support, cognitive behavioral approaches, social skills training, peer support, crisis planning and stress management. Funds can also be used for training and outreach for mental health and health care providers on the early identification of psychosis and to pay for housing and travel expenses if these are barriers to participating in a first episode program. (SS Chapter 7, Article 11)

Out-of-Home Placement: Makes changes to the child protection law to conform to the federal Family First Law. A definition of “trauma” is added to the statute along with including youth who are at-risk of sex trafficking.

New requirements are added for any residential treatment program that is going to receive Title IVE funds to pay for room and board – now referred to as a QRTP – qualified residential treatment program. This includes requiring trauma informed treatment, having a nurse on staff clinical staff, and being accredited by the CARF, Joint Commission, COA or another agency. QRTPs must work with the family including siblings and provide discharge and aftercare for at least six months.

There will be a certification process for QRTPs along with programs serving youth who have been sex trafficked/exploited, supervised independent living programs for youth aged 18 and older, and residential settings supporting youth who are prenatal/postpartum/parenting support.

Under child protection (260C) a juvenile screening team must be appointed when a child needs residential treatment. The county must ask the parents for recommendations as to whom to include on the team to ensure the team will be child-centered and so the county doesn’t include people that the parents think wouldn’t have the child’s best interests in mind. If placement is recommended, then a family and permanency team is formed. The county will do a relative search to see if someone can care for the child instead of the child going into residential treatment. Only if the court finds that a specific relative would present a safety or health risk would they not contact that person. The child should be placed with their siblings unless it’s not possible due to the child’s specialized needs.
When a child is placed into a QRTP there is a “qualified individual” who must do the assessment
(note we do not have a clear picture of who qualifies to be a qualified individual). If a level of
care determination was done under the Children’s Mental Health Act, that needs to be shared with the screening team.

Children in voluntary placement – 260D – will also see changes. This section of law was
developed many years ago as an alternative for families whose children needed residential
treatment due to their mental illness and not due to them being involved in child protection.
Because of the new federal law, changes had to be made here, too. But be sure to read the next
section as well. Under 260D families have a little more say in terms of who is part of the family
and permanency team and who is contacted in the relative search.

NAMI Minnesota worked hard on this language in 260C and 260D to make sure that parents had
input into the process. (Chapter 30, Article 10)

**Residential Treatment:** Creates an alternative pathway for children with mental illnesses
needing residential treatment so that they don’t have to go through child protection – 260C or
260D – involuntary or voluntary treatment. Federal Title IVE pays for the room and board for residential treatment which means that families have to go through child protection and meet the new Family First law. But under this new law, we will use state funds to pay for room and board which mean that families do not have to go through child protection and will go through the revised process that is in the Children’s Mental Health Act.

If a family uses Medical Assistance or needs county funds to pay for treatment in a residential
facility, they contact the county. The county will assess the child’s needs (called a level of care determination) to determine if they need residential treatment. There will be a meeting to discuss the findings and make decisions about residential treatment. Families need to be invited to that meeting and be provided with all the information used to make a decision. Treatment plans must be reviewed after ninety days, and discharge planning must begin within 30 days of the child entering the residential program. Appropriates $4.184 million in FYs 22-23 and $4.136 million in FYs 24-25 to facilitate these voluntary placements. (SS Chapter 7, Article 11)

**Residential Mental Health Workgroup:** Creates a children’s residential mental health task
force to develop recommendations on how to fund room and board costs for residential treatment into the future. The group must also consider strategies to address systemic barriers when children transition back to the community. (SS Chapter 7, Article 11)

**Reducing Reliance on Children’s Congregate Care Settings:** Appropriates $200,000 for DHS
to analyze the effectiveness of treatment received by medical assistance enrollees at children’s residential treatment programs and Psychiatric Residential Treatment Facilities (PRFTs). Stakeholders must be consulted such as MDH, MDE, hospitals, children’s treatment facilities, social workers, juvenile justice officials, and parents of children receiving care. This report must be submitted to the legislature by February 1, 2022, identifying the system obstacles for these children transitioning back to the community, gaps in care for children with acute mental health and substance use disorder needs, and providing recommendations to address these gaps, including costs. (SS Chapter 7, Article 17)
PRTF and CABHH Mobile Unit: Appropriates $5 million in FYs 22-23 to pilot a mobile transition unit to support children and youth to transition to the community from a PRTF or the Child and Adolescent Behavioral Health Hospital (CABHH). Funding expires in 2024 and counties will have the opportunity to continue supporting this service. (SS Chapter 7, Article 15)

School-Linked Behavioral Health Grants: Renames the school-linked mental health grants as school-linked behavioral health grants and allows funds to be used to provide substance use disorder services in schools. Appropriates $2.5 million per fiscal year from 2022 through 2025 in school-linked behavioral health grants for mental health services in schools. Appropriates $1.750 million per fiscal year from 2022 through 2025 for school-linked substance use disorder services. (SS Chapter 7, Article 11)

Screening: Allows DHS to work with counties and Tribal Nations to access screening results in order to evaluate and improve programs. Mental health screenings are an option for children entering the child protection system and juvenile justice systems. (Chapter 30, Article 13)

Youth ACT: Expands the eligibility for Youth Assertive Community Treatment Teams (ACT) to children as young as 8 and to youth up to age 26. Previously, only youth between the ages of 16-20 were eligible for the program. Youth ACT teams provide intensive, community-based treatment using a team-based approach modeled off adult ACT teams. Individual Youth ACT teams must specialize and serve young children between 8 and 16 or older youth between 14 and 26. To serve additional clients, there is an appropriation of $1.263 million in FYs 22-23 and $2.293 million in FYs 24-25. (SS Chapter 7, Article 11)

Criminal Justice/Juvenile Justice/Legal Issues

911 and Mobile Crisis Teams: Requires the 911 system to refer mental health crisis calls to mental health crisis teams where available, also known as “Travis’ Law” named after Travis Jordan who was killed by police in 2018 during a mental health crisis. NAMI will be working with 911 dispatch, law enforcement, and crisis teams to ensure that this law will be implemented recognizing the limitations in resources available around the state. (SS Chapter 11, Article 2)

911 Telecommunicator Working Group: Creates a 15-member working group to recommend state-wide standards for 911 dispatchers or “telecommunicators.” Membership is made up of first responders including mental health crisis team providers, firefighters, police, sheriffs, EMTs, counties, and emergency communication boards and associations. Appropriates $9,000 for the group which must submit a legislative report by January 15, 2022, with recommendations for a statutory definition of 911 telecommunicators, as well as minimum requirements for certification, training, and continuing education. (SS Chapter 11, Article 2)

Alternatives to Incarceration: Appropriates $320,000 to fund programs in Anoka, Crow Wing, and Wright County to divert people from incarceration into substance use disorder and mental health treatment. (SS Chapter 11, Article 1)

Assaulting Employees of Criminal Justice System: Increases the punishment for assaulting a peace officer, prosecuting attorney, judge, or correctional employee, and causing great bodily
harm. It was a sentence of 10-20 years and now it is 15-25 years and/or a $35,000 fine. If a weapon is used it is 25-30 years and/or a fine of $40,000. (SS Chapter 11, Article 2)

Community Corrections: Appropriates $1.22 million for community corrections and requires the Department of Corrections (DOC) to convene a working group to study and recommend a sustainable system for providing community supervision in Minnesota, including standards for core supervision activities. Currently in Minnesota, probation and parole or community supervision are provided by three entities. Most supervision is handled by Community Corrections Act Counties, but the remaining cases are supervised by the DOC or directly by counties. The DOC is supposed to subsidize the work of the Community Corrections Act Counties but has not been able to meet their legislatively mandated amount in many years. While Minnesota has one of the lowest incarceration rates in the country, we are consistently in the top five states for most people under supervision. (SS Chapter 11, Article 1)

Dementia and Alzheimer’s Training for Police: Requires the Peace Officer Standards and Training Board (POST) to create a list of approved entities and training courses on working with people with dementia and Alzheimer’s disease. Courses must be taught by trainers with at least two years of direct experience and must include instruction on topics like wandering, driving, abuse, neglect, and crisis intervention. (SS Chapter 11, Article 2)

Driver’s License/ID: Allows someone to not have their photo on their license or ID card if the department has a photo on file taken within the last four years (or has a photo that meets the requirement) and the person is “homebound” meaning that due to a medical, physical, or mental health condition they cannot leave their house. This must be documented in writing by a physician, case worker, or social worker. (SS Chapter 5)

Fines and Fees: Allows courts to reduce or waive fines and fees if they would cause undue financial hardship on a person convicted of a crime or their immediate family. Courts may also impose community service instead of charging the fines and fees. (SS Chapter 11, Article 3)

Firefighter Wellness: Provides $4 million to create the Hometown Heroes Assistance Program. The program will offer all firefighters five therapy sessions a year and additional therapy to address trauma experienced on the job. In addition to some monetary support and education for firefighters diagnosed with cancer or heart disease, the program will provide two hours annually of training on evidence-based suicide prevention strategies and trauma related to the job, as well as funding to develop a psychotherapy program specific to the needs of firefighters. (SS Chapter 11, Article 2)

Healthy Start Act: Allows the Commissioner of Corrections to conditionally release pregnant women from prison for their pregnancy and up to one year after giving birth. People would be released to community programs including prenatal and postnatal care, parenting skills programs, employment, vocational training, and substance use disorder and mental health treatment. $100,000 is appropriated each year of the biennium to implement the program, and the commissioner must report to the legislature every April 1 on the number of people released. (Chapter 17) (SS Chapter 11, Article 1)
**Immunity for Assisting Assault Victims:** Provides immunity from certain drug charges for people calling 911 for help relating to a sexual assault. Victims and people calling on behalf of a victim will be immune from prosecution if evidence of drug possession or underage alcohol use is found solely as a result of calling for help. The law also prohibits revoking a person’s pretrial release or probation if they are immune under this section. The act of assisting a victim may also be used as a mitigating factor for charges that are not covered by this type of immunity. (SS Chapter 11, Article 2)

**Innovation in Community Safety Grants:** Appropriates $400,000 each year to the Department of Public Safety (DPS) to provide grants to communities with higher rates of poverty and violent crime. DPS must work with community members and organizations to establish grant advisory boards to assist in selecting grantees. Grants may be used to address a number of issues such as bullying, cultural disengagement and abuse, and can fund the Minnesota SafeStreets program; community healing, healing circles, wellness, and restorative justice; establishing or maintaining co-responder models, building on existing mobile mental health crisis teams; and establishing or maintaining community-based mental health and social services. (SS Chapter 11, Article 2)

**Jail Oversight:** Creates minimum standards for mental health care and policies in jails through administrative rules. The Department of Corrections must promulgate rules with specific guidance for jail facilities on:

- screening, assessment, and treatment of people with mental illnesses and substance use disorders;
- a policy on the administration of involuntary medication;
- suicide prevention plans and training;
- verification of medications in a timely manner;
- well-being checks;
- discharge planning including providing medications at discharge;
- policies on referring and transferring people to noncorrectional medical and mental health facilities;
- use of solitary confinement and mental health checks;
- critical incident debriefings;
- clinical management of substance use disorders;
- policies for incarcerated people with special needs;
- policies on the use of telehealth in jails;
- sharing medical information with providers;
- a code of conduct policy for jail staff and annual training; and
- policies on reviews when a death occurs in a jail.

Jail administrators are required to report deaths within 24 hours of receiving notification and to report within ten days of the incident on all suicide attempts, emergencies, and uses of force resulting in great bodily harm. The DOC can issue correction orders or suspend or revoke the license of a jail that is not meeting minimum standards and must post on the DOC’s website the facility and the reason for the corrective action. Additionally, all routine inspection reports
(every two years) must be posted on the DOC’s website and made publicly available within 30 days of the completion of the inspection.

The law also establishes death review teams in the event a person dies in jail or as a result of an incident in a jail. Teams include the jail administrator, an outside medical expert, and if necessary, a mental health expert. Within 90 days of the incident, the teams will review and assess to make recommendations on policy changes if the death could have been prevented and report to the commissioner. Appropriates $1,484,000 to implement these changes.

The commissioner must provide an annual report to the legislature on the implementation of this legislation as well as comprehensive data on the number of deaths in facilities, uses of force, suicide attempts, transfers from jails to medical facilities, demographic information, and summary data of complaints made against staff. The commissioner is also directed to form a state correctional facilities security audit group made up of DOC representatives, sheriffs, security experts, the ombuds for corrections, and a minority and majority member from each body of the legislature. The group will create minimum security standards to be inspected every two years by the DOC. $111,000 is appropriated over the biennium for these security audits. (SS Chapter 11, Article 9)

**Police Training:** Appropriates $6 million each year until 2026 to fund police training for crisis intervention, de-escalation, and cultural competency. It was named the Philando Castile Memorial Training Fund. Requires documentation on course timelines, instructor qualifications, goals, and objectives, and requires course approval by the POST Board. The POST Board must review all courses after one year and must also keep a list of licensees who completed courses and evaluations of instructors. An additional $2.9 million was appropriated to reimburse local governments for police officer training. (SS Chapter 11 Article 9)

**Prison Release Planning:** Requires the DOC to provide people with comprehensive support when they are released from prison. All people being released from prison after serving any amount of time must be provided with a one-month supply of non-narcotic medication and a prescription for 60 days of additional medication refills – this would include people being released after probation violations. For people who are being released after serving their original sentence (not including probation violations) the commissioner must provide:

- assistance in applying for Medical Assistance or MinnesotaCare;
- assistance in obtaining a Social Security card, a birth certificate, copies of criminal records, a medical discharge summary, and records of programs completed in prison; and
- information on voting rights, the expungement process, local career workforce centers, any fines and fees owed, as well as information on obtaining medical records and applying for benefits like SNAP.

The commissioner must also develop a homelessness mitigation plan by October 2022 and report to the legislature annually on efforts to decrease releasing people from prison into homelessness. The bill also makes identification cards issued by the DOC or the Federal Bureau of Prisons acceptable forms of secondary identification when applying for a primary ID. Appropriates
$389,000 in the biennium to implement these changes and adjusts the base budget for prerelease services in FYs 24 and 25. (Chapter 24)(SS Chapter 11, Article 1)

**Study on Neuropsychological Exams in Court:** Requires the state court administrator to conduct a study looking at presentence examinations for people with traumatic brain injuries, fetal alcohol syndrome disorder, and strokes. The state court administrator must report on whether these examinations should be required under law, what type of crimes they should apply to, and best practices for conducting the exams. Appropriates $30,000 in 2022 for the study which must include consulting prosecutors, public defenders, law enforcement, judges, probation officers, mental health providers, people impacted by this issue, and other interested parties. A report is due to the legislature by February 15, 2022. (SS Chapter 11, Article 2)

**Use of Force in Correctional Facilities:** Bans correctional officers from using choke holds, prone restraints, and tying a person’s limbs behind their back unless use of deadly force is justified. The law also creates a duty to report excessive force or neglect by corrections officers to administration within 24 hours of witnessing the incident. (SS Chapter 11, Article 9)

**Veterans’ Treatment Court:** Creates an alternative sentencing process and Veterans Treatment Court Program for veterans who commit a misdemeanor, gross misdemeanor, or certain lower-level felonies. Veterans must consent to a process to determine whether sexual trauma, traumatic brain injury, PTSD, a substance use disorder, or a mental health condition resulted from their service and if it impacted the crime they are charged with. If criteria are met, veterans will be sentenced to probation instead of incarceration, including Veterans Treatment Courts where available. The new law lists the components of a Veterans Treatment Court including access to treatment, monitoring, inclusion of family members, and partnerships with other agencies such as the VA. Veterans who are successful in the program can have public records of their case sealed, except for private records kept by the Bureau of Criminal Apprehension (BCA). (SS Chapter 12, Article 3)

**Victim Notification for Certain Discharges from Civil Commitment:** Clarifies how a victim of someone committed as someone who has a mental illness and is dangerous to the public can be notified. The victim can send a request directly to the treatment facility where the committed individual is held. (SS Chapter 11, Article 6)

**Sign and Release Warrants:** Requires law enforcement to notify and release a person, rather than arrest them, when they have missed their first appearance in court for certain charges. This only applies the first time a person has missed their appearance and the if summons was issued by mail and returned undeliverable. If the prosecutor finds a public safety risk, they may require bail or conditions of release. Law enforcement may ask a person to sign an acknowledgement that they were notified of their new court date, but the defendant is not required to sign it. The officer will then make a record of the notification and deactivate the warrant as soon as practicable. The law applies to warrants issued on or after January 1, 2024, and requires sheriffs and county district courts to develop procedures to implement this change. (SS Chapter 11, Article 9)
Early Childhood, Education and Special Education

Charter Schools: Requires charter schools to follow the same standards as public schools that prohibit the use of corporal punishment, or the use of physical force such as hitting or spanking to address student behavior. (SS Chapter 13, Article 4)

Digital Well-Being: Appropriates $1 million in FY 22 to the LiveMore ScreenLess organization to address the negative effects of screen overuse and misuse on the development of young people, including the development of depression and anxiety. LiveMore ScreenLess must develop a resource hub promoting digital well-being and identify a network of local and national organizations to address issues including excessive social media use, suicide prevention, and other priorities. The organization must also develop peer-to-peer training for young people to serve as mentors on appropriate screen use. (SS Chapter 13, Article 2)

Home Visiting: Directs the Department of Health (MDH) to award grants to community health boards, nonprofit organizations, and Tribal Nations to start up, sustain, or expand voluntary home visiting programs. Adds criteria on how grant money can be used - to establish, sustain, or expand evidence-based, evidence informed, or promising practice home visiting programs that address health equity, use community-driven strategies, serve families with young children or pregnant women who are high risk or have high needs. This program is for pregnant women or families of young children who are high-risk due to low income, a parent having a mental illness or substance use disorder or experiencing housing instability or domestic abuse. (Chapter 30, Article 3)(SS Chapter 7, Article 1)

Medicaid Billing in Schools: Calls on the Departments of Education (MDE) and Human Services to work with stakeholders to develop a strategy for schools to bill Medical Assistance (MA) for services provided through an Individualized Education Program (IEP) or a Family Service Plan. They must also look at how to reduce administrative burdens for schools in billing MA. The Commissioners of Education and Human Services must issue a report to the legislature by November 1, 2021, laying out their strategy. (SS Chapter 13, Article 5)

Mental Health Education: Requires that when school districts or charter schools include information on preventing suicide or self-harm in their health curriculum, they must use resources provided by MDE or another evidence-based curriculum. (SS Chapter 13, Article 6)

Nonexclusionary Discipline: Appropriates $1.75 million for a one-time grant to school districts, intermediate districts, coops, and charter schools to train school staff on strategies and tools to avoid exclusionary disciplinary practices such as suspensions, expulsions, and student withdrawal agreements. (SS Chapter 13, Article 3)

Sanneh Foundation: Appropriates $1.5 million a year to support students who aren’t doing well in school by providing academic and behavioral interventions and social emotional learning. (SS Chapter 13, Article 2)
**Screen Time:** Prevents a child in a publicly funded preschool or kindergarten from using a tablet or smartphone without engagement from a teacher or other students. This does not apply to students with an IEP or a 504 plan. (SS Chapter 13)

**Special Education Funding:** Appropriates $10.425 million for what is called “cross subsidy aid” or what the local district pays for special education. (SS Chapter 13, Article 5)

**Special Education Recovery Services and Supports:** Requires MDE, local school districts, and charter schools to collaborate with the families of students with disabilities to address the disruption of educational progress due to distance learning caused by the COVID-19 pandemic. This must include a meeting between members of an IEP team to determine what special education services and supports are necessary to address the lack of progress on the student’s IEP goals or loss of learning and skills due to distance learning and COVID-19. The IEP team should also look at other factors impacting the student such as family loss, trauma, and illness. Potential supports include but are not limited to extended school year services, additional IEP supports, mental health supports and compensatory services. (SS Chapter 13, Article 5)

**Suicide Prevention:** Appropriates $265,000 to continue the online, evidence-based suicide prevention training (called Kognito) that can be taken by all school staff. This training must be available free of charge for all school districts, charter schools, intermediate school districts, school cooperatives, and Tribal schools in Minnesota. (SS Chapter 13, Article 6)

### Employment

**Avivo:** Appropriates $650,000 each year to provide education and job skills training integrated with chemical and mental health care services to low-income people. (SS Chapter 10)

**Better Futures:** Appropriates $300,000 each year to provide job training for people leaving prison with a felony level offense. (SS Chapter 10)

**IPS:** Maintains current funding levels at $2.55 million a year for the Individual and Placement and Supports, an evidence-based employment program for people with serious mental illnesses. (SS Chapter 10)

**Reasonable Accommodations for Employees:** Updates the Minnesota Human Rights Act stating that employers must initiate an informal interactive process with an applicant or employee with a disability to determine reasonable accommodations. (SS Chapter 11, Article 3)

**Ujamaa Place:** Appropriates $400,000 each year for job training, employment preparation, internships, housing, education, and vocational training. (SS Chapter 10)

**Unemployment Benefits:** Removes the requirement that if people receive Social Security Disability Benefits it will reduce their unemployment benefits by 50%. SSA must have approved of the person working and that a health care professional certified the person could work. (SS Chapter 10)
**Health Care**

**Dental Care under Medical Assistance:** Increases the dental care rates under MA or MinnesotaCare by 98%. To ensure the impact of this rate increase, managed care or county-based purchasing plans must meet a performance benchmark where at least 55% of children and adults continuously enrolled in a public health program receive at least one dental visit during the coverage year between 2022 and 2024. A report on utilization of dental care under managed care must be sent to the legislature every year. If these benchmarks are not met, dental care will be carved out of managed care and be run by a single administrator. (SS Chapter 7, Article 1)

**Hospital Beds:** Provides clarification for the exemption from the public interest review when a hospital system is redistributing beds within their system. The transferred beds must first replace any mental health or substance use disorder beds that had previously been closed before transferring beds for any other purpose.

Establishes a new process for a health system to close one of its hospitals, relocate health services to another campus, or cease offering maternity and newborn care, intensive care unit services, inpatient mental health treatment, or inpatient substance use disorder treatment. A hospital system wanting to close beds must notify the MDH within 120 days of the closure. Within 45 days of receiving the notice of a hospital closure, downsizing or relocation, MDH must hold a public hearing where the health system must provide an explanation for why they are closing or limiting services and a description of the steps being taken by the health system to ensure continued access to these services, and provide an opportunity for public comment. A health system is exempt from this process if the closure is due to a natural disaster or an inability to provide acceptable care due to a workforce shortage.

Allows Regions Hospital to add 45 new beds, 5 of which must be for mental health. These additional beds cannot be added until the 15 beds authorized previously for mental health are built. Allows 30 new mental health beds for children to be added at PrairieCare. (SS Chapter 7, Article 3)

**Medical Assistance Reimbursement Rates:** Requires DHS to submit an annual report to the legislature on the mean and median reimbursement rates for MA - managed care and county-based purchasing plans and fee-for-service - for certain health care services, including inpatient hospital services and mental health services. (SS Chapter 7, Article 1)

**Periodontal Treatment:** Expands dental coverage under MA to include nonsurgical treatment for periodontal disease or gum disease. (SS Chapter 7, Article 1)

**Postpartum Health Coverage:** Extends postpartum MA coverage from 60 days to 12 months. This will increase access to treatment for postpartum mental illnesses and substance use disorders. This change is effective July 1, 2022, or upon federal approval, whichever is later. (SS Chapter 7, Article 1)

**Medications:** Requires DHS to hold a public hearing before removing a medication from the preferred drug list, or the list of medications that do not require a prior authorization. The
commissioner must provide adequate notice before the hearing and include any public health or clinical evidence that was used to make this decision including any impact on health disparities. For medications on this list, even if it is a brand name, the co-payment is $1 instead of $3.

Allows a 90-day supply for certain generic medications under MA. DHS will determine what medications can be offered a 90-day supply and must publish the list online and provide a 15-day comment-period for public input.

Weight loss drugs can now be covered under MA.

Requires DHS to solicit recommendations from medical organizations, pharmacists, and consumer groups about the composition of the formulary committee (the committee that decides what medications can be covered under MA) and the policies and procedures for how the committee operates. Right now, the requirements to even testify, are quite onerous. (SS Chapter 7, Article 1)

**Telehealth:** Allows for continued flexibility to use telehealth services with video and audio (phone) communication. Telehealth can be used for mental health and substance use disorder services if it is in the best interest of the patient. Removes the weekly cap on the number of telehealth visits a patient can have under MA and requires that telehealth services are reimbursed at the same rate as in-person treatment.

Case management can be done through telehealth, but some situations still require in-person contact or periodic in-person contact. Those situations include children in out-of-home placements, first-time assessments for community-based living services, or reassessments where there is an anticipated change in condition or needs. The prohibition on telehealth for ACT teams is removed. Who can use telehealth under MA is broadened to include peer specialists, mental health rehab workers, mental health behavioral aides, and alcohol and drug counselors.

Private health insurers (not self-insured or ERISA plans) are required to cover telehealth services the same way they would for in-person care. This means that a Minnesota based health plan cannot limit telehealth services based on geography, nor can they deny coverage or charge a lower rate simply because the service was provided via telehealth. Private health plans must also cover audio-only telehealth services when they are appropriate through July 1, 2023. In most cases, unscheduled phone calls would not be covered by insurance, unless it is a mental health or substance use disorder crisis. It also does not allow plans to create a separate network of just telehealth providers and must allow patients to receive telehealth from their in-person provider.

There are documentation requirements for providers to receive payment from MA, including type of service provided and reason for using telehealth instead of an in-person appointment. Certain prescription drugs, such as controlled substances, must have in-person examinations. However, medication assisted therapy prescriptions for substance use disorders may use telehealth examinations.

The bill requires a study be conducted on the impact of telehealth expansion and on pay differences for telehealth services compared to in-person services. Specific areas of concern are
access to health care, quality of care, health outcomes, patient satisfaction, value-based payments, and innovation in care delivery. Among these, the study is concerned with the impact of telehealth on health care disparities, any negative impacts, and quality of telehealth compared to in-person care. There will be an initial report to the legislature by January 15, 2023, with the results and recommendations about continued use of audio-only telehealth. The question with audio-only delivery is if it can eliminate barriers to care for certain populations while keeping care effective and at a high quality. The final report will be presented by January 15, 2024. (SS Chapter 7, Article 6)

**Tobacco Cessation:** Appropriates $8 million in FYs 22-23 and $8 million in FYs 24-25 for tobacco and vaping prevention efforts. (SS Chapter 7, Article 15)

**Transplant Discrimination:** Prohibits a health plan providing coverage for anatomical gifts, organ transplants, or related treatment and services from denying eligibility or coverage based on an enrollee’s disability. Prohibits health care providers and entities that match anatomical gift donors to potential recipients from discriminating in determining eligibility for an anatomical gift or organ donation or providing services related to anatomical gifts or organ donations, based on an individual’s disability. Allows a provider or match organization to take an individual’s disability into account if the disability is medically significant to the organ transplant or anatomical gift. (Chapter 30, Article 14)

<table>
<thead>
<tr>
<th>Higher Education</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Emergency Assistance:</strong> Allocates $269,000 a year to pay for immediate student needs that might prevent them from completing a term such as emergency housing, food, and transportation. (SS Chapter 2, Article 1)</td>
</tr>
</tbody>
</table>

| Fostering Independence Grants: Creates a grant program to subsidize higher education costs at a Minnesota State College and University or the U of MN for people who are or have been in foster care. In order to be eligible, they must be between the age of 13 and 27, have a high school degree, be accepted to or currently attending a Minnesota State School, and have been in foster care in Minnesota after the age of 13 (even if they were subsequently adopted). They have to apply for all other sources of financial aid. The Office of Higher Education must raise awareness about this program and support eligible applicants to complete their applications. (SS Chapter 2) |

| Mental Health Awareness: Invests $1.5 million in one-time funding to create a mental health awareness program at each Minnesota State College for the 2022/2023 academic year. This must include (1) a unique webpage at each institution with tools for self-assessment, links to community resources, and emergency resources, (2) mandatory mental health first aid and suicide prevention training for faculty, students, and staff, (3) information on maintaining good mental health and symptoms of mental illnesses at student orientation, and (4) a messaging strategy to share information on mental health with students during high stress times, including sharing suicide prevention lifelines and text lines. It also requires a pilot on the use of trained peer support for students with mental health conditions. (SS Chapter 2) |
**Housing/Homelessness**

**Emergency Shelter:** Increases funding for the emergency services grant by $12 million in FYs 22-23 and 24-25. This is a grant program administered by DHS that supports emergency shelters for people experiencing homelessness. (SS Chapter 7, Article 15)

**Eviction Moratorium:** Phases out Minnesota’s state eviction moratorium effective June 30, 2021. A landlord can only terminate a lease at the request of the tenant, if the tenant seriously endangers the safety of others or property, engages in serious criminal offences like prostitution or dealing drugs, and other material violations of a lease. Starting 45 days after enactment on August 13, a landlord may terminate or not renew a lease for a tenant for the non-payment of rent if they are not eligible for COVID-19 emergency rental assistance. Starting on September 12, landlords can file evictions for tenants who are behind on their rent and not eligible for emergency rental assistance. Landlords must provide a 15-day written notice before an eviction for the non-payment of rent is filed. Starting on October 12, most of the emergency COVID eviction protections end, allowing landlords to terminate a lease for any legal reason in the lease. The only exception at this time is that landlords cannot evict a tenant for the non-payment of rent if they have a pending COVID-19 rental assistance application. (SS Chapter 8, Article 5)

**Homeless Youth Birth Records:** Simplifies the process for a young person experiencing homelessness to obtain a free and certified birth record. Acceptable documents to confirm the applicant’s identity include an unexpired government issued photo ID, a formal statement from a witness that has known the applicant for two years, or a statement from someone who provides homeless services to the applicant. A birth record obtained in this manner expires after six months, after which the applicant must surrender their birth record and receive a new birth record. (SS Chapter 7, Article 2)

**Homeless Youth Identification Card:** Creates a process for a young person experiencing homelessness to obtain an identification card. To receive the identification card, the young person must submit an application with their full name and birth date, physical characteristics like height and eye color, a birth certificate, and a statement from a staff person at a school or human services agency verifying that the young person lives in Minnesota. This ID card must be provided free of charge. (SS Chapter 7, Article 2)

**Housing Infrastructure Bonds:** Appropriates $100 million in new Housing Infrastructure Bonds (HIB), with $18.333 million dedicated for the rehab or development of single-family homes and $15 million for infrastructure improvements at manufactured home parks. (SS Chapter 8, Article 4)

**Housing Stabilization Services:** Increases administrative funding by $879,000 in FYs 22-23 and $350,000 in FY 24 for the Housing Stabilization Services Medical Assistance benefit. Many providers have faced significant hurdles to becoming licensed for this service and additional administrative resources should be beneficial. (SS Chapter 7, Article 15) Wording is updated in the law to refer to “housing stabilization” instead of “housing supports.” Requires training on vulnerable adults’ documentation of services electronically or on paper. (Chapter 30, Article 13)
**Housing Supports Absence Policy:** Reserves a person’s bed at a housing supports program if they are temporarily absent due to admission to a residential mental health or substance use disorder program, a hospital, or nursing home. The county or tribe must pay the housing support provider during this temporary absence, not to exceed 92 days in a calendar year. (SS Chapter 7, Article 13)

**Housing Supports Rate:** Increases the base rate for Housing Supports (formerly GRH) by $50 per month for a total appropriation of $3.239 million in FYs 22-23 and $7.365 million in FYs 24-25. (SS Chapter 7, Article 13)

**Open Access Connections:** Appropriates $70,000 to this nonprofit that provides voicemail to homeless and low-income people. (SS Chapter 8, Article 1)

**Pro-Rated Rent:** Requires a landlord to offer prorated rent if the lease ends before the end of the month. This means that the tenant must pay the average daily rate of rent for the days they were still in the rental unit. (SS Chapter 8)

**Recuperative Care:** Requires DHS to develop a recuperative care service that can be funded by MA to serve people with chronic health care conditions who are homeless and are being discharged from the ER or hospital. (Chapter 30, Article 1)

**Service Animal Documentation:** Clarifies the process for a tenant with a disability to seek a reasonable accommodation from their landlord to have a service animal or support animal. A support animal provides emotional support and does not need to be trained to perform a specific disability related task. A landlord may require a tenant to provide documentation from a medical professional that confirms the tenant’s disability and the relationship between the tenant’s disability and their service or emotional support animal. Eligible medical professionals include physicians, mental health professionals, and alcohol and drug counselors. A landlord cannot request this documentation if the tenant’s disability is already known by the landlord. It also deletes language requiring the dog to be easily recognized as having been trained at a school for seeing eye dogs, etc. (SS Chapter 8)

**Sprinklers:** Requires automatic sprinkler systems in public housing if it would be required in a building that is being built today. The owner of the building must report their plan for doing this by August 1, 2023. (SS Chapter 10)

**Task Force on Shelter:** Creates a task force to strengthen Minnesota’s emergency shelter system, develop standards for shelter providers, and examine the need for and feasibility of establishing state oversight for emergency shelter providers. Membership includes residents and former residents of shelters, shelter providers, relevant departments, advocates, and other interested parties. The task force must submit a report to the legislature by February 1, 2022. (SS Chapter 8, Article 6)
Human Services

Adoption: Requires DHS to reimburse costs of seeking adoption of a child up to $2,000 to adults receiving NorthStar Kinship assistance benefits or an adult adopting a special needs child. Note that children with special needs who are not citizens or residents of the US are not eligible unless the international adoption was dissolved. (Chapter 30, Article 9)

Case Management Re-Design: Calls on the DHS to create a statewide rate methodology for community-based agencies that have a contract with a county to provide targeted case management services. This work must be done in collaboration with key stakeholders and consider important factors like prevailing wages, administrative costs, caseload sizes, and other cost-drivers for providers. A final draft of this rate methodology must be published at least 30 days before posting the state plan amendment and provide meaningful opportunities for community feedback. Includes a definition of a culturally specific case management program. (SS Chapter 7, Article 11)

Customized-Living: Creates a time-limited exception for a customized-living provider to become licensed without qualifying as an assisted living program. Creates a new set of consumer protections for customized living settings that qualify for this exemption, including a contract that must be signed between the resident, or their representative, and the provider. This contract must explain the process for a referral if the contract is terminated and must include a statement on resident rights making it clear that the resident can decorate their room, access food at any time, have guests at a time of their choosing, and the right to a lockable door. Exempt settings must also have an emergency plan, training on dementia, continuing education standards for facility managers, and a prohibition on physical or chemical restraints for the purposes of discipline or convenience. Calls on DHS to publish a report on customized living by January 15, 2022. (SS Chapter 7, Article 13)

Foster Care: Requires counties to provide health and education records along with social and medical history to children leaving foster care if they are 14 years or older. The law also makes sure that youth aging out of the foster care system have a successful transition to adulthood by expanding who is eligible for this service and expanding case management to age 23. (Chapter 30, Article 10)

HCBS Waiver Suspension: Allows for the temporary suspension of a person’s Home and Community-Based Services (HCBS) waiver while they are receiving treatment for up to 121 days at a hospital, nursing home, transitional care unit, inpatient substance use disorder treatment setting, or Intensive Residential Treatment Services (IRTS) Facility. Upon discharge, the person’s HCBS waiver will be restored at the level it was prior to admission without requiring a new assessment. This solves the issue where if someone was in a facility for over 30 days, they lost their waiver and had to reapply which could take 30-90 days. (Chapter 30, Article 12)

HCBS Waivers: Makes it a bit more difficult for people who do not have a current service agreement to obtain residential care, such as community residential care, customized living services or 24-hour customized living services. A person would need to have complex behavioral or medical needs, considered all other options, and decided these alternatives are not appropriate.
Requires DHS to develop and implement curriculum for assessors and case managers on understanding informed decision making. (SS Chapter 7, Article 10 and 13)

**Health Services Advisory Council:** The council advises DHS on health services covered under MA and MinnesotaCare. This now 13-member council adds a health care or mental health care professional actively engaged in the treatment of people with mental illnesses. (Chapter 30, Article 1)

**Licensing and Background Studies:** Updates standards for human services background studies in response to a severe back-log due to the COVID-19 pandemic. Important changes include allowing the DHS to contract with more than one fingerprint collection vendor, increasing the cost of conducting a background study to reflect the cost of this work, creates a task force to review human services background checks and to identify weaknesses in the program such as excluding potentially qualified applicants. The emergency COVID-19 waiver related to background studies is also extended for one year after the conclusion of Governor Walz’s emergency powers and will expire on July 1, 2022. (Chapter 7, Article 2)

**Medical Cannabis:** Allows for patients enrolled in the Medical Cannabis program to use whole cannabis flower, including the smoking of cannabis, to meet their medical needs. (Chapter 30, Article 3)

**MFIP/DWP Application:** Allows for someone to apply for and be interviewed for MFIP or Diversionary Work Program (DWP) by telephone or the Internet (telepresence). If the person applies online or over the Internet, then they must submit a written application within 30 days. Interviews may take place at the county office, a mutually agreed upon location, a telehealth platform, or by telephone. (Chapter 30, Article 7)

**MFIP Reporting:** Requires a county to contact the person by phone or in writing to obtain the missing information to complete the MFIP household reporting form. (Chapter 30, Article 8)

**Non-Emergency Medical Transportation (NEMT):** Allows the Department of Human Services to provide monthly transportation passes to meet the NEMT needs of recipients who live in communities with strong public transportation networks. (SS Chapter 7, Article 1)

**Personal Care Assistants (PCA):** Reduces the number of hours required to qualify for an enhanced PCA service rate or an enhanced Community First Services and Supports (CFSS) service rate from 12 to 10 hours. Effective January 1, 2022, or upon federal approval, whichever occurs later. Substantially increases PCA rates with an appropriation of $67.560 million in FYs 22-23 and $103.887 million in FYs 24-25. PCAs can transport clients. (SS Chapter 7, Article 13)

**Pharmacist Gag Clause:** Prohibits a health carrier (plan) or Pharmacy Benefit Manager (PBM) from preventing a pharmacist from sharing the cost for the pharmacy to buy a drug, as well as the amount a PBM or health carrier is reimbursing the pharmacist to prescribe the medication. Also prevents a PBM from restricting a conversation between the pharmacist and health carrier about the cost of acquiring the medication, or the reimbursement a PBM offers for prescribing a medication. (Chapter 30, Article 5)
State Advisory Council on Mental Health: Updates the membership to remove a defunct organization and add a representative from MDH, the American Indian Mental Health Advisory Council, and a consumer-run mental health advocacy group. (Chapter 30)

Timely Provider Credentialing: Requires a health plan to decide about credentialing a provider (such as a mental health professional) within 45 days of receiving a complete clean application. The health plan must also notify the provider within 3 days after they have determined there is a problem with their application such as missing information or a problem with the provider. If the health plan finds a substantive quality or safety concern with the applicant, the plan is allowed 30 days to investigate these concerns (Chapter 30, Article 6)

Waiver Re-Imagine: Moves forward with DHS’ efforts to implement the Waiver Re-Imagine program. Requires the department to seek federal approval to reconfigure the HCBS waiver programs into a two-waiver structure for independent and residential options, as well as the development of a payment methodology where the recipient can allocate their own resources. Finally, DHS must also seek authority to transfer the management of HCBS waiver funds from the county to DHS. DHS must regularly seek the input of the public during the implementation of the Waiver Re-Imagine project. This must include an advisory council made up of people with disabilities, family members, mental health and substance use disorder advocates, providers, and other key stakeholders. (SS Chapter 7, Article 13)

Juvenile Justice

Alternatives to Arrest: Authorizes law enforcement to refer a child to a diversion program for petty offenses. If the child is successful in the program, they won’t end up in the juvenile justice system. (SS Chapter 11, Article 9)

Extended Jurisdiction Juveniles: Requires the DOC to include data on children convicted as extended jurisdiction juveniles (EJJ). EJJ is used when a child between the ages of 14-17 is convicted of certain serious offenses and the court imposes a juvenile sentence and then an adult sentence for when the child ages out of the juvenile system. If the child keeps the conditions of their juvenile sentence, they will be placed on probation instead of serving the adult sentence incarcerated. If they are not in good standing at the end of their juvenile sentence, they will then enter the adult prison system. The law requires the DOC to report on the demographics of children convicted as EJJ and analysis on the rates of success and length of probation or executed adult sentences. This legislation was motivated by historical racial and geographical disparities in the use of EJJ. (SS Chapter 11, Article 9)

Juvenile Justice Unit: Appropriates $200,000 each year to the DPS to establish and maintain a Juvenile Justice Unit. This money will go to fund positions through the Juvenile Justice Advisory Committee, including a full-time position dedicated to improving mental health services in the juvenile system and supporting children of incarcerated parents. (SS Chapter 11, Article 1)

Shackling Ban: Bans the use of restraints on children when appearing in court unless the court finds there is no less restrictive alternatives to prevent harm or flight. Each judicial district must develop protocols to implement this law by April 1, 2022. (SS Chapter 11, Article 9)
Mental Health Care

**County Share at CABHS:** Requires counties to cover the cost of care at the Child and Adolescent Behavioral Health Services (CABHS) facility in Willmar when the patient is ready for discharge. This was previously only a requirement for state-operated mental health programs for adults at the Community Behavioral Health Hospitals (CBHHs) and the Anoka Metro Regional Treatment Center (AMRT). (SS Chapter 7, Article 12)

**Certified Community Behavioral Health Clinic (CCBHC):** Expands CCBHCs which are “one stop shops” for mental health and substance use disorder care for any that meet federal requirements without limits on geographic area or region. DHS must consult with key stakeholders including CCBHC providers when developing or making changes to this certification process. Clarifies that CCBHCs may collaborate with existing mobile crisis teams to comply with standards for CCBHCs and may coordinate with other entities to provide other mandated services. Provides flexibility for DHS to continue accessing Federal CCBHC demonstration project funding if this is available. Clarifies aspects of the prospective payment rate including making it provider specific. (Chapter 30, Article 11)

**Direct Care and Treatment:** Requires DHS to assess state-operated treatment programs to determine the extent to which these programs function as safety-net services and to make recommendations on how state-operated programs can enhance the continuum of services and improve access, along with identifying new care delivery models addressing community needs (such as urgent care, facilities that provide a higher level of care to meet complex needs, crisis respite, caregiver respite for older adults, crisis stabilization, and community residential short-and long-term stay options). The report must include how to fund it. (SS Chapter 7, Article 12)

**Gambling:** Requires DHS, in consultation with MDH and chairs of relevant legislative committees to look at who is managing the current compulsive gambling program and whether a different division or agency should be responsible for it. (Chapter 30, Article 11)

**Mental Health Rates:** Appropriates $486,000 in FY 22 and $696,000 in FY 23 for an analysis of the current rate-setting methodology of outpatient mental health and substance use disorder treatment under MA and MinnesotaCare. A preliminary report must be submitted by January 14, 2023, and final report by January 15, 2024. The final report must include legislative language necessary to modify the existing rate structure or implement a new rate methodology. (SS Chapter 7, Article 15)

**Mobile Crisis Services:** The Uniform Services Standards bill also consolidates crisis response services for children and adults into one section of state law. This does not include residential crisis stabilization services, which are still only available for adults. Establishes the standards for crisis standards to include employing evidence-based practices to reduce the risk of suicide or self-injurious behavior, engaging the recipient and developing a plan for responding to mental health crises including engaging via phone or text until a face-to-face visit is possible, accepting calls from third-parties like family or friends, providing support to third parties including restricting access to items that may be used for a suicide attempt, and considering other available services that could meet the recipient’s needs. Ensures that crisis teams must engage the
recipient’s family and natural supports whenever possible. Clarifies that the training for mobile crisis teams under the Uniform Service Standards must focus on providing crisis services to children and adults, including training on evidence-based practices to reduce the risk of suicide or self-harm. There is also a significant, one-time funding increase of $16.429 million in FYs 22-23 and $4.117 million in FY 24 in the Health and Human Services omnibus budget bill. (SS Chapter 7, Article 11)

**Uniform Service Standards**: Creates a uniform licensing framework for community-based mental health providers in a new chapter of law numbered 245I. Before the passage of this bill, there were conflicting certification standards and multiple definitions for key terms governing mental health services such as IRTS and community-based mental health clinics and common standards for key terms like mental health professional, diagnostic assessment, treatment supervision and others. The differences were found in the children’s mental health act, the adult mental health act, and Medical Assistance law.

 Specifies the training that staff in mental health programs must receive including initial training (client rights, emergency procedures, and specific needs of the clients they will serve), before interacting with clients (mental illness, de-escalation, psychotropic medications and their side-effects, and co-occurring substance use disorders), and within 90 days (trauma-informed care, person-centered treatment, culturally responsive practices). The training standards for programs serving children are different and staff must receive training within 90 days of starting employment on trauma-informed care, family-centered treatment plans, culturally responsive practices, and child development. Before the passage of this law, there were different training standards for community-based mental health providers.

 Creates a common set of standards for diagnostic assessments and treatment planning. When conducting a diagnostic assessment, the mental health professional or clinical trainee may delay obtaining information from the patient if this would retraumatize the patient or make it more challenging to engage the patient in treatment. Allows up to ten sessions in a year of therapy, (individual, group, family) under a brief diagnostic assessment, as well as up to five days of day treatment or partial hospitalization. Other key changes include requiring the use of the DC:0-5 framework published by Zero to Three for the diagnosis of children under the age of five.

 The common standard for an individual treatment plan, which is developed after a diagnostic assessment, must include a person-centered and culturally appropriate planning process where the family members and the natural supports of both children and adult clients must have the opportunity to observe and participate if it is in the best interest of the client. If the client’s family and natural supports are not included, the provider must document why these individuals were not included.

 Standardizes client rights across community-based mental health programs. The provider must provide a copy of these rights on admission and, if the provider restricts the client’s rights, they must document the approval of this restriction and why it was necessary.

 The provider must return the client’s property upon discharge. If the client leaves property at the facility or program, the provider must hold it in storage for a minimum of 30 days. Develops a
new set of certification standards to replace the rule 29 standards for a mental health clinic. This includes minimum staffing levels, treatment supervision requirements, application standards, and the process for DHS to submit corrective orders or to decertify a provider.

Simplifies the standards for IRTS and Residential Crisis Stabilization (RCS) programs. Creates new discharge standards for these programs as well, including program-initiated discharges. Defines a successful discharge as accomplishing the goals in the treatment plan and arranging for the client to continue receiving treatment at a less intensive setting.

Importantly, this language also sets standards for a program-initiated discharge. In order to discharge a patient who has not completed their treatment goals, the patient must not be engaging in treatment and be so disruptive that the level of care is ineffective or unsafe and the client is not making progress in their treatment goals despite persistent efforts from the provider. A client can also be discharged before completing their treatment goals if they meet the criteria for a more intensive level of care and that care is available. The provider must notify the client, the client’s family or natural supports, and their case manager of a decision to make a program-initiated discharge.

Following a discharge, the provider must provide the client with a discharge summary explaining why they were discharged, the alternatives considered by the provider, who was involved in this decision, and the recommended supports for the client to transition to another program. There are also numerous technical and conforming changes to bring the rest of statute into alignment with the many changes in the Uniform Service Standards Section. (Chapter 30)

<table>
<thead>
<tr>
<th>Miscellaneous</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Youth Recreation Providers:</strong> Requires all employees or supervisors of a public or private youth recreation program like a theater camp to be mandatory reporters of suspected child abuse within the past three years. (SS Chapter 7, Article 10)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Substance Use Disorder</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Culturally Responsive:</strong> Defines culturally responsive and disability responsive substance use disorder treatment programs (instead of calling it special populations) and increases rates for these programs by 5%. Also requires DHS to develop a statewide implementation plan for providers to meet the CLAS standards (Culturally and Linguistically Appropriate Services). (SS Chapter 7, Article 11)</td>
</tr>
</tbody>
</table>

| New Programs: Requires providers who are developing new substance use disorder treatment programs to notify the county at least 60 days prior to submitting the application to DHS. The notification must include who they will be serving and a description of the program. The county then submits their recommendation to DHS as to whether the program should go forward or not. (Chapter 30, Article 2) |
**Opiate Antagonist**: Prohibits a life insurance provider from modifying, canceling, or altering a policy solely because the applicant has a prescription for an opiate antagonist such as naltrexone and naloxone. (Chapter 10)

**Opioid Prescribing Work Group**: Adds two people to the work group who have used or are using opioids to manage chronic pain and a person from MDH. (Chapter 30, Article 1)

**Opioid Treatment Providers**: Requires DHS to evaluate the rate structure for opioid treatment programs and make recommendations to the legislature. (SS Chapter 7, Article 11)

**Paperwork Reduction**: Requires DHS to collaborate with counties, managed care organizations, substance use disorder professional associations, and other key stakeholders to recommend systems improvements that will reduce paperwork requirements for providers. The commissioner must contract with a vendor to develop recommendations. (SS Chapter 7, Article 11)

**Pathfinder**: Provides for Anoka County and the North Metro Mental Health Roundtable to work with an academic institution to evaluate the effectiveness of the telephone-based Pathfinder Companion application that connects people with substance use disorders with peers, resources, providers, and others. Appropriates $550,000. (SS Chapter 7, Article 11)

**Sober Housing**: Creates a task force to make recommendations on how to increase access to sober housing programs, promote person-centered practices and cultural responsiveness, potential oversight strategies, and to ensure that basic consumer protections for sober housing residents. Task force members include NAMI Minnesota, residents and former residents of MN sober housing programs, sober housing providers, and other key stakeholders. The report is due to the legislature by September 1, 2022. (SS Chapter 7, Article 11)

**Substance Use Disorder Community of Practice Task Force**: Appropriates $500,000 in FYs 22-23 and 24-25 to create a task force to identify gaps, increase knowledge, and improve treatment outcomes for people with substance use disorders and reduce disparities by using evidence-based practices. It includes members from relevant agencies, providers, Tribal Nations, and individuals with lived experience. (SS Chapter 7, Article 11)

**Substance Use Disorder Demonstration Project**: Allows outpatient substance use disorder providers to participate in the substance use disorder demonstration project and obtain an enhanced rate. Prevents providers from qualifying for the enhanced rate if they are not complying with the provider standards for this program by July 1, 2022. Calls on DHS to create a workgroup of program participants and seek a five-year extension of the demonstration project. (SS Chapter 7, Article 11)

**Workforce**

**Continuing Education**: Requires continuing education for psychologists, Licensed Marriage and Family Therapists (LMFTs), social workers, and Licensed Professional ‘Clinical Counselors (LPCCs) to include at least four hours on addressing the psychological needs of individuals from
diverse socioeconomic and cultural backgrounds. Topics include understanding culture, its functions, and strengths that exist in varied cultures; understanding clients’ cultures and differences among and between cultural groups; understanding the nature of social diversity and oppression; and understanding cultural humility. These standards are effective July 1, 2023. (SS Chapter 7, Article 4)

**Culturally Informed and Responsive Mental Health Task Force:** Creates a task force to make recommendations on recruiting diverse mental health professionals, training all mental health providers on cultural competency and cultural humility, assessing the quality of current efforts to provide culturally competent care, and to increase the number of mental health organizations owned, managed, or led by someone from the Black, Indigenous, and people of color (BIPOC) community. The task force membership includes the licensing boards, education programs, providers, advocates, and others. Annual reports must be provided to the legislature. The task force ends in January 2025. Appropriates $222,000 in FYs 22-23 and $194,000 in FY 24 to fund this task force. (SS Chapter 7, Article 11)

**Increasing Diversity of Mental Health Supervisors:** Requires MDH to work with relevant licensing boards to develop a grant program for mental health professionals of color or from underrepresented communities to become supervisors. This includes social workers, marriage and family therapists, psychologists, and professional clinical counselors. Eligible grantees must provide services in the community where at least 25% of their patients are on a public health program like MA or a formal sliding fee schedule. This work is supported with a one-time appropriation of $1 million in FYs 22-23. (SS Chapter 7, Article 4) In addition, funding under children’s mental health grants can be used to pay for supervision or clinical trainees who are BIPOC. (SS Chapter 7, Article 11)

**Internationally Trained Professionals:** Provides $1M each year to help internationally trained professionals obtain the training needed to take the license exams. Includes providing English instruction and supportive services. (SS Chapter 10)

**Loan Forgiveness:** Expands MDH’s health professional loan forgiveness program to licensed alcohol and drug counselors that practice in rural or underserved urban communities. This change is temporarily authorized in statute and not permanently added until July 1, 2025. Appropriates $6.624 million in FYs 22-23 and $7.624 million in FYs 24-25 and adds that these funds are for medical residents, LADCs and mental health professionals – including pediatric psychiatry - who agree to deliver at least 25% of their patient encounters to people on MA or MinnesotaCare or through formal sliding fee scales. (SS Chapter 7, Article 3)

**Mental Health Practitioners:** Expands who can be a mental health practitioner to include someone in the process of completing a practicum or internship as part of their undergraduate or graduate level program in social work, psychology, or counseling. This means that a mental health agency can bill for the work being provided by people doing a practicum or internship and the intern can be paid for their work. (SS Chapter 7, Article 11)

**Mental Health Professional Licensing Boards:** Requires licensing boards for psychologists, LMFTs, and LPCs to have members from outside of the seven-county metro, people of color,
and underrepresented communities (defined as a group that is not in the majority with respect to race, ethnicity, national origin, sexual orientation, gender identity, or physical ability). (Note the Board of Social Work adopted these standards a year ago). (SS Chapter 7, Article 4)

**PSYPACT:** Authorizes Minnesota to enter the Psychology Interjurisdictional Compact or PSYPACT. Under this agreement, a psychologist licensed in one compact state can provide treatment via telemedicine or limited in-person treatment in any compact state. (Chapter 27)

**Acronyms:**
- CABHS = Child and Adolescent Behavioral Health Services
- CADI = Community Access for Disability Inclusion
- CARF = Commission on Accreditation of Rehabilitation Facilities
- CCBHC = Certified Community Behavioral Health Centers
- CH = Chapter in Session Law
- CLAS = Culturally and Linguistically Appropriate Services
- COA = Council on Accreditation
- DHS = Department of Human Services
- DOC = Department of Corrections
- DPS = Department of Public Safety
- FY = Fiscal Year
- HCBS = Home and Community Based Services
- IEP = Individual Educational Program
- IMD = Institute for Mental Disease
- IRTS = Intensive Residential Treatment Services
- MA = Medical Assistance or Medicaid
- MDH = Minnesota Department of Health
- MFIP = Minnesota Family Investment Program
- PBIS = Positive Behavior Interventions and Support
- PBM = Pharmacy Benefit Manager
- PCA = Personal Care Attendant
- POST Board = Peace Officer Standards and Training Board
- PRTF = Psychiatric Residential Treatment Facility
- QRTP = Qualified Residential Treatment Program
- SNAP = Supplemental Nutrition Assistance Program
- SS = Special Session
- SSA = Social Security Administration
- SUD = Substance Use Disorder

NAMI Minnesota
1919 University Avenue West, Suite 400
St. Paul, MN 55104
www.namimn.org

August 8, 2021