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S.F. No. 3249

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DATE	D-PG	OFFICIAL STATUS
02/17/2022	5055	Introduction and first reading
		Referred to Human Services Reform Finance and Policy
03/29/2022	5906	Authors added Abeler; Senjem
04/04/2022	6170a	Comm report: To pass as amended and re-refer to Health and Human Services Finance and Policy
04/05/2022	6462a	Comm report: To pass as amended and re-refer to Finance
	6468	Joint rule 2.03, referred to Rules and Administration
	6470	Chief author stricken, shown as co-author Rosen
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04/26/2022	7637a	Comm report: To pass as amended
	7677	Second reading

A bill for an act

relating to mental health; creating a mental health provider supervision grant program; modifying adult mental health initiatives; modifying intensive residential treatment services; modifying mental health fee-for-service payment rate; removing county share; creating mental health urgency room grant program; directing the commissioner to develop medical assistance mental health benefit for children; establishing forensic navigator services; creating an online music instruction grant program; creating an exception to the hospital construction moratorium for projects that add mental health beds; appropriating money; amending Minnesota Statutes 2020, sections 144.55, subdivisions 4, 6; 144.551, by adding a subdivision; 245.4661, as amended; 256B.0622, subdivision 5a; Minnesota Statutes 2021 Supplement, sections 245I.23, by adding a subdivision; 256B.0625, subdivisions 5, 13e, 56a; proposing coding for new law in Minnesota Statutes, chapters 144; 245; 611; repealing Minnesota Statutes 2020, section 245.4661, subdivision 8.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MINNESOTA:

Section 1. **[144.1508] MENTAL HEALTH PROVIDER SUPERVISION GRANT PROGRAM.**

Subdivision 1. **Definitions.** (a) For purposes of this section, the following terms have the meanings given.

(b) "Mental health professional" means an individual who meets one of the qualifications specified in section 245I.04, subdivision 2.

(c) "Underrepresented community" has the meaning given in section 148E.010, subdivision 20.

Subd. 2. **Grant program established.** The commissioner of health shall award grants to licensed or certified mental health providers who meet the criteria in subdivision 3 to fund supervision of interns and clinical trainees who are working toward becoming a mental

health professional and to subsidize the costs of licensing applications and examination fees for clinical trainees.

Subd. 3. **Eligible providers.** In order to be eligible for a grant under this section, a mental health provider must:

(1) provide at least 25 percent of the provider's yearly patient encounters to state public program enrollees or patients receiving sliding fee schedule discounts through a formal sliding fee schedule meeting the standards established by the United States Department of Health and Human Services under Code of Federal Regulations, title 42, section 51c.303; or

(2) primarily serve underrepresented communities.

Subd. 4. **Application; grant award.** A mental health provider seeking a grant under this section must apply to the commissioner at a time and in a manner specified by the commissioner. The commissioner shall review each application to determine if the application is complete, the mental health provider is eligible for a grant, and the proposed project is an allowable use of grant funds. The commissioner must determine the grant amount awarded to applicants that the commissioner determines will receive a grant.

Subd. 5. **Allowable uses of grant funds.** A mental health provider must use grant funds received under this section for one or more of the following:

(1) to pay for direct supervision hours for interns and clinical trainees, in an amount up to $7,500 per intern or clinical trainee;

(2) to establish a program to provide supervision to multiple interns or clinical trainees; or

(3) to pay licensing application and examination fees for clinical trainees.

Subd. 6. **Program oversight.** During the grant period, the commissioner may require grant recipients to provide the commissioner with information necessary to evaluate the program.

Sec. 2. Minnesota Statutes 2020, section 144.55, subdivision 4, is amended to read:

Subd. 4. **Routine inspections; presumption.** Any hospital surveyed and accredited under the standards of the hospital accreditation program of an approved accrediting organization that submits to the commissioner within a reasonable time copies of (a) its currently valid accreditation certificate and accreditation letter, together with accompanying recommendations and comments and (b) any further recommendations, progress reports

and correspondence directly related to the accreditation is presumed to comply with application requirements of subdivision 1 and the standards requirements of subdivision 3 and no further routine inspections or accreditation information shall be required by the commissioner to determine compliance. Notwithstanding the provisions of sections 144.54 and 144.653, subdivisions 2 and 4, hospitals shall be inspected only as provided in this section. The provisions of section 144.653 relating to the assessment and collection of fines shall not apply to any hospital. The commissioner of health shall annually conduct, with notice, validation inspections of a selected sample of the number of hospitals accredited by an approved accrediting organization, not to exceed ten percent of accredited hospitals, for the purpose of determining compliance with the provisions of subdivision 3. If a validation survey discloses a failure to comply with subdivision 3, the provisions of section 144.653 relating to correction orders, reinspections, and notices of noncompliance shall apply. The commissioner shall also conduct any inspection necessary to determine whether hospital construction, addition, or remodeling projects comply with standards for construction promulgated in rules pursuant to subdivision 3. The commissioner may also conduct inspections to determine whether a hospital or hospital corporate system continues to satisfy the conditions on which a hospital construction moratorium exception was granted under section 144.551, subdivision 1a. Pursuant to section 144.653, the commissioner shall inspect any hospital that does not have a currently valid hospital accreditation certificate from an approved accrediting organization. Nothing in this subdivision shall be construed to limit the investigative powers of the Office of Health Facility Complaints as established in sections 144A.51 to 144A.54.

EFFECTIVE DATE. This section is effective the day following final enactment.

Sec. 3. Minnesota Statutes 2020, section 144.55, subdivision 6, is amended to read:

Subd. 6. **Suspension, revocation, and refusal to renew.** (a) The commissioner may refuse to grant or renew, or may suspend or revoke, a license on any of the following grounds:

(1) violation of any of the provisions of sections 144.50 to 144.56 or the rules or standards issued pursuant thereto, or Minnesota Rules, chapters 4650 and 4675;

(2) permitting, aiding, or abetting the commission of any illegal act in the institution;

(3) conduct or practices detrimental to the welfare of the patient; or

(4) obtaining or attempting to obtain a license by fraud or misrepresentation; or

(5) with respect to hospitals and outpatient surgical centers, if the commissioner determines that there is a pattern of conduct that one or more physicians or advanced practice

registered nurses who have a "financial or economic interest," as defined in section 144.6521, subdivision 3, in the hospital or outpatient surgical center, have not provided the notice and disclosure of the financial or economic interest required by section 144.6521.

(b) The commissioner shall not renew a license for a boarding care bed in a resident room with more than four beds.

(c) The commissioner shall not renew licenses for hospital beds issued to a hospital or hospital corporate system pursuant to a hospital construction moratorium exception under section 144.551, subdivision 1a, if the commissioner determines the hospital or hospital corporate system is not satisfying the conditions on which the exception was granted.

EFFECTIVE DATE. This section is effective the day following final enactment.

Sec. 4. Minnesota Statutes 2020, section 144.551, is amended by adding a subdivision to read:

Subd. 1a. **Exception for increased mental health bed capacity.** (a) From August 1, 2022, to July 31, 2027, subdivision 1, paragraph (a), and sections 144.552 and 144.553, do not apply to:

(1) those portions of any erection, building, alteration, reconstruction, modernization, improvement, extension, lease, or other acquisition by or on behalf of a hospital that increase the mental health bed capacity of a hospital; or

(2) the establishment of a new psychiatric hospital.

(b) Any hospital that increases its bed capacity or is established under this subdivision must use all the newly licensed beds exclusively for mental health services.

(c) The commissioner shall monitor the implementation of exceptions under this subdivision. Each hospital or hospital corporate system granted an exception under this subdivision shall submit to the commissioner each year a report on how the hospital or hospital corporate system continues to satisfy the conditions on which the exception was granted.

(d) Any hospital found to be in violation of this subdivision is subject to sanction under section 144.55, subdivision 6, paragraph (c).

(e) By January 15, 2027, the commissioner of health shall submit to the chairs and ranking minority members of the legislative committees and divisions with jurisdiction over health a report containing the location of every hospital that has expanded its capacity or been established under this subdivision and summary data by location of the patient

population served in the newly licensed beds, including age, duration of stay, and county of residence. A hospital that expands its capacity or is established under this subdivision must provide the patient information the commissioner requests to fulfill the requirements of this paragraph. For the purposes of section 144.55, subdivision 6, paragraph (c), a hospital's failure to provide data requested by the commissioner is a failure to satisfy the conditions on which an exception is granted under this subdivision.

EFFECTIVE DATE. This section is effective the day following final enactment.

Sec. 5. **[245.096] CHANGES TO GRANT PROGRAMS.**

Prior to making any changes to a grant program administered by the Department of Human Services, the commissioner of human services must provide a report on the nature of the changes, the effect the changes will have, whether any funding will change, and other relevant information, to the chairs and ranking minority members of the legislative committees with jurisdiction over human services. The report must be provided prior to the start of a regular session and the proposed changes cannot be implemented until after the adjournment of that regular session.

Sec. 6. Minnesota Statutes 2020, section 245.4661, as amended by Laws 2021, chapter 30, article 17, section 21, is amended to read:

245.4661 ~~PILOT PROJECTS;~~ ADULT MENTAL HEALTH INITIATIVE SERVICES.

Subdivision 1. ~~**Authorization for pilot projects**~~ **Adult mental health initiative services.** ~~The commissioner of human services may approve pilot projects to provide alternatives to or enhance coordination of~~ Each county board must provide or contract for sufficient infrastructure for the delivery of mental health services ~~required under the Minnesota Comprehensive Adult Mental Health Act, sections 245.461 to 245.486~~ for adults in the county with serious and persistent mental illness through adult mental health initiatives. A client may be required to pay a fee for services pursuant to section 245.481. Adult mental health initiatives must be designed to improve the ability of adults with serious and persistent mental illness to receive services.

Subd. 2. **Program design and implementation.** ~~The pilot projects~~ Adult mental health initiatives shall be ~~established to design, plan, and improve the~~ responsible for designing, planning, improving, and maintaining a mental health service delivery system for adults with serious and persistent mental illness that would:

(1) provide an expanded array of services from which clients can choose services appropriate to their needs;

(2) be based on purchasing strategies that improve access and coordinate services without cost shifting;

(3) prioritize evidence-based services and implement services that are promising practices or theory-based practices so that the service can be evaluated according to subdivision 5a;

~~(3)~~ (4) incorporate existing state facilities and resources into the community mental health infrastructure through creative partnerships with local vendors; and

~~(4)~~ (5) utilize existing categorical funding streams and reimbursement sources in combined and creative ways, except appropriations to regional treatment centers and all funds that are attributable to the operation of state-operated services are excluded unless appropriated specifically by the legislature for a purpose consistent with this section or section 246.0136, subdivision 1.

Subd. 3. **~~Program~~ Adult mental health initiative evaluation.** Evaluation of each ~~project~~ adult mental health initiative will be based on outcome evaluation criteria negotiated with each ~~project~~ county or region prior to implementation.

Subd. 4. **Notice of ~~project~~ adult mental health initiative discontinuation.** Each ~~project~~ adult mental health initiative may be discontinued for any reason by the ~~project's~~ managing entity or the commissioner of human services, after 90 days' written notice to the other party.

Subd. 5. **Planning for ~~pilot projects~~ adult mental health initiatives.** (a) Each local plan for ~~a pilot project~~ adult mental health initiative services, with the exception of the placement ~~of a Minnesota specialty treatment facility as defined in paragraph (c)~~ of intensive residential treatment services facilities licensed under chapter 245I, must be developed under the direction of the county board, or multiple county boards acting jointly, as the local mental health authority. The planning process for each ~~pilot~~ adult mental health initiative shall include, but not be limited to, mental health consumers, families, advocates, local mental health advisory councils, local and state providers, representatives of state and local public employee bargaining units, and the department of human services. As part of the planning process, the county board or boards shall designate a managing entity responsible for receipt of funds and management of ~~the pilot project~~ adult mental health initiatives.

(b) For ~~Minnesota specialty~~ intensive residential treatment services facilities, the commissioner shall issue a request for proposal for regions in which a need has been identified for services.

~~(c) For purposes of this section, "Minnesota specialty treatment facility" is defined as an intensive residential treatment service licensed under chapter 245I.~~

Subd. 5a. **Evaluations.** The commissioner of management and budget, in consultation with the commissioner of human services, and within available appropriations, shall create and maintain an inventory of adult mental health initiative services administered by the county boards, identifying evidence-based services and services that are theory-based or promising practices. The commissioner of management and budget, in consultation with the commissioner of human services, shall select adult mental health initiative services that are promising practices or theory-based activities for which the commissioner of management and budget shall conduct evaluations using experimental or quasi-experimental design. The commissioner of human services, in consultation with the commissioner of management and budget, shall encourage county boards to administer adult mental health initiative services to support experimental or quasi-experimental evaluation and shall require county boards to collect and report information that is needed to complete the inventory and evaluation for any adult mental health initiative service that is selected for an evaluation. The commissioner of management and budget, under section 15.08, may obtain additional relevant data to support the inventory and the experimental or quasi experimental evaluation studies.

Subd. 6. **Duties of commissioner.** (a) For purposes of ~~the pilot projects~~ adult mental health initiatives, the commissioner shall facilitate integration of funds or other resources as needed and requested by each ~~project~~ adult mental health initiative. These resources may include:

(1) community support services funds administered under Minnesota Rules, parts 9535.1700 to 9535.1760;

(2) other mental health special project funds;

(3) medical assistance, MinnesotaCare, and housing support under chapter 256I if requested by the ~~project's~~ adult mental health initiative's managing entity, and if the commissioner determines this would be consistent with the state's overall health care reform efforts; and

(4) regional treatment center resources consistent with section 246.0136, subdivision 1.

(b) The commissioner shall consider the following criteria in awarding ~~start-up and implementation~~ grants for ~~the pilot projects~~ adult mental health initiatives:

(1) the ability of the ~~proposed projects~~ initiatives to accomplish the objectives described in subdivision 2;

(2) the size of the target population to be served; and

(3) geographical distribution.

(c) The commissioner shall review overall status of the ~~projects~~ initiatives at least every two years and recommend any legislative changes needed by January 15 of each odd-numbered year.

(d) The commissioner may waive administrative rule requirements ~~which~~ that are incompatible with the implementation of the ~~pilot project~~ adult mental health initiative.

(e) The commissioner may exempt the participating counties from fiscal sanctions for noncompliance with requirements in laws and rules ~~which~~ that are incompatible with the implementation of the ~~pilot project~~ adult mental health initiative.

(f) The commissioner may award grants to an entity designated by a county board or group of county boards to pay for start-up and implementation costs of the ~~pilot project~~ adult mental health initiative.

Subd. 7. **Duties of county board.** The county board, or other entity which is approved to administer ~~a pilot project~~ an adult mental health initiative, shall:

(1) administer the ~~project~~ initiative in a manner ~~which~~ that is consistent with the objectives described in subdivision 2 and the planning process described in subdivision 5;

(2) assure that no one is denied services for ~~which~~ that they would otherwise be eligible; and

(3) provide the commissioner of human services with timely and pertinent information through the following methods:

(i) submission of mental health plans and plan amendments which are based on a format and timetable determined by the commissioner;

(ii) submission of social services expenditure and grant reconciliation reports, based on a coding format to be determined by mutual agreement between the ~~project's~~ initiative's managing entity and the commissioner; and

(iii) submission of data and participation in an evaluation of the ~~pilot projects~~ adult mental health initiatives, to be designed cooperatively by the commissioner and the ~~projects~~ initiatives.

Subd. 8. **Budget flexibility.** The commissioner may make budget transfers that do not increase the state share of costs to effectively implement the restructuring of adult mental health services.

Subd. 9. **Services and programs.** (a) The following three distinct grant programs are funded under this section:

(1) mental health crisis services;

(2) housing with supports for adults with serious mental illness; and

(3) projects for assistance in transitioning from homelessness (PATH program).

(b) In addition, the following are eligible for grant funds:

(1) community education and prevention;

(2) client outreach;

(3) early identification and intervention;

(4) adult outpatient diagnostic assessment and psychological testing;

(5) peer support services;

(6) community support program services (CSP);

(7) adult residential crisis stabilization;

(8) supported employment;

(9) assertive community treatment (ACT);

(10) housing subsidies;

(11) basic living, social skills, and community intervention;

(12) emergency response services;

(13) adult outpatient psychotherapy;

(14) adult outpatient medication management;

(15) adult mobile crisis services;

(16) adult day treatment;

(17) partial hospitalization;

(18) adult residential treatment;

(19) adult mental health targeted case management;

(20) intensive community rehabilitative services (ICRS); and

(21) transportation.

Subd. 10. **Commissioner duty to report on use of grant funds biennially.** By November 1, 2016, and biennially thereafter, the commissioner of human services shall provide sufficient information to the members of the legislative committees having jurisdiction over mental health funding and policy issues to evaluate the use of funds appropriated under this section ~~of law~~. The commissioner shall provide, at a minimum, the following information:

(1) the amount of funding to adult mental health initiatives, what programs and services were funded in the previous two years, gaps in services that each initiative brought to the attention of the commissioner, and outcome data for the programs and services that were funded; and

(2) the amount of funding for other targeted services and the location of services.

Subd. 11. **Adult mental health initiative funding.** When implementing the reformed funding formula to distribute adult mental health initiative funds, the commissioner shall ensure that no adult mental health initiative region receives less than the amount the region received in fiscal year 2022 in combined adult mental health initiative funding and Moose Lake Alternative funding.

Sec. 7. Minnesota Statutes 2021 Supplement, section 245I.23, is amended by adding a subdivision to read:

Subd. 19a. **Locked facilities; additional requirements.** (a) License holders that prohibit clients from leaving the facility by locking exit doors or other methods must meet the additional requirements of this subdivision.

(b) The license holder must meet all applicable building and fire codes to operate a building with locked exit doors. The license holder must have the appropriate health license for operating a program with locked exit doors as determined by the Department of Health.

(c) The license holder's policies and procedures must describe the types of court orders that authorize the facility to prohibit clients from leaving the facility.

(d) For each client at the facility under a court order the license holder must maintain documentation of the order that authorizes the facility to prohibit the client from leaving the facility.

(e) Upon admission, the license holder must document in the client file that the client was informed:

(1) that the client has the right to leave the facility according to the rights in section 144.651, subdivision 21; or

(2) that the client cannot leave the facility due to an order that authorizes the license holder to prohibit the client from leaving the facility.

(f) If the license holder prohibits a client from leaving the facility, the client's treatment plan must reflect this restriction.

EFFECTIVE DATE. This section is effective July 1, 2022, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 8. Minnesota Statutes 2020, section 256B.0622, subdivision 5a, is amended to read:

Subd. 5a. **Standards for intensive residential rehabilitative mental health services.** (a) The standards in this subdivision apply to intensive residential mental health services.

(b) The provider of intensive residential treatment services must have sufficient staff to provide 24-hour-per-day coverage to deliver the rehabilitative services described in the treatment plan and to safely supervise and direct the activities of clients, given the client's level of behavioral and psychiatric stability, cultural needs, and vulnerability. The provider must have the capacity within the facility to provide integrated services for chemical dependency, illness management services, and family education, when appropriate. Notwithstanding any other provision of law, the license holder may operate a locked facility to provide treatment for patients who have been transferred from a jail or have been deemed incompetent to stand trial and a judge determines that the patient needs to be in a secure facility. The locked facility must meet building and fire code requirements.

(c) At a minimum:

(1) staff must provide direction and supervision whenever clients are present in the facility;

(2) staff must remain awake during all work hours;

(3) there must be a staffing ratio of at least one to nine clients for each day and evening shift. If more than nine clients are present at the residential site, there must be a minimum of two staff during day and evening shifts, one of whom must be a mental health practitioner or mental health professional;

(4) if services are provided to clients who need the services of a medical professional, the provider shall ensure that these services are provided either by the provider's own medical staff or through referral to a medical professional; and

(5) the provider must ensure the timely availability of a licensed registered nurse, either directly employed or under contract, who is responsible for ensuring the effectiveness and safety of medication administration in the facility and assessing clients for medication side effects and drug interactions.

(d) Services must be provided by qualified staff as defined in section 256B.0623, subdivision 5, who are trained and supervised according to section 256B.0623, subdivision 6, except that mental health rehabilitation workers acting as overnight staff are not required to comply with section 256B.0623, subdivision 5, paragraph (a), clause (4), item (iv).

(e) The clinical supervisor must be an active member of the intensive residential services treatment team. The team must meet with the clinical supervisor at least weekly to discuss clients' progress and make rapid adjustments to meet clients' needs. The team meeting shall include client-specific case reviews and general treatment discussions among team members. Client-specific case reviews and planning must be documented in the client's treatment record.

(f) Treatment staff must have prompt access in person or by telephone to a mental health practitioner or mental health professional. The provider must have the capacity to promptly and appropriately respond to emergent needs and make any necessary staffing adjustments to ensure the health and safety of clients.

(g) The initial functional assessment must be completed within ten days of intake and updated at least every 30 days, or prior to discharge from the service, whichever comes first.

(h) The initial individual treatment plan must be completed within 24 hours of admission. Within ten days of admission, the initial treatment plan must be refined and further developed, except for providers certified according to Minnesota Rules, parts 9533.0010 to 9533.0180. The individual treatment plan must be reviewed with the client and updated at least monthly.

EFFECTIVE DATE. This section is effective July 1, 2022, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 9. Minnesota Statutes 2021 Supplement, section 256B.0625, subdivision 5, is amended to read:

Subd. 5. **Community mental health center services.** Medical assistance covers community mental health center services provided by a community mental health center that meets the requirements in paragraphs (a) to (j).

(a) The provider must be certified as a mental health clinic under section 245I.20.

(b) In addition to the policies and procedures required by section 245I.03, the provider must establish, enforce, and maintain the policies and procedures for oversight of clinical services by a doctoral-level psychologist or a board-certified or board-eligible psychiatrist. These policies and procedures must be developed with the involvement of a doctoral-level psychologist and a board-certified or board-eligible psychiatrist, and must include:

(1) requirements for when to seek clinical consultation with a doctoral-level psychologist or a board-certified or board-eligible psychiatrist;

(2) requirements for the involvement of a doctoral-level psychologist or a board-certified or board-eligible psychiatrist in the direction of clinical services; and

(3) involvement of a doctoral-level psychologist or a board-certified or board-eligible psychiatrist in quality improvement initiatives and review as part of a multidisciplinary care team.

(c) The provider must be a private nonprofit corporation or a governmental agency and have a community board of directors as specified by section 245.66.

(d) The provider must have a sliding fee scale that meets the requirements in section 245.481, and agree to serve within the limits of its capacity all individuals residing in its service delivery area.

(e) At a minimum, the provider must provide the following outpatient mental health services: diagnostic assessment; explanation of findings; family, group, and individual psychotherapy, including crisis intervention psychotherapy services, psychological testing, and medication management. In addition, the provider must provide or be capable of providing upon request of the local mental health authority day treatment services, multiple family group psychotherapy, and professional home-based mental health services. The

provider must have the capacity to provide such services to specialized populations such as the elderly, families with children, persons who are seriously and persistently mentally ill, and children who are seriously emotionally disturbed.

(f) The provider must be capable of providing the services specified in paragraph (e) to individuals who are dually diagnosed with mental illness or emotional disturbance, and substance use disorder, and to individuals who are dually diagnosed with a mental illness or emotional disturbance and developmental disability.

(g) The provider must provide 24-hour emergency care services or demonstrate the capacity to assist recipients in need of such services to access such services on a 24-hour basis.

(h) The provider must have a contract with the local mental health authority to provide one or more of the services specified in paragraph (e).

(i) The provider must agree, upon request of the local mental health authority, to enter into a contract with the county to provide mental health services not reimbursable under the medical assistance program.

(j) The provider may not be enrolled with the medical assistance program as both a hospital and a community mental health center. The community mental health center's administrative, organizational, and financial structure must be separate and distinct from that of the hospital.

(k) The commissioner may require the provider to annually attest that the provider meets the requirements in this subdivision using a form that the commissioner provides.

(l) Managed care plans and county-based purchasing plans shall reimburse a provider at a rate that is at least equal to the fee-for-service payment rate. The commissioner shall monitor the effect of this requirement on the rate of access to the services delivered by mental health providers. If, for any contract year, federal approval is not received for this paragraph, the commissioner must adjust the capitation rates paid to managed care plans and county-based purchasing plans for that contract year to reflect the removal of this provision. Contracts between managed care plans and county-based purchasing plans and providers to whom this paragraph applies must allow recovery of payments from those providers if capitation rates are adjusted in accordance with this paragraph. Payment recoveries must not exceed the amount equal to any increase in rates that results from this provision. This paragraph expires if federal approval is not received for this paragraph at any time.

Sec. 10. Minnesota Statutes 2021 Supplement, section 256B.0625, subdivision 13e, is amended to read:

Subd. 13e. **Payment rates.** (a) The basis for determining the amount of payment shall be the lower of the ingredient costs of the drugs plus the professional dispensing fee; or the usual and customary price charged to the public. The usual and customary price means the lowest price charged by the provider to a patient who pays for the prescription by cash, check, or charge account and includes prices the pharmacy charges to a patient enrolled in a prescription savings club or prescription discount club administered by the pharmacy or pharmacy chain. The amount of payment basis must be reduced to reflect all discount amounts applied to the charge by any third-party provider/insurer agreement or contract for submitted charges to medical assistance programs. The net submitted charge may not be greater than the patient liability for the service. The professional dispensing fee shall be $10.77 for prescriptions filled with legend drugs meeting the definition of "covered outpatient drugs" according to United States Code, title 42, section 1396r-8(k)(2). The dispensing fee for intravenous solutions that must be compounded by the pharmacist shall be $10.77 per claim. The professional dispensing fee for prescriptions filled with over-the-counter drugs meeting the definition of covered outpatient drugs shall be $10.77 for dispensed quantities equal to or greater than the number of units contained in the manufacturer's original package. The professional dispensing fee shall be prorated based on the percentage of the package dispensed when the pharmacy dispenses a quantity less than the number of units contained in the manufacturer's original package. The pharmacy dispensing fee for prescribed over-the-counter drugs not meeting the definition of covered outpatient drugs shall be $3.65 for quantities equal to or greater than the number of units contained in the manufacturer's original package and shall be prorated based on the percentage of the package dispensed when the pharmacy dispenses a quantity less than the number of units contained in the manufacturer's original package. The National Average Drug Acquisition Cost (NADAC) shall be used to determine the ingredient cost of a drug. For drugs for which a NADAC is not reported, the commissioner shall estimate the ingredient cost at the wholesale acquisition cost minus two percent. The ingredient cost of a drug for a provider participating in the federal 340B Drug Pricing Program shall be either the 340B Drug Pricing Program ceiling price established by the Health Resources and Services Administration or NADAC, whichever is lower. Wholesale acquisition cost is defined as the manufacturer's list price for a drug or biological to wholesalers or direct purchasers in the United States, not including prompt pay or other discounts, rebates, or reductions in price, for the most recent month for which information is available, as reported in wholesale price guides or other publications of drug or biological pricing data. The maximum allowable cost of a multisource drug may

be set by the commissioner and it shall be comparable to the actual acquisition cost of the drug product and no higher than the NADAC of the generic product. Establishment of the amount of payment for drugs shall not be subject to the requirements of the Administrative Procedure Act.

(b) Pharmacies dispensing prescriptions to residents of long-term care facilities using an automated drug distribution system meeting the requirements of section 151.58, or a packaging system meeting the packaging standards set forth in Minnesota Rules, part 6800.2700, that govern the return of unused drugs to the pharmacy for reuse, may employ retrospective billing for prescription drugs dispensed to long-term care facility residents. A retrospectively billing pharmacy must submit a claim only for the quantity of medication used by the enrolled recipient during the defined billing period. A retrospectively billing pharmacy must use a billing period not less than one calendar month or 30 days.

(c) A pharmacy provider using packaging that meets the standards set forth in Minnesota Rules, part 6800.2700, is required to credit the department for the actual acquisition cost of all unused drugs that are eligible for reuse, unless the pharmacy is using retrospective billing. The commissioner may permit the drug clozapine to be dispensed in a quantity that is less than a 30-day supply.

(d) If a pharmacy dispenses a multisource drug, the ingredient cost shall be the NADAC of the generic product or the maximum allowable cost established by the commissioner unless prior authorization for the brand name product has been granted according to the criteria established by the Drug Formulary Committee as required by subdivision 13f, paragraph (a), and the prescriber has indicated "dispense as written" on the prescription in a manner consistent with section 151.21, subdivision 2.

(e) The basis for determining the amount of payment for drugs administered in an outpatient setting shall be the lower of the usual and customary cost submitted by the provider, 106 percent of the average sales price as determined by the United States Department of Health and Human Services pursuant to title XVIII, section 1847a of the federal Social Security Act, the specialty pharmacy rate, or the maximum allowable cost set by the commissioner. If the average sales price is unavailable, the amount of payment must be the lower of the usual and customary cost submitted by the provider, the wholesale acquisition cost, the specialty pharmacy rate, or the maximum allowable cost set by the commissioner. The commissioner shall discount the payment rate for drugs obtained through the federal 340B Drug Pricing Program by 28.6 percent. With the exception of paragraph (f), the payment for drugs administered in an outpatient setting shall be made to the

administering facility or practitioner. A retail or specialty pharmacy dispensing a drug for administration in an outpatient setting is not eligible for direct reimbursement.

(f) Notwithstanding paragraph (e), payment for injectable drugs used to treat substance use disorder or mental illness administered by a practitioner or pharmacist in an outpatient setting shall be made either to the administering facility, the practitioner, the administering pharmacy or pharmacist, or directly to the dispensing pharmacy. The practitioner, administering facility, or administering pharmacy or pharmacist shall submit the claim for the drug if they purchase the drug directly from a wholesale distributor licensed under section 151.47 or from a manufacturer licensed under section 151.252. The dispensing pharmacy shall submit the claim if the pharmacy dispenses the drug pursuant to a prescription issued by the practitioner and delivers the filled prescription to the practitioner for subsequent administration. Payment shall be made according to this section. The commissioner shall ensure that claims are not duplicated. A pharmacy shall not dispense a practitioner-administered injectable drug described in this paragraph directly to an enrollee.

~~(f)~~ (g) The commissioner may establish maximum allowable cost rates for specialty pharmacy products that are lower than the ingredient cost formulas specified in paragraph (a). The commissioner may require individuals enrolled in the health care programs administered by the department to obtain specialty pharmacy products from providers with whom the commissioner has negotiated lower reimbursement rates. Specialty pharmacy products are defined as those used by a small number of recipients or recipients with complex and chronic diseases that require expensive and challenging drug regimens. Examples of these conditions include, but are not limited to: multiple sclerosis, HIV/AIDS, transplantation, hepatitis C, growth hormone deficiency, Crohn's Disease, rheumatoid arthritis, and certain forms of cancer. Specialty pharmaceutical products include injectable and infusion therapies, biotechnology drugs, antihemophilic factor products, high-cost therapies, and therapies that require complex care. The commissioner shall consult with the Formulary Committee to develop a list of specialty pharmacy products subject to maximum allowable cost reimbursement. In consulting with the Formulary Committee in developing this list, the commissioner shall take into consideration the population served by specialty pharmacy products, the current delivery system and standard of care in the state, and access to care issues. The commissioner shall have the discretion to adjust the maximum allowable cost to prevent access to care issues.

~~(g)~~ (h) Home infusion therapy services provided by home infusion therapy pharmacies must be paid at rates according to subdivision 8d.

~~(h)~~ (i) The commissioner shall contract with a vendor to conduct a cost of dispensing survey for all pharmacies that are physically located in the state of Minnesota that dispense outpatient drugs under medical assistance. The commissioner shall ensure that the vendor has prior experience in conducting cost of dispensing surveys. Each pharmacy enrolled with the department to dispense outpatient prescription drugs to fee-for-service members must respond to the cost of dispensing survey. The commissioner may sanction a pharmacy under section 256B.064 for failure to respond. The commissioner shall require the vendor to measure a single statewide cost of dispensing for specialty prescription drugs and a single statewide cost of dispensing for nonspecialty prescription drugs for all responding pharmacies to measure the mean, mean weighted by total prescription volume, mean weighted by medical assistance prescription volume, median, median weighted by total prescription volume, and median weighted by total medical assistance prescription volume. The commissioner shall post a copy of the final cost of dispensing survey report on the department's website. The initial survey must be completed no later than January 1, 2021, and repeated every three years. The commissioner shall provide a summary of the results of each cost of dispensing survey and provide recommendations for any changes to the dispensing fee to the chairs and ranking members of the legislative committees with jurisdiction over medical assistance pharmacy reimbursement.

~~(i)~~ (j) The commissioner shall increase the ingredient cost reimbursement calculated in paragraphs (a) and ~~(f)~~ (g) by 1.8 percent for prescription and nonprescription drugs subject to the wholesale drug distributor tax under section 295.52.

Sec. 11. Minnesota Statutes 2021 Supplement, section 256B.0625, subdivision 56a, is amended to read:

Subd. 56a. **Officer-involved community-based care coordination.** (a) Medical assistance covers officer-involved community-based care coordination for an individual who:

(1) has screened positive for benefiting from treatment for a mental illness or substance use disorder using a tool approved by the commissioner;

(2) does not require the security of a public detention facility and is not considered an inmate of a public institution as defined in Code of Federal Regulations, title 42, section 435.1010;

(3) meets the eligibility requirements in section 256B.056; and

(4) has agreed to participate in officer-involved community-based care coordination.

(b) Officer-involved community-based care coordination means navigating services to address a client's mental health, chemical health, social, economic, and housing needs, or any other activity targeted at reducing the incidence of jail utilization and connecting individuals with existing covered services available to them, including, but not limited to, targeted case management, waiver case management, or care coordination.

(c) Officer-involved community-based care coordination must be provided by an individual who is an employee of or is under contract with a county, or is an employee of or under contract with an Indian health service facility or facility owned and operated by a tribe or a tribal organization operating under Public Law 93-638 as a 638 facility to provide officer-involved community-based care coordination and is qualified under one of the following criteria:

(1) a mental health professional;

(2) a clinical trainee qualified according to section 245I.04, subdivision 6, working under the treatment supervision of a mental health professional according to section 245I.06;

(3) a mental health practitioner qualified according to section 245I.04, subdivision 4, working under the treatment supervision of a mental health professional according to section 245I.06;

(4) a mental health certified peer specialist qualified according to section 245I.04, subdivision 10, working under the treatment supervision of a mental health professional according to section 245I.06;

(5) an individual qualified as an alcohol and drug counselor under section 245G.11, subdivision 5; or

(6) a recovery peer qualified under section 245G.11, subdivision 8, working under the supervision of an individual qualified as an alcohol and drug counselor under section 245G.11, subdivision 5.

(d) Reimbursement is allowed for up to 60 days following the initial determination of eligibility.

(e) Providers of officer-involved community-based care coordination shall annually report to the commissioner on the number of individuals served, and number of the community-based services that were accessed by recipients. The commissioner shall ensure that services and payments provided under officer-involved community-based care coordination do not duplicate services or payments provided under section 256B.0625, subdivision 20, 256B.0753, 256B.0755, or 256B.0757.

~~(f) Notwithstanding section 256B.19, subdivision 1, the nonfederal share of cost for officer-involved community-based care coordination services shall be provided by the county providing the services, from sources other than federal funds or funds used to match other federal funds.~~

Sec. 12. **[611.41] DEFINITIONS.**

(a) For the purposes of sections 611.41 to 611.43, the following terms have the meanings given.

(b) "Cognitive impairment" means any deficiency in the ability to think, perceive, reason, or remember caused by injury, genetic condition, or brain abnormality.

(c) "Competency restoration program" means a structured program of clinical and educational services that is designed to identify and address barriers to a defendant's ability to understand the criminal proceedings, consult with counsel, and participate in the defense.

(d) "Forensic navigator" means a person who provides the services under section 611.42, subdivision 2.

(e) "Mental illness" means an organic disorder of the brain or a substantial psychiatric disorder of thought, mood, perception, orientation, or memory.

Sec. 13. **[611.42] FORENSIC NAVIGATOR SERVICES.**

Subdivision 1. **Availability of forensic navigator services.** Counties must provide or contract for enough forensic navigator services to meet the needs of adult defendants in each judicial district upon a motion regarding competency pursuant to Minnesota Rule of Criminal Procedure 20.01.

Subd. 2. **Duties.** (a) Forensic navigators shall provide services to assist defendants with mental illnesses and cognitive impairments. Services may include, but are not limited to:

(1) developing bridge plans under subdivision 3 of this section;

(2) coordinating timely placement in court-ordered competency restoration programs;

(3) providing competency restoration education;

(4) reporting to the county on the progress of defendants in a competence restoration program;

(5) providing coordinating services to help defendants access needed mental health, medical, housing, financial, social, transportation, precharge and pretrial diversion, and other necessary services provided by other programs and community service providers; and

(6) communicating with and offering supportive resources to defendants and family members of defendants.

(b) As the accountable party over the defendant, forensic navigators must meet at least quarterly with the defendant.

(c) If a defendant's charges are dismissed, the appointed forensic navigator may continue assertive outreach with the individual for up to 90 days to assist in attaining stability in the community.

Subd. 3. **Bridge plans.** (a) The forensic navigator must prepare bridge plans with the defendant. The bridge plan must include:

(1) a confirmed housing address the defendant will use, including but not limited to emergency shelters;

(2) if possible, the dates, times, locations, and contact information for any appointments made to further coordinate support and assistance for the defendant in the community, including but not limited to mental health and substance use disorder treatment, or a list of referrals to services; and

(3) any other referrals, resources, or recommendations the forensic navigator deems necessary.

(b) Bridge plans and any supporting records or other data submitted with those plans are not accessible to the public.

Subd. 4. **Distribution of appropriated amounts.** Each fiscal year, the commissioner of human services must distribute the total amount appropriated for forensic navigator services under this section to counties based upon their proportional share of persons deemed incompetent to stand trial and using the forensic navigator services during the prior fiscal year.

Sec. 14. **[611.43] COMPETENCY RESTORATION CURRICULUM.**

(a) By January 1, 2023, counties must choose a competency restoration curriculum to educate and assist defendants receiving forensic navigator services to attain the ability to:

(1) rationally consult with counsel;

(2) understand the proceedings; and

(3) participate in the defense.

(b) The curriculum must be flexible enough to be delivered by individuals with various levels of education and qualifications, including but not limited to professionals in criminal justice, health care, mental health care, and social services.

Sec. 15. **DIRECTION TO COMMISSIONER OF HUMAN SERVICES; DEVELOPMENT OF MEDICAL ASSISTANCE ELIGIBLE MENTAL HEALTH BENEFIT FOR CHILDREN IN CRISIS.**

(a) The commissioner of human services, in consultation with providers, counties, and other stakeholders, must develop a covered service under medical assistance to provide residential crisis stabilization for children. The benefit must:

(1) consist of services that contribute to effective treatment to children experiencing a mental health crisis;

(2) provide for simplicity of service, design, and administration;

(3) support participation by all payors; and

(4) include services that support children and families that comprise of:

(i) an assessment of the child's immediate needs and factors that lead to the mental health crisis;

(ii) individualized treatment to address immediate needs and restore the child to a precrisis level of functioning;

(iii) 24-hour on-site staff and assistance;

(iv) supportive counseling;

(v) skills training as identified in the child's individual crisis stabilization plan;

(vi) referrals to other service providers in the community as needed and to support the child's transition from residential crisis stabilization services;

(vii) development of a crisis response action plan; and

(viii) assistance to access and store medication.

(c) Eligible services must not be denied based on service location or service entity.

(d) When developing the new benefit, the commission must also make recommendations or propose a method for medical assistance enrollees to also receive a housing support benefit to cover room and board.

(e) No later than February 1, 2023, the commissioner, in consultation with counties, stakeholders, and providers, must submit to the chairs and ranking minority members of the legislative committees with jurisdiction over human services policy and finance a timeline for developing the fiscal and service analysis for the mental health benefit under this section, and a deadline for the commissioner to submit a state plan amendment to the Centers for Medicare and Medicaid Services.

Sec. 16. **MENTAL HEALTH URGENCY ROOM GRANTS.**

Subdivision 1. **Establishment.** The commissioner of human services must establish a competitive grant program for medical providers and nonprofits seeking to become a first-contact resource for youths having a mental health crisis through the use of urgency rooms.

Subd. 2. **Goal.** The goal of this grant program is to address emergency mental health needs by creating urgency rooms that can be used by youths age 25 and under having a mental health crisis as a first-contact resource.

Subd. 3. **Eligible applicants.** (a) To be eligible for a grant under this section, applicants must be:

(1) an existing medical provider, including hospitals or emergency rooms;

(2) a nonprofit that is in the business of providing mental health services; or

(3) a nonprofit serving an underserved or rural community that will partner with an existing medical provider or nonprofit that is in the business of providing mental health services.

(b) Applicants must have staff who are licensed mental health professionals as defined under Minnesota Statutes, section 245I.02, subdivision 27.

(c) Applicants may have the capability to:

(1) perform a medical evaluation and mental health evaluation upon a youth's admittance to an urgency room;

(2) accommodate a youth's stay for up to 72 hours;

(3) conduct a substance use disorder screening;

(4) conduct a mental health crisis assessment;

(5) provide peer support services;

(6) provide crisis stabilization services;

(7) provide access to crisis psychiatry; and

(8) provide access to care planning and case management.

(d) Applicants must have a connection to inpatient and outpatient mental health services, including a physical health screening.

(e) Applicants that are not medical providers must agree to partner with a nearby emergency room or hospital to provide services in the event of an emergency.

(f) Applicants must agree to accept patients regardless of their insurance status or their ability to pay.

Subd. 4. **Applications.** (a) Entities seeking grants under this section shall apply to the commissioner. The grant applicant must include a description of the project that the applicant is proposing, the amount of money that the applicant is seeking, a proposed budget describing how the applicant will spend the grant money, and how the applicant intends to meet the goals of the program. Nonprofits that serve an underserved or rural community that are partnering with an existing medical provider or nonprofit that is in the business of providing mental health services must submit a joint application with the partnering entity.

(b) Priority must be given to applications that:

(1) demonstrate a need for the program in the region;

(2) provide a detailed service plan, including the services that will be provided and to whom, and staffing requirements;

(3) provide an estimated cost of operating the program;

(4) verify financial sustainability by detailing sufficient funding sources and the capacity to obtain third-party payments for services provided, including private insurance and federal Medicaid and Medicare financial participation;

(5) demonstrate an ability and willingness to build on existing resources in the community; and

(6) agree to an evaluation of services and financial viability by the commissioner.

Subd. 5. **Grant activities.** Grantees must use grant money to create urgency rooms to provide emergency mental health services and become a first-contact resource for youths having a mental health crisis. Grant money uses may include funding for:

(1) expanding current space to create an urgency room;

(2) performing medical or mental health evaluations;

(3) developing a care plan for the youth; or

(4) providing recommendations for further care, either at an inpatient or outpatient facility.

Subd. 6. **Reporting.** (a) Grantees must provide a report to the commissioner in a manner specified by the commissioner on the following:

(1) how grant funds were spent;

(2) how many youths the grantee served; and

(3) how the grantee met the goal of the grant program.

(b) The commissioner must provide a report to the chairs and ranking minority members of the legislative committees with jurisdiction over human services regarding grant activities one year from the date all grant contracts have been executed. The commissioner must provide an updated report two years from the date all grant contracts have been executed on the progress of the grant program and how grant funds were spent. This report must be made available to the public.

Sec. 17. **MENTAL HEALTH GRANTS FOR HEALTH CARE PROFESSIONALS.**

Subdivision 1. **Grants authorized.** (a) The commissioner of health shall develop a grant program to award grants to health care entities, including but not limited to health care systems, hospitals, nursing facilities, community health clinics or consortium of clinics, federally qualified health centers, rural health clinics, or health professional associations for the purpose of establishing or expanding programs focused on improving the mental health of health care professionals.

(b) Grants shall be awarded for programs that are evidenced-based or evidenced-informed and are focused on addressing the mental health of health care professionals by:

(1) identifying and addressing the barriers to and stigma among health care professionals associated with seeking self-care, including mental health and substance use disorder services;

(2) encouraging health care professionals to seek support and care for mental health and substance use disorder concerns;

(3) identifying risk factors associated with suicide and other mental health conditions; or

(4) developing and making available resources to support health care professionals with self-care and resiliency.

Subd. 2. **Allocation of grants.** (a) To receive a grant, a health care entity must submit an application to the commissioner by the deadline established by the commissioner. An application must be on a form and contain information as specified by the commissioner and at a minimum must contain:

(1) a description of the purpose of the program for which the grant funds will be used;

(2) a description of the achievable objectives of the program and how these objectives will be met; and

(3) a process for documenting and evaluating the results of the program.

(b) The commissioner shall give priority to programs that involve peer-to-peer support.

Subd. 3. **Evaluation.** The commissioner shall evaluate the overall effectiveness of the grant program by conducting a periodic evaluation of the impact and outcomes of the grant program on health care professional burnout and retention. The commissioner shall submit the results of the evaluation and any recommendations for improving the grant program to the chairs and ranking minority members of the legislative committees with jurisdiction over health care policy and finance by October 15, 2024.

Sec. 18. **ONLINE MUSIC INSTRUCTION GRANT PROGRAM.**

(a) The commissioner of health shall award a grant to a community music education and performance center to partner with schools and early childhood centers to provide online music instruction to students and children for the purpose of increasing student self-confidence, providing students with a sense of community, and reducing individual stress. In applying for the grant, an applicant must commit to providing at least a 30 percent match of the funds allocated. The applicant must also include in the application the measurable outcomes the applicant intends to accomplish with the grant funds.

(b) The grantee shall use grant funds to partner with schools or early childhood centers that are designated Title I schools or centers or are located in rural Minnesota, and may use the funds in consultation with the music or early childhood educators in each school or early

childhood center to provide individual or small group music instruction, sectional ensembles, or other group music activities, music workshops, or early childhood music activities. At least half of the online music programs must be in partnership with schools or early childhood centers located in rural Minnesota. A grantee may use the funds awarded to supplement or enhance an existing online music program within a school or early childhood center that meets the criteria described in this paragraph.

(c) The grantee must contract with a third-party entity to evaluate the success of the online music program. The evaluation must include interviews with the music educators and students at the schools and early childhood centers where an online music program was established. The results of the evaluation must be submitted to the commissioner of health and to the chairs and ranking minority members of the legislative committees with jurisdiction over mental health policy and finance by December 15, 2025.

Sec. 19. **APPROPRIATION; REDUCTION.**

(a) $2,343,000 in fiscal year 2023 is appropriated from the general fund to the commissioner of health for the health care professionals mental health grant program. This is a onetime appropriation.

(b) The general fund appropriation to the commissioner of health for the Office of Medical Cannabis, estimated to be $781,000, is eliminated.

Sec. 20. **APPROPRIATION; SCHOOL-LINKED MENTAL HEALTH GRANTS.**

$2,400,000 in fiscal year 2023 is appropriated from the general fund to the commissioner of human services for school-linked mental health grants under Minnesota Statutes, section 245.4901.

Sec. 21. **APPROPRIATION; SHELTER-LINKED MENTAL HEALTH GRANTS.**

$2,000,000 in fiscal year 2023 is appropriated from the general fund to the commissioner of human services for shelter-linked youth mental health grants under Minnesota Statutes, section 256K.46.

Sec. 22. **APPROPRIATION; MOBILE CRISIS SERVICES.**

The general fund base for grants for adult mobile crisis services under Minnesota Statutes, section 245.4661, subdivision 9, paragraph (b), clause (15), is increased by $4,000,000 in fiscal year 2024 and increased by $8,000,000 in fiscal year 2025.

Sec. 23. **APPROPRIATION; MENTAL HEALTH URGENCY ROOMS GRANT PROGRAM.**

$4,500,000 in fiscal year 2023 is appropriated from the general fund to the commissioner of human services for mental health urgency room grants. This is a onetime appropriation.

Sec. 24. **APPROPRIATION; MENTAL HEALTH PROFESSIONAL LOAN FORGIVENESS.**

Notwithstanding the priorities and distribution requirements under Minnesota Statutes, section 144.1501, $2,750,000 is appropriated in fiscal year 2023 from the general fund to the commissioner of health for the health professional loan forgiveness program to be used for loan forgiveness only for individuals who are eligible mental health professionals under Minnesota Statutes, section 144.1501. Notwithstanding Minnesota Statutes, section 144.1501, subdivision 2, paragraph (b), if the commissioner of health does not receive enough qualified mental health professional applicants within fiscal year 2023 to use this entire appropriation, the remaining funds shall be carried over to the next biennium and allocated proportionally among the other eligible professions in accordance with Minnesota Statutes, section 144.1501, subdivision 2.

Sec. 25. **APPROPRIATION; MENTAL HEALTH PROVIDER SUPERVISION GRANT PROGRAM.**

$2,000,000 is appropriated in fiscal year 2023 from the general fund to the commissioner of health for the mental health provider supervision grant program under Minnesota Statutes, section 144.1508.

Sec. 26. **APPROPRIATION; INTENSIVE RESIDENTIAL TREATMENT SERVICES.**

(a) $2,914,000 in fiscal year 2023 is appropriated from the general fund to the commissioner of human services to provide start-up funds to intensive residential treatment service providers to provide treatment in locked facilities for patients who have been transferred from a jail or who have been deemed incompetent to stand trial and a judge has determined that the patient needs to be in a secure facility. The base for this appropriation is $180,000 in fiscal year 2024 and $0 in fiscal year 2025.

(b) Of this appropriation, $115,000 in fiscal year 2023 is for administration and $3,000 in fiscal year 2023 is for systems costs.

(c) The base for administration is $179,000 in fiscal year 2024 and is available until June 30, 2025. The base for systems costs is $1,000 in fiscal year 2024 and $0 in fiscal year 2025.

Sec. 27. **APPROPRIATION; ADULT MENTAL HEALTH INITIATIVE GRANTS.**

(a) The general fund base for adult mental health initiative services under Minnesota Statutes, section 245.4661, is increased by $10,325,000 in fiscal year 2025 and thereafter, and is increased by an additional $10,232,000 in fiscal year 2026 and thereafter.

(b) $400,000 in fiscal year 2023 is appropriated from the general fund to the commissioner of management and budget to create and maintain an inventory of adult mental health initiative services and to conduct evaluations of adult mental health initiative services that are promising practices or theory-based activities under Minnesota Statutes, section 245.4661, subdivision 5a.

Sec. 28. **APPROPRIATION; FORENSIC NAVIGATORS.**

$6,000,000 in fiscal year 2023 is appropriated from the general fund to the commissioner of human services for costs associated with providing forensic navigator services under Minnesota Statutes, section 611.42.

Sec. 29. **APPROPRIATION.**

$300,000 in fiscal year 2023 is appropriated from the general fund to the commissioner of health for a grant for the online music instruction grant program. This is a onetime appropriation and is available until June 30, 2025.

Sec. 30. **APPROPRIATION; OFFICER-INVOLVED COMMUNITY-BASED CARE COORDINATION.**

$11,000 in fiscal year 2023 is appropriated from the general fund to the commissioner of human services for medical assistance expenditures for officer-involved community-based care coordination. The general fund base for this appropriation is $10,000 in fiscal year 2024 and $15,000 in fiscal year 2025.

Sec. 31. **APPROPRIATION; MENTAL HEALTH BENEFIT FOR CHILDREN IN CRISIS.**

$92,000 is appropriated from the general fund to the commissioner of human services for the development of a medical assistance eligible mental health benefit for children in crisis under section 14. This is a onetime appropriation.

Sec. 32. **APPROPRIATION; MANAGED CARE DIRECTED PAYMENT RATE FOR MENTAL HEALTH SERVICES.**

$28,000 in fiscal year 2023 is appropriated from the general fund to the commissioner of human services to monitor the fee-for-service mental health minimum rate under Minnesota Statutes, section 256B.0625, subdivision 5. The general fund base for this appropriation is $32,000 in fiscal year 2024 and $32,000 in fiscal year 2025.

Sec. 33. **REPEALER.**

Minnesota Statutes 2020, section 245.4661, subdivision 8, is repealed.

245.4661 PILOT PROJECTS; ADULT MENTAL HEALTH SERVICES.

Subd. 8. **Budget flexibility.** The commissioner may make budget transfers that do not increase the state share of costs to effectively implement the restructuring of adult mental health services.