NAMI Minnesota
2019 Minnesota Legislative Session
Summary of New Laws Affecting
Children and Adults with Mental Illnesses and Their Families

Adult Mental Health

Farmers' Mental Health: Increases base funding $250,000 per year to provide mental health supports to Minnesota farmers and the agricultural community. Also appropriates $50,000 a year to conduct additional community outreach on farms and provide rural mental health services including the 24-hour hotline, service availability, and mental health forums. Of this appropriation, $12,000 each year is to provide professional development training for Farm Business Management instructors in the Minnesota State System. (SS Ch 1, Article 1)

Maternal Mental Health: Designates May as Maternal Mental Health Awareness Month in order to increase awareness of the prevalence of pregnancy and postpartum mental health issues and to educate people about the symptoms and treatment options. (SS CH 9, Art, 13)

Room and Board: Allows Intensive Residential Treatment Services (IRTS) facilities and crisis homes to receive the higher room and board rate currently available to substance use disorder residential treatment facilities. Also specifies that housing supports providers cannot limit the number of hours a client works. (SS CH 9, Art. 6)

Children's Mental Health

Background Studies: Requires anyone working in a children's residential facility to have a background check whether or not they will have direct contact with children. The Department of Human Services will charge no more than $51 per study. Does not allow the department to set aside a disqualification of a crime for someone working in a children's residential facility that was a physical assault or battery or a drug-related offense within the past five years. (SS CH 9, Art. 2)

Care Coordination: Requires hospitals when discharging a child with a high-cost medical or chronic condition who needs care when they leave the hospital and who may be at-risk for recurrent hospitalization or emergency department services to notify the primary care physician or the MA managed care provider and make arrangements for home health care or care coordination. It's not clear if this includes serious mental illnesses, which can at times be considered a chronic condition. (SS CH 9, Art. 11)

Children's Intensive Services Reform: Appropriates $7.917 million in FYs 2020-2021 and $18.187 million in FYs 2022-2023 to support intensive children's mental health services. The Centers for Medicare and Medicaid (CMS) determined that most of Minnesota's children's residential treatment programs were Institutes of Mental Disease (IMDs), which means that services cannot be billed to Medical Assistance. The legislature filled in the loss of funding last

year until May 30 of this year. This new funding will be used to cover the lost federal share for residential treatment services starting June 1. Another key use of this funding will be adding additional Psychiatric Residential Treatment Facility (PRTF) beds in Minnesota. PRTFs offer a higher level of care than Minnesota's residential mental health treatment and can bill MA. This will allow 80 new PRTF beds to be developed in 2020 and another 70 PRTF beds in 2023. The department can prioritize programs that will serve children and youth with aggressive and risky behavior, multiple diagnoses, neurodevelopmental disorders or complex trauma related issues. $400,000 is available each year for start-up grants for new PRTFs. (SS CH 9, Art. 6)

Child Welfare Training Academy: Funds the Child Welfare Training Academy at $4.160 million in FYs 2020-2021 and $5.761 in FYs 2022-2023. This will create a statewide child welfare training academy that will offer evidence-based trainings through five regional hubs. It will create the state's first standardized curriculum and certification process to address the issues in Minnesota's child protection system. There is also one-time funding to conduct a child welfare caseload study. (SS CH 9, Art. 1)

Family Enhancement Center: Appropriates $100,000 in one-time funding to the Family Enhancement Center in Minneapolis to increase access to children's mental health services. (SS CH 9, Art. 6)

Foster Care: Allows Medical Assistance (MA) to be paid for children in foster care but who aren't eligible for Title IV-E funds but are eligible for foster care or kinship assistance. This means these children will have increased access to a variety of mental health services. (SS CH 9, Art. 7)

Foster Home Variances: Allows a variance to the number of additional foster children in a home if it is to care for the siblings, the child of a youth, the child has a special connection to the family, or the family is specially trained to care for children with serious disabilities. The foster home must prove there is no risk of harm to current children and that they have enough room. (SS CH 9, Art. 2)

Health Care Disparities: Requires the Department of Health in consultation with the Department of Education to develop a plan to convene groups to examine the health and educational disparities for children from communities of color and American Indian communities. The plan must be provided to the legislature next session. It also establishes the Community Solutions for Healthy Child Development grant program to improve outcomes of these children and appropriates $1 million a year. (SS CH 9, Art, 11)

PANDAS: Appropriates $158,000 in FYs 2020-2021 and $210,000 in FYs 2022-2023 to reimburse for PANDAS and PANS treatment that would not otherwise be covered by the individual's health plan. Pediatric Autoimmune Neuropsychiatric Disorders Associated with Streptococcal Infections (PANDAS) and Pediatric Acute-Onset Neuropsychiatric Syndrome (PANS) are very challenging health conditions that can lead to ADHD, sudden mood changes, Obsessive Compulsive Disorder, and other challenges like hyperactivity or unusual, jerky movements. (SS CH 9 Art. 8)

School-Linked Mental Health: Expands the list of eligible grantees for the school-linked mental health program to include a community mental health center or clinic, an Indian health facility, a Children's Therapeutic Services and Supports (CTSS) provider, or an MA enrolled mental health or substance use provider with at least two mental health professionals or two alcohol and drug counselors qualified to provide clinical services to children and families.

This legislation also clarifies that allowable grant expenses for school-linked mental health grants include identifying and diagnosing a mental illness; delivering mental health treatment to children and families via telemedicine; supporting families in meeting the needs of their child with a mental illness including navigating the health care, social services, and the juvenile justice system; providing transportation for students during the summer to receive school-linked services; building the capacity of school staff to meet the needs of students with mental illnesses; and purchasing equipment and developing the infrastructure for telemedicine. Grantees are also required to provide data to the Department of Human Services to evaluate the effectiveness of the program.

The Department of Human Services must also collaborate with the Department of Education, representatives from the education community, mental health providers and advocates in order to assess and make recommendations for Minnesota's school-linked mental health program. These recommendations must include strategies to promote stability among current school-linked grantees, assessing the minimum number of full-time equivalents needed per students to effectively meet the goals of the program, developing a funding formula that promotes sustainability and consistency across grant cycles, reviewing existing data practices and evaluation strategies, and analyzing the impact on outcomes when a school has school-linked mental health services, a multi-tiered system of supports like PBIS, and sufficient school support personnel to meet student needs. This report must be provided to the legislature by January 15, 2020. Funding for school-linked mental health grants also increased by $1.201 million in FYs 2020-2021 and $9.6 million in FYs 2022-2023. (SS CH 9, Art. 6)

TEFRA Enrollment: Simplifies TEFRA enrollment and notifies people about potential eligibility for TEFRA through MNsure. TEFRA is a program that allows families with higher incomes to access MA if they have a child with a serious medical or mental illness. Appropriates $122,000 in FYs 2020-2021 and $126,000 in FYs 2022-2023. This includes developing content on TEFRA for the MNsure portal and the creation of a stakeholder group to convene and make recommendations on other strategies to simplify the enrollment and renewal process for TEFRA. (SS CH 9, Art. 5)

TEFRA Fees: Reduces the family fees under TEFRA by 15%. A family whose income is between 275-545% of poverty would have their fee go from 1.94% to 1.65% of adjusted gross income. (SS CH 9, Art. 5)

Tribal Child Welfare Initiative Expansion: Appropriates $15.534 million in FYs 2020-2021 and $25.003 million to strengthen the delivery of child welfare and child abuse prevention services to American Indian children and families. (SS CH 9, Art. 1)

Criminal Justice/Juvenile Justice/Legal Issues

Community Supervision Pilot Project: Appropriates one-time grant funding of $400,000 to Anoka County for a pilot project to provide enhanced assessment, case management, treatment services, and community supervision for offenders with mental illnesses and symptoms that put them at risk of recidivism or heightened risk of harming themselves or others. Included in this pilot project will be the development of a multidisciplinary case-load management team made up of at least one probation officer and social services professional who share case management responsibilities. Anoka County must submit a report to the legislature by October 1, 2021 on the impact of the pilot project. (SS CH 9, Art. 6)

Competency Restoration Task Force: Establishes a task force to address the increasing numbers of people deemed incompetent to stand trial and who end up in a state operated program from a jail. Members include representatives from various state agencies, county attorneys, public defenders, Minnesota's Protection and Advocacy System, Ombudsman for Mental Health and Developmental Disabilities, MN Hospital Association, counties, Chiefs of Police, Psychological Association, Psychiatric Society, advocates, Sheriff's Association, Sentencing Guidelines Commission, providers, crime victims and more. There are specific actions that must be taken, including identifying current resources, analyzing trends, conducting case reviews, and researching what other states are doing. A preliminary report is due by February 1, 2020 with a final report due the following year. $200,000 is appropriated to the Department of Human Services to help carry out this work. (SS CH 9, Art, 6)

Corrections Ombudsperson: Re-starts the Ombudsperson for Corrections office in Minnesota. This office is a neutral, third party to investigate complaints from prisons, jails or juvenile detention facilities. The ombudsperson can prescribe the methods by which complaints are to be made, reviewed, and acted upon; determine the scope and manner of investigations to be made; determine how findings and recommendations will be shared; have access to information including examining records and documents; enter and inspect, at any time, the premises; subpoena any person to appear, give testimony, or produce documentary or other evidence that the ombudsperson deems relevant to a matter under inquiry; and be present at commissioner of corrections parole, supervised release, and parole revocation hearings and deliberations. Minnesota has been without a Corrections Ombudsperson since the program was eliminated in 2003. (SS CH 5, Art. 3)

Correctional Officers: Appropriates $7.6 million in FYs 2020-2021 to hire 67 correctional officers and $11.103 million in FYs 2022-2023 to hire 78 correctional officers for Minnesota prisons. There is also $2.675 million in FYs 2020-2021 and $4.076 million in FYs 2022-2023 to recruit and retain correctional officers. (SS CH 5, Art. 1)

Family Law: Appropriates a little over $1 million a year to provide legal services to low-income clients on family law issues. (SS CH 5, Art. 1)

Juvenile Justice Reform: Appropriates $280,000 per year to provide juvenile justice services and resources to Minnesota counties, as well as $220,000 a year in grants for local organizations to establish juvenile detention alternatives. (SS CH5, Art. 1)

Mental Health Screening: Creates a process for jails to share a positive mental health screen with the local county social service agency upon that inmate's discharge to the community. Private information may be shared about this inmate with the positive mental health screen in order to provide support to apply for MA, make a referral for case management, acquire a state ID card, make a timely appointment with a therapist or community mental health provider, provide a prescription for a medication, or coordinate mental health and substance use disorder services. If the offender refuses services, all their private data received from the jail must be destroyed within 15 days. (SS CH 9, Art. 6)

Police Officer Training: Appropriates $6 million per year in FYs 2020-2021 to strengthen police officer training, including crisis intervention training and de-escalation techniques when encountering someone experiencing a mental health crisis. Appropriates $2,949,000 each year is for reimbursements to local governments for peace officer training costs. $100,000 each year is for training state and local community safety personnel in the use of crisis de-escalation techniques. The board must ensure that training opportunities provided are reasonably distributed statewide. (SS CH 5, Art. 1)

Public Defenders: Appropriates $3 million per year for new public defenders and support staff and adds additional funding to increase their salaries. (SS CH 5, Art. 1)

Psychological Exams: Funds the additional $1 million a year to carry out mandated psychological services to assess whether someone is competent to stand trial. (SS CH 5, Art. 1)

Solitary Confinement: Restricts the use of solitary confinement in statute, rather than a department policy. Limits the use of solitary confinement to the most serious or persistent rule violations such as a serious threat to life, property, people or self. There will be a continuum of interventions including step-down management and a due process method for all discipline proceedings. The department will design and implement a system of incentives so that an inmate can "earn" their way back into the general population. It establishes minimum standards for conditions in a solitary unit including dimmed lights during evening hours and requires that everyone placed in solitary confinement receive a mental health screening within 24 hours of their placement. There are to be daily wellness checks by health services staff to assess the mental health of someone in solitary and a review by the Commissioner after 30 days. People cannot be discharged back to the community if they have spent more than 60 days in solitary confinement absent a compelling reason like inmate safety. It requires the Department of Corrections to deliver a yearly report to the legislature on the use of solitary confinement in Minnesota prisons including information as to the numbers placed in solitary, their ages and race, length of time and disciplinary sanctions by infraction. (SS CH 5, Art. 3)

Treatment Courts: Funds $306,000 each year for current treatment courts. (SS CH 5, Art. 1)

Veterans: Appropriates $200,000 each year for a grant to a domestic abuse prevention program that provides interdisciplinary, trauma-informed treatment and evidence-informed intervention for veterans and current or former service members and their whole families affected by domestic violence. The grantee must offer a combination of services for perpetrators of domestic violence and their families, including individual and group therapy, evaluation and research of programming, and short- and long-term case management services to ensure stabilization and increase in their overall mental health functioning and well-being. (SS CH 5, Art. 1)

Early Childhood, Education and Special Education

Child Care: Requires more timely responses to people seeking childcare who are homeless. Exempts these families from activity participation requirements for three months. (SS CH 9, Art. 1)

District or Statewide Assessments: Requires the Department of Education to amend Minnesota Rules to allow, but not require, a report on a student's performance on general or state districtwide assessments if they have an Individualized Education Program (IEP). (SS CH 11, Art. 4)

Due Process: Adds that a parent who disagrees with the Individualized Education Program (IEP) can, instead of requesting a conciliation conference, identify the specific part of the proposal the parent objects to and request a meeting with appropriate members of the IEP team. If a parent wants a conciliation conference, they will need to specifically request one. (SS CH 11, Art. 4)

Dyslexia Screening: Requires every student not reading at grade level in kindergarten, grade 1 and grade 2, to be screened for the characteristics of dyslexia. This test will be developed at the local level. Students grade three and older must be screened for dyslexia using a locally developed test if they are facing challenges with reading, unless a different reason for the reading difficulty has already been identified. (SS CH 11, Art. 2)

Dyslexia Training: Requires board-approved teacher preparation programs for teachers of elementary school, early childhood education, special education, and reading intervention to include instruction on supporting students with dyslexia. This instruction must be modeled on standards set by the International Dyslexia Association and include the nature and symptoms of dyslexia, resources available for students who show the characteristics of dyslexia, evidence-based approaches for students with the characteristics of dyslexia, and outcomes of intervention and lack of intervention for students who show the characteristics of dyslexia. (SS CH 11, Art. 3)

Mental Health Education: Requires the Department of Education to provide school districts and charter schools with curriculum on mental illnesses for students between grades 4-12 for health classes on a yearly basis. This information will be gathered by Minnesota mental health advocates and must also include resources on suicide and self-harm prevention. (SS CH 11, Art. 5)

Safe Schools: Increases funding for safe schools based on the closing balance of the safe schools supplemental aid on June 30, 2019. It could be anywhere from $30 to $33 million. It can be used for school liaison officers; drug abuse prevention programs; crime prevention; voluntary opt-in suicide prevention tools; violence prevention; licensed school counselors, licensed school nurses, licensed school social workers, licensed school psychologists, and licensed alcohol and chemical dependency counselors; facility security enhancements including laminated glass, public announcement systems, emergency communications devices, and equipment and facility modifications related to violence prevention and facility security; improving the school climate; or to pay costs for co-locating and collaborating with mental health professionals who are not district employees or contractors. (SS CH 11, Art. 5)

Special Education Funding: Increases special education funding by $90.691 million in FYs 2020/2021 and $142.191 million in FYs 2022-2023. This will freeze what is called "special education cross-subsidy" which is the amount of money local schools use to pay for special education costs that are not covered by state or federal funds. The per pupil aid for special ed is also increased. (SS CH 11, Art. 4)

Suicide Prevention Training: Appropriates $265,000 for an evidence-based, online suicide prevention training program for teachers and other school personnel. This training must be available across the state for every school district, charter school, intermediate school-district, service cooperative, and tribal school. The Department of Education must also survey training users to assess the value of the training, track the number of teachers trained, and the time it took to complete the training and share this information with the Legislature. (SS CH 11, Art. 5)

Employment

Individual Placements and Supports: Appropriates $1.8 million in one-time funding for Individual Placements and Supports (IPS). This is an evidence-based program that supports people with serious mental illnesses find and keep employment. This funding must be used to expand to areas of the state without an IPS program and to expand existing IPS programs, including those that do not currently receive state funding. (SS CH 7, Art. 1)

Jobs: Provides $250,000 each year to Avivo to provide low-income individuals with career education and job skills training that is fully integrated with chemical and mental health services. (SS CH 7, Art. 1)

Reentry: Appropriates $150,000 each year for a grant to Better Futures Minnesota to provide job skills training to individuals who have been released from incarceration for a felony-level offense and are no more than 12 months from the date of release. Appropriates $188,000 each year for a grant to AccessAbility Incorporated to provide job skills training to individuals who have been released from incarceration for a felony-level offense and are no more than 12 months from the date of release. $500,000 each year is for a grant to Ujamaa Place for job training, employment preparation, internships, education, training in vocational trades, housing, and organizational capacity building. (SS CH 7, Art. 1)

State Jobs: Creates an Advisory Task Force on State Employment and Retention of Employees with Disabilities. It includes members from a variety of commissions and departments that focus on people with disabilities. They are to provide a report to the legislature on how to attract and retain employees with a disability by January 15, 2021. (SS CH 10, Art. 2)

Vocational Rehabilitation: Appropriates $14.3 million per year for Vocational Rehabilitation Services. This is a vital program operated by the Department of Employment and Economic Development (DEED) that helps people with disabilities find a job. (SS Ch 7, Art. 1)

Health Care

Blue Ribbon Commission: Establishes a Blue Ribbon Commission to advise the legislature and governor in transforming the health and human services system to be more efficient and less costly. It includes legislators, commissioners for health and human services, people with expertise in health and human services – including cultural responsiveness. A report is due by October 1, 2020. (SS CH 9, Art, 7)

Disability Waivers: Appropriates $34.234 million in FYs 2020-2021 and $30.271 million in FYs 2022-2023 to add a competitive workforce factor in the rates to ensure that Home and Community Based Services (HCBS) providers receive adequate reimbursement through the DWRS system. The Disability Waiver Rate System or DWRS is the uniform, statewide methodology to determine reimbursement rates for HCBS under Medical Assistance, including the CADI waiver which provides supports for people with mental illnesses. Minnesota created the DWRS system in response to a decision from CMS that our HCBS system was out of compliance. (SS CH 9, Art. 5)

Emergency Prescription Refills: Allows a pharmacist to fill a prescription without a current prescription (such as when the number of refills allowed have been used up) if the patient has been compliant with taking the medication, the pharmacy has a record of the patient receiving this medication, the pharmacy has been unable to contact the prescriber, the drug is essential to sustain the life of the patient or continue therapy for a chronic condition, failure to dispense the medication would harm the health of the patient, and the drug is not a controlled substance. If these criteria are met, the pharmacist can dispense a 30-day supply or the quantity in the earlier prescription, whichever is less. The pharmacy may only dispense the same drug to the same patient using this new law once every 12 months. (SS CH 9, Art. 9)

Hospital Bed Moratorium: Changes the public interest review process for adding more hospital beds. There is currently a moratorium on the development of new inpatient hospital beds. In order to add beds, a hospital must go through a public interest review to determine whether there is a need for additional inpatient beds. This legislation changes the definition of available beds for the purpose of the public interest review from all existing hospital bed licenses to every bed that is immediately available or could be brought online within two days. Following the creation of the hospital moratorium, many systems chose to "save" bed licenses for future expansion. This change will require the Department of Health to only consider existing beds – instead of the total number of bed licenses - when making the public interest review. The department must

review the application within 150 days and then provide a copy to chairs of appropriate legislative committees. (SS CH 9, Art. 11)

Medicaid Waivers: Requires the Department of Human Services to develop a plan to consolidate the five current Medicaid Waivers – including the CADI waiver that serves people with mental illnesses – into two new waivers to make it easier to navigate and administer. The plan must include any necessary state plan amendments, rule changes, funding that is necessary to make these changes and the work done by the department to solicit feedback and input from providers, people accessing a Medicaid waiver, family members, and advocacy organizations. The report is due in January of 2021. People with disabilities on Medical Assistance use a waiver to receive the additional services and supports necessary for them to live independently in the community. Requires at least a yearly review of the plan. (SS CH 9 Art. 5)

MA Spenddown: Appropriates funding to decrease the MA spenddown to 100% of the Federal Poverty Guideline on July 1, 2022. The MA spenddown is a requirement for someone who qualifies for MA due to their disability to "spenddown" their income on health care to currently 81% of the poverty level. (SS CH 9, Art. 5)

MNChoices: Adds that an assessment must be "conversation-based" and that it be completed in consultation with someone who knows the person, especially if the there is a legal representative. A report from the current provider must be completed 60 days before the end of the service agreement. A community support plan must be completed within 60 days – this is for new or reassessments. (SS CH 9, Art. 5)

Network Adequacy: Creates new requirements for Health Maintenance Organizations (HMOs) and health plans when they are seeking a waiver from network adequacy standards. In Minnesota, a network is adequate if there is a mental health provider within 30 minutes or 30 miles. If a health plan or HMO is unable to satisfy this requirement, their waiver application must demonstrate that there are no providers of a specific type in a county, provide specific information about the steps already taken and the steps they will take to address network adequacy within a specified time frame. Waivers will expire after three years for an HMO and one year for a health plan. The department can allow an HMO or health plan to address network adequacy through telemedicine. The HMO or health plan must also update its website once a month with any changes to the provider network such as a provider being moved out-of-network and provide a list of the current waivers in a format easily accessible to current or prospective enrollees. The Department of Health must also create a clear and easily accessible process for accepting complaints from enrollees regarding network adequacy. (SS CH 9, Art. 8)

Nonemergency Medical Transportation: Requires individual drivers to be enrolled with the Department of Human Services. A provider who is terminated cannot re-enroll for five years and if they seek to re-enroll after that time will be put on a one-year probation. (SS CH 9, Art. 7)

Pharmaceutical Assistance Programs: Requires the boards of Medical Practice and Nursing to annually provide its licensees with a list of resources and programs available to help patients who cannot afford their medications. This information is listed on the Board of Pharmacy's website. (SS CH 9, Art. 9)

Pharmacy Benefit Managers (PBMs): Requires every PBM operating in the state to be licensed by the Department of Commerce. In order to satisfy the requirements for a license, the PBM must comply with requirements for network adequacy including the documentation of steps taken to meet network adequacy standards; disclose information to the plan sponsor including the wholesale cost of drugs, prior-authorization use, and rebates on prescription drugs; and to deliver a yearly report to the Department of Commerce with this information.

PBMs must also disclose any pharmacies that the PBM has an ownership stake in. For the pharmacies that the PBM does have a stake in, the PBM will not be able to require the use of this pharmacy or charge higher rates for getting a prescription from another pharmacy. The legislation also provides protections for pharmacies from price gouging from PBMs, such as the creation of a price maximum for generic drugs and a formal appeal process to contest the cost of a medication.

It will also be easier for people with multiple medications to treat a chronic illness to synchronize their prescription refills to avoid multiple trips to the pharmacist. Finally, this legislation prevents PBMs from putting a "gag-clause" in their contract that prevents a pharmacist from sharing information on the prescribed medication including viable alternatives, information on the cost of the medication including the health plan share, and the availability of therapeutically equivalent medications that may be cheaper for the individual. (Chapter 39)

Provider Tax: Ends the sunset and brings the provider tax back at a slightly lower rate of 1.8% rate. The provider tax is the primary funding source for the Health Care Access Fund (HCAF). The HCAF is a major funding source for MA expansion and other important health care programs. (SS CH 6, Art. 9)

Step Therapy: Requires that people on Medicaid (fee-for-service or managed care), county-based purchasing, or an integrated partnership be able to bypass step therapy if they have already tried the drug before under a different health plan and it was ineffective or there was an adverse event or the prescriber submits an evidence-based peer-reviewed clinical practice guideline as to why the person should be able to have the drug prescribed instead of the one through step therapy. The plan can still require a different drug if it is supported by evidence-based peer-reviewed clinical practice guidelines, FDA or manufacturers prescribing information. (SS CH 9, Art. 7)

Telemedicine: Allows community health workers to provide services by telemedicine. (SS CH 9, Art. 7)

Tobacco Cessation: Funds statewide tobacco cessation services through the Department of Health. This includes public awareness activities, telephone-based coaching, written materials, web-based texting, and tobacco cessation medications. (SS CH 9, Art. 11)

Higher Education

Argosy University: Provides financial assistance to students at Argosy University, which suddenly closed, who were receiving state grant funding for their higher education. This includes

making direct payments of state financial aid to eligible former Argosy students and releasing them from liability for any SELF student loans for the spring 2019 semester. Many students were studying clinical psychology at Argosy. (Chapter 34)

College-Linked Mental Health: Appropriates $250,000 in one-time money to allow for up to five community or technical colleges to have a community mental health provider co-locate at their campus and provide mental health services to students. These services must be provided without charge to students who are uninsured, have high co-payments, or their insurance does not cover the needed mental health services. In order to be eligible, the community or technical college must already have a faculty counselor. (CH 64)

Emergency Assistance for Postsecondary Students: Provides an increase of $188,000 for the biennium to meet the immediate needs of students in college such as emergency housing, food, and transportation. (CH 64)

Housing/Homelessness

Bridges Housing Voucher: Increases base funding for the Bridges Housing Voucher Program by $250,000 per year. The Bridges Housing Voucher Program provides rental assistance for adults with a serious mental illness who are on a waiting list for a Section 8 Housing Voucher. (SS CH 1, Art. 5)

Emergency Shelter: Appropriates $3 million in one-time funding for FYs 20-21 for emergency services grants. This funding can be used to support street outreach, drop-in or day shelters, motel vouchers in Greater Minnesota, and other emergency services for people experiencing homelessness. (SS CH 9, Art. 14)

Family Homeless Prevention and Assistance Program (FHPAP): Appropriates $3.5 million for FYs 20-21 for rental assistance to serve adults, youth, and children at risk of experiencing homelessness. (SS CH 1, Ar. 5)

Homework Starts at Home: Appropriates base funding for the Homework Starts at Home Program at $3.5 million. This program provides assistance to homeless or highly mobile families with children eligible for enrollment in prekindergarten through grade 12. (SS CH 1, Art. 5)

Housing Infrastructure Bonds: Allocates $60 million in bonding dollars for the preservation of federally subsidized rental housing, construction of permanent supportive housing for people experiencing or at risk of homelessness, and for Community Land Trust land acquisitions for single-family home ownership. (SS CH 13)

Housing Support Eligibility: Makes eligible for up to three months of housing support anyone discharged from a residential mental health or substance use treatment facility who doesn't have housing. This will help people leaving settings like a crisis home successfully transition from this level of care and not go from treatment to homelessness. Begins in July 2020. (SS CH 9, Art. 6)

Shelter-Linked Mental Health: Appropriates $500,000 in one-time money to fund shelter-linked mental health programs. This builds on the experience with the school-linked program and will allow community mental health providers to co-locate and provide mental health services to youth experiencing homelessness at the shelter. Grant dollars can be used to develop programming to prepare youth for mental health services, provide on-site mental health services or mental health case management, increase the capacity of housing provider staff to work with youth with mental illnesses, purchase equipment for telemedicine, and to fill in gaps in a youth's health insurance. Results of the grant will be included in the biennial homeless youth report. (SS CH 9, Art. 6)

Human Services

Certified Child Care Centers: Requires them to have behavior guidance policies to ensure that positive approaches are used, and children are not subject to being hit, restrained, etc. These centers are not required to be licensed for various reasons including because they serve one family and want to receive childcare assistance payments. (SS CH 9, Art. 2)

Change of Ownership: Clarifies the process programs or facilities licensed by the Department of Human Services must follow when a license holder sells, merges or consolidates with another program. Creates a streamlined process when one organization is essentially acquiring a similar program. (SS CH 9, Art. 2)

Grant Programs: Requires Management and Budget to consult with the Department of Human Services and the Department of Health to establish a plan to review services delivered under grant programs to determine if they are effective or are a promising practice. (SS CH 9, Art. 2 and Art. 11)

Homeless Youth: Requires the Departments of Human Services, Health and Public Safety to provide recommendations next year as to how to provide homeless youth with access to birth records and MN identification cards at no cost. (SS CH 9, Art. 1)

MFIP: Increases the Minnesota Family Investment Program (MFIP) cash assistance by $100 dollars a month. This is the first increase in 33 years for the cash assistance program for families with children and very low incomes. (SS CH 9, Art. 14)

Technology: Establishes a task force on the use of technology to assist people with disabilities to live more independently in community settings and increase their quality of life. Includes representatives from disability providers, counties, and advocacy organizations including NAMI Minnesota. The report is due by June 30 each year and the task force expires in June 2021. (SS CH 9, Art. 5)

Mental Health Care

Behavioral Health Homes: Makes important policy changes to Behavioral Health Homes (BHH). BHHs provide comprehensive care management, care coordination, health promotion

and wellness, comprehensive transitional care, patient and family support, and referral to community and social support services. Key policy changes include ensuring that anyone with a mental illness – and not just a serious mental illness – is eligible for BHH services, as well as providing additional options for discharging a client from BHH services. Someone can now be discharged from a BHH if the provider is unable to locate or contact the client after at least three months of persistent efforts to do so or if the client is unwilling to participate in treatment. Before this discharge takes place, the BHH provider must have a face-to-face meeting with the individual and their identified supports to discuss treatment options including continuing with BHH services. This policy language also allows a community health worker to do care navigation and allows for billable visits under a brief diagnostic assessment. Language is added clarifying who can be a BHH provider, what training is required, staff qualifications, and service delivery standards. (SS CH 9 Art. 6)

Certified Community Behavioral Health Clinic (CCBHC): Provides funding for CCBHCs. CCBHCs are a new treatment model that serve as a one-stop-shop for mental health, substance use disorder, and primary care needs. Minnesota is 1 of 8 states that are currently participating in a federally funded pilot project to deliver the CCBHC model. The legislature appropriated $4.699 million in FYs 2020-2021 and $18.170 million in FYs 2022-2023 to support the enhanced rate for CCBHCs and to expand to new CCBHCs. The federal match for CCBHC services was due to expire on July of 2019 but Congress has extended that to September 13, 2019. In addition, DHS has obtained waiver approval for continued federal matching funds until July 2020, with the condition that DHS apply for a Medicaid State Plan Amendment for ongoing federal match after July 2020. The state legislation and budget provides the necessary authority and matching funds to allow DHS to obtain ongoing federal funding.

There is also a requirement for the Department of Human Services to establish an ongoing prospective payment system under Medical Assistance for CCBHC providers to update the payment system that was developed under the pilotTo the extent allowed by federal law, the state legislation allows the Department to limit the number of providers who can access this rate in order to maintain the financial sustainability of the CCBHC model. When determining who will receive the CCBHC MA rate, the department must consider whether the provider offers a comprehensive and integrated range of services for all age groups, were certified as CCHBCs during the federal demonstration project, receive CCBHC grants from the U.S. Department of Health and Human Services, or focus on serving people in tribal areas or other underserved communities. This language may be moot since it now appears that ongoing federal approval will not allow states to place limits on the number of CCBHC providers.

The prospective payment system must also be based on federal CCBHC guidelines with the exception that the department must redo the rates every three years. There must be a 60-day appeals process during rebasing, the prospective CCBHC rate must be adjusted annually according to the Medicare Economic Index, and other provisions.

This year's CCBHC legislation also includes a number of clarifications regarding CCBHC staffing and service requirements. These clarifications continue requirements that applied during the pilot, including the requirement for CCBHCs to hire licensed alcohol and drug counselors and provide substance use disorder services. (SS CH 9, Art. 6)

County Share: Creates an process to review the county's liability for the cost of care when there is a delay in a client being discharged from a state operated program due to the facility not providing notice, providing notice on a weekend or holiday, the required documentation was not was not completed in order for the discharge to occur, or the facility disagrees with the discharge plan. Right now, the county pays 100% for the cost of care when a client no longer needs the level of care at a state operated program. (SS CH 9, Art. 3)

Fetal Alcohol Spectrum Disorders (FASD) Grants: Increases funding for FASD grants by $500,000 a year. The Minnesota Proof Alliance, formerly known as MOFAS, will make these grants available to a local group made up of at least one local government and at least one community-based organization in order to reduce the incidence of FASD and other prenatal drug-related effects in children. (SS CH 9, Art. 14)

Mental Health Parity: Increases the ability of the Departments of Health and Commerce to prospectively enforce mental health parity laws. Mental health parity laws and regulations state that if a health plan covers mental health and substance use disorder treatment it must cover them in the same way that it does other health conditions, like diabetes. Right now, enforcement depends on people making complaints, which is hard to do in the middle of a mental health crisis.

This legislation defines Nonquantitative Treatment Limits (NQTLs) in Minnesota law using the language in federal regulations. This means a process, strategy or standards they use to cover treatment. This can include medical necessity, formulary design, health plans with multiple network tiers, criteria for having a provider in-network including credentialing and reimbursement rates, step-therapy or fail first protocols, restrictions based on geographic location, facility type or provider specialty, in and out-of-network geographic limitations, limitations on inpatient services for situations where the enrollee is a threat to self or others, exclusions for court-ordered and involuntary holds, experimental treatment limitations, and provider reimbursement rates. It clarifies that a health plan cannot impose an NQTL for mental health or substance use disorder treatment that is more restrictive than the processes for other medical or surgical benefits.

In order to better ensure that Minnesota health plans are complying with mental health parity, the Department of Commerce may request information from health plans to compare how they cover mental health and substance use disorder treatment with other medical conditions. This can include a comparison of prior authorization requirements, drug formulary design, claim denials, rehabilitation services, and other information the Commissioner of Commerce deems appropriate.

There is also policy language that mental health therapy visits and medication maintenance visits must be considered primary care visits for the purpose of enrollee cost-sharing requirements like a co-payment or a deductible.

The final component in the mental health parity legislation is the requirement for the Department of Commerce to issue a yearly report to the legislature starting on June 1, 2021. This report must describe the process for mental health parity enforcement and identify any enforcement actions

taken by the Department of Commerce including number of formal enforcement actions, the benefit classifications examined, and the subject matter of each enforcement action. The report must also detail any corrective actions and describe information provided to the public about mental health parity protections in both state and federal law. This report must be available to the public in nontechnical and easy to understand language. (SS CH 9, Art. 8)

Mental Health Provider Travel Time: Allows for mental health providers to receive reimbursement under MA for travel costs to provide mental health services, so long as there is documentation that the service is delivered to a client on MA and not at the providers' office. Other information is also required for documentation. (SS CH 9, Art. 6)

Mobile Crisis Services: Increases funding for mobile crisis services by $2.5 million in FYs 2020-2021 and $9.793 million in FYs 2022-2023. Mobile crisis teams provide assessment, intervention, and stabilization services to someone experiencing a mental health crisis in the community. (SS CH 9, Art. 14)

Suicide Prevention: Increases funding for suicide prevention by $5.460 million in FYs 2020-2021 and $7.46 million in FYs 2022-2023. This funding will be used for community suicide prevention grants, evidence-based training for educators and school staff, suicide prevention curriculum for students, implementation of the zero-suicide model, and a Minnesota based network of suicide prevention lifelines. (SS CH 9, Art .14)

Miscellaneous

Driver's License: Requires the Department of Transportation to issue a driver's license or Minnesota identification card bearing a graphic or written identifier for an autism spectrum disorder or a mental health condition upon request. The applicant must submit the written request for the identifier at the time the photograph or electronically produced image is taken. The commissioner must not include any specific medical information on the driver's license or Minnesota identification card. Upon a request by an applicant for a driver's license, instruction permit, or Minnesota identification card the department must maintain electronic records of names and contact information for up to three emergency contacts for the applicant. The request must be made on a form prescribed by the commissioner. The form must be available on the department's website. A person who has provided emergency contact information under this subdivision may change, add, or delete the information at any point. (SS CH 3, Art. 3)

Substance Use Disorder

Background Studies: Allows the Department of Human Services to set aside disqualifications for certain crimes when the person is going to work in the substance use disorder field, the person has successfully completed treatment and has no further disqualifying crimes and has been abstinent for at least one year. If the department set aside the disqualifications once for working in a program the person does not have to go through the entire process again if seeking employment in a different program. (SS CH 9, Art. 2)

County Staff: Requires the Department of Human Services in collaboration with counties, to identify specific training and experience to qualify county staff who are not alcohol or drug counselors to conduct comprehensive assessments and treatment coordination. (SS CH 9, Art, 2)

Family Treatment: Creates a licensed family-based substance use disorder treatment program where the child is with the parent who is receiving treatment. The treatment facility must provide parenting skills training, parent education, and individual or family counseling under a framework that involves understanding, recognizing and responding to the effects of all types of trauma. The agency responsible for the child (under Child Protection) must determine it is in the child's best interest to stay with the parent and there must be a safety plan for the child if the parent leaves or is discharged from the program. Many of the provisions of child protection, including court reviews, remain along with an option for a voluntary placement agreement. (SS CH 9, Art. 1)

Groups: Specifies that treatment services provided in a group setting cannot exceed a ratio of 48 clients to one staff. One of the staff must meet certain professional qualifications. (SS CH 9, Art. 6)

Opioids: Creates funding for programs to address the opioid crisis. It does this by increasing the fees for the manufacturers, wholesalers, and distributors of opioids in Minnesota. The Opiate Epidemic Response Advisory Council will decide on how the funding will be used including prevention and education, training on treatment of opioid addiction, the expansion and enhancement of the continuum of care for opioid related substance use disorders, and the development of measures to assess and protect the ability of cancer patients and other people suffering with severe chronic pain to access the prescription pain medications they need to maintain their quality of life. This work includes reviewing local, state and national initiatives, establishing priorities for the state response to the opioid epidemic, recommending specific projects to be funded, ensuring that these recommendations are aligned with other state and federal funding sources, developing measurable outcomes to determine effectiveness of funded programs, and developing recommendations for a long-term use for funding in an opioid prevention account.

The Council consists of 19 voting members made up of two representatives, two senators, a member from the Board of Pharmacy, Minnesota Medical Association, opioid treatment programs, Minnesota Society of Addiction Medicine, professional offering alternative pain management therapies like acupuncture, a nonprofit working to address the opioid epidemic, the MN Ambulance Association, the courts (a judge or law enforcement officer), Minnesota Hospital Association, and local health department, along with a Minnesota resident who is in opioid addiction recovery, two members from the tribes, one public member suffering from chronic pain, and one mental health advocate representing people with mental illnesses. The Commissioners of Human Services, Health, and Corrections or their designees shall be nonvoting members. The Department of Human Services will coordinate appointments to ensure geographic, racial, and gender diversity.

The opioid bill also makes a number of policy changes including allowing for an advance healthcare directive to prohibit administering an opiate, allowing correctional employees,

volunteer firefighters, and licensed school nurses to administer an opioid antagonist like Narcan, limits on the number of days and the quantity of opiates prescribed, and requiring everyone who can prescribe opioids to receive at least two hours of training on best-practices for opioid prescribing as part of their continuing education requirements.

The Department of Health is to do statewide mapping of current community-based nonnarcotic pain management and wellness programs and to fund up to five demonstration projects in different areas of the state to provide these resources. Funding is maintained for the two Project Echo projects at St Gabriel's and Hennepin Health Care. (Ch 63)

Residential Treatment: Clarifies that a care coordinator in a facility must have one hour of supervision monthly from an alcohol or drug counselor or a mental health professional who has substance use disorder assessment and treatment covered in their scope of practice. (SS CH 9, Art. 2)

Substance Use Disorder 1115 Demonstration Waiver: Instructs DHS to seek an 1115 demonstration waiver for residential providers in order to be able to use MA for short-term residential substance use disorder treatment. Any residential facility with 16 or more beds that are primarily used to treat mental health or substance use disorder are considered an Institute of Mental Disease (IMD), which means that the state cannot bill Medical Assistance. Recently, the Federal Government changed a rule that allows an exception to the IMD rule for short-term residential treatment for substance use disorder. This will improve access to this important service and generate a savings of over $16 million in FY 2021 and almost $40 million by FY 2023. (SS CH 9, Art. 6)

System Improvement: Requires the Department of Human Services to consult with counties, providers, advocates, tribes, and other stakeholders to develop a plan to make system improvements, including minimizing regulatory paperwork. (SS CH9, Art. 6)

Telemedicine for Substance Use Disorder: Allows telemedicine to be used for a substance use disorder assessment. (SS CH 9, Art. 6)

Timely Access to Substance Use Disorder Treatment: Provides additional flexibility to substance use disorder providers for assessment requirements. This includes allowing someone on MA to begin accessing substance use disorder services immediately if they screen positive for a substance use disorder following a brief screening within a primary care clinic, hospital, another medical setting, or a school. After a maximum of four hours of individual or group substance use disorder treatment, two hours of substance use disorder treatment coordination, and two hours of peer support services, the individual must obtain a full assessment. (SS CH 9, Art. 6)

Treatment Facilities: Changes are made to substance use disorder treatment facility requirements including adopting definitions of group counseling, requiring an initial service plan to be initiated within 24 hours of initiating services and individual treatment plans within ten days in a residential program and five days in a nonresidential program, requiring a comprehensive assessment within three days, having the client state their desire for family

involvement in the treatment program, identifying any medical concerns, and defining peer support services. An opioid treatment facility must be registered as a narcotic treatment program through the DEA, be accredited or certified. Medication to treat an opioid use disorder can now be prescribed by a licensed health care provider who is a prescriber. (SS CH 9, Art. 6)

Workforce

Behavior Analysts: Adds board-certified behavior analysts or board-certified assistant behavior analysts to the list of who can be a positive support analyst under Medicaid Waivers. In addition, the training and instruction required to be a positive support analyst is increased and more clearly defined. (SS CH 9, Art, 5)

Licensing Fees: Increases the licensing application fees for the Board of Social Work to $75 for and $115 for a license by endorsement. License fees are increased as well ranging from $115 for a licensed social worker to $335 for an LICSW. (SS CH 9, Art. 10)

Psychiatry Residency Programs: Extends the length of the primary care residency program from three to four years so that psychiatry residency programs can access the program. The legislature previously funded a residency program for primary care, which includes child and adult psychiatry. A mistake in the legislation limited the program to three years when psychiatry residency programs require four years. (SS CH 9, Art. 11)

Traditional Healers: Appropriates $2 million a year through 2024 for traditional healing grants. This will support the tribal nations and five urban Indian communities to offer traditional healers and to increase the capacity of the culturally specific providers in the mental health substance use disorder health workforce. (CH 63)

Acronyms:

- Art = Article in the Chapter
- CADI = Community Access for Disability Inclusion
- CH = Chapter in Session Law
- FY = Fiscal Year
- IMD = Institute for Mental Disease
- IRTS = Intensive Residential Treatment Services
- MA = Medical Assistance or Medicaid
- PBIS = Positive Behavior Interventions and Support
- PRTF = Psychiatric Residential Treatment Facility
- SS = Special Session