

SENATE

STATE OF MINNESOTA

NINETY-FOURTH SESSION

S.F. No. 1953

(SENATE AUTHORS: MANN)		
DATE	D-PG	OFFICIAL STATUS
02/27/2025	565	Introduction and first reading Referred to Health and Human Services
03/17/2025	837a	Comm report: To pass as amended and re-refer to Human Services See HF2115

1.1

A bill for an act

1.2

relating to mental health; modifying the definition of mental illness; making changes

1.3

to medical assistance transportation reimbursement rates; establishing a grant

1.4

program for children at risk of bipolar disorder; requiring a report; appropriating

1.5

money for the children's first episode of psychosis program; amending Minnesota

1.6

Statutes 2024, sections 245.462, subdivision 20; 245.467, subdivision 4; 245.4711,

1.7

subdivisions 1, 4; 245.4712, subdivisions 1, 3; 245.4889, subdivision 1; 245I.05,

1.8

subdivisions 3, 5; 245I.11, subdivision 5; 256B.0625, subdivisions 3b, 17, 20;

1.9

proposing coding for new law in Minnesota Statutes, chapter 245.

1.10

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

1.11

Section 1. Minnesota Statutes 2024, section 245.462, subdivision 20, is amended to read:

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Subd. 20. **Mental illness.** (a) "Mental illness" means an organic disorder of the brain or

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a clinically significant disorder of thought, mood, perception, orientation, memory, or

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behavior that is detailed in a diagnostic codes list published by the commissioner, and that

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seriously limits a person's capacity to function in primary aspects of daily living such as

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personal relations, living arrangements, work, and recreation.

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(b) An "adult with acute mental illness" means an adult who has a mental illness that is

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serious enough to require prompt intervention.

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(c) For purposes of enrolling in case management and community support services, a

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"person with serious and persistent mental illness" means an adult who has a mental illness

1.21

and meets at least one of the following criteria:

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(1) the adult has undergone ~~two~~ one or more episodes of inpatient, residential, or crisis

1.23

residential care for a mental illness within the preceding ~~24~~ 12 months;

(2) the adult has experienced a continuous psychiatric hospitalization or residential treatment exceeding six months' duration within the preceding 12 months;

(3) the adult has been treated by a crisis team two or more times within the preceding 24 months;

(4) the adult:

(i) has a diagnosis of schizophrenia, bipolar disorder, major depression, schizoaffective disorder, posttraumatic stress disorder, generalized anxiety disorder, panic disorder, eating disorder, or borderline personality disorder;

(ii) indicates a significant impairment in functioning; and

(iii) has a written opinion from a mental health professional, in the last three years, stating that the adult is reasonably likely to have future episodes requiring inpatient or residential treatment, of a frequency described in clause (1) or (2), or the need for in-home services to remain in one's home, unless ongoing case management or community support services are provided;

(5) the adult has, in the last ~~three~~ five years, been committed by a court as a person ~~who is mentally ill~~ with a mental illness under chapter 253B, or the adult's commitment has been stayed or continued; or

~~(6) the adult (i) was eligible under clauses (1) to (5), but the specified time period has expired or the adult was eligible as a child under section 245.4871, subdivision 6; and (ii) has a written opinion from a mental health professional, in the last three years, stating that the adult is reasonably likely to have future episodes requiring inpatient or residential treatment, of a frequency described in clause (1) or (2), unless ongoing case management or community support services are provided; or~~

~~(7)~~ (6) the adult was eligible as a child under section 245.4871, subdivision 6, and is age 21 or younger.

(d) For purposes of enrolling in case management and community support services, a "person with a complex post-traumatic stress disorder" or "C-PTSD" means an adult who has a mental illness and meets the following criteria:

(1) the adult has post-traumatic stress disorder (PTSD) symptoms that significantly interfere with daily functioning related to intergenerational trauma, racial trauma, or unresolved historical grief; and

(2) the adult has a written opinion from a mental health professional that includes documentation of:

(i) culturally sensitive assessments or screenings and identification of intergenerational trauma, racial trauma, or unresolved historical grief;

(ii) significant impairment in functioning due to the PTSD symptoms that meet C-PTSD condition eligibility; and

(iii) increasing concerns within the last three years that indicates the adult is at a reasonable likelihood of experiencing significant episodes of PTSD with increased frequency, impacting daily functioning unless mitigated by targeted case management or community support services.

(e) Adults may continue to receive case management or community support services if, in the written opinion of a mental health professional, the person needs case management or community support services to maintain the person's recovery.

EFFECTIVE DATE. Paragraph (d) is effective upon federal approval. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 2. Minnesota Statutes 2024, section 245.467, subdivision 4, is amended to read:

Subd. 4. **Referral for case management.** Each provider of emergency services, day treatment services, outpatient treatment, community support services, residential treatment, acute care hospital inpatient treatment, or regional treatment center inpatient treatment must inform each of its clients with serious and persistent mental illness or a complex post-traumatic stress disorder of the availability and potential benefits to the client of case management. If the client consents, the provider must refer the client by notifying the county employee designated by the county board to coordinate case management activities of the client's name and address and by informing the client of whom to contact to request case management. The provider must document compliance with this subdivision in the client's record.

EFFECTIVE DATE. This section is effective upon federal approval. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 3. Minnesota Statutes 2024, section 245.4711, subdivision 1, is amended to read:

Subdivision 1. **Availability of case management services.** (a) ~~By January 1, 1989,~~ The county board shall provide case management services for all adults with serious and persistent mental illness or a complex post-traumatic stress disorder who are residents of the county

and who request or consent to the services and to each adult for whom the court appoints a case manager. Staffing ratios must be sufficient to serve the needs of the clients. The case manager must meet the requirements in section 245.462, subdivision 4.

(b) Case management services provided to adults with serious and persistent mental illness or a complex post-traumatic stress disorder eligible for medical assistance must be billed to the medical assistance program under sections 256B.02, subdivision 8, and 256B.0625.

(c) Case management services are eligible for reimbursement under the medical assistance program. Costs associated with mentoring, supervision, and continuing education may be included in the reimbursement rate methodology used for case management services under the medical assistance program.

EFFECTIVE DATE. This section is effective upon federal approval. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 4. Minnesota Statutes 2024, section 245.4711, subdivision 4, is amended to read:

Subd. 4. **Individual community support plan.** (a) The case manager must develop an individual community support plan for each adult that incorporates the client's individual treatment plan. The individual treatment plan may not be a substitute for the development of an individual community support plan. The individual community support plan must be developed within 30 days of client intake and reviewed at least every 180 days after it is developed, unless the case manager receives a written request from the client or the client's family for a review of the plan every 90 days after it is developed. The case manager is responsible for developing the individual community support plan based on a diagnostic assessment and a functional assessment and for implementing and monitoring the delivery of services according to the individual community support plan. To the extent possible, the adult with serious and persistent mental illness or a complex post-traumatic stress disorder, the person's family, advocates, service providers, and significant others must be involved in all phases of development and implementation of the individual community support plan.

(b) The client's individual community support plan must state:

(1) the goals of each service;

(2) the activities for accomplishing each goal;

(3) a schedule for each activity; and

(4) the frequency of face-to-face contacts by the case manager, as appropriate to client need and the implementation of the individual community support plan.

EFFECTIVE DATE. This section is effective upon federal approval. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 5. Minnesota Statutes 2024, section 245.4712, subdivision 1, is amended to read:

Subdivision 1. **Availability of community support services.** (a) County boards must provide or contract for sufficient community support services within the county to meet the needs of adults with serious and persistent mental illness or a complex post-traumatic stress disorder who are residents of the county. Adults may be required to pay a fee according to section 245.481. The community support services program must be designed to improve the ability of adults with serious and persistent mental illness or a complex post-traumatic stress disorder to:

(1) find and maintain competitive employment;

(2) handle basic activities of daily living;

(3) participate in leisure time activities;

(4) set goals and plans; and

(5) obtain and maintain appropriate living arrangements.

The community support services program must also be designed to reduce the need for and use of more intensive, costly, or restrictive placements both in number of admissions and length of stay.

(b) Community support services are those services that are supportive in nature and not necessarily treatment oriented, and include:

(1) conducting outreach activities such as home visits, health and wellness checks, and problem solving;

(2) connecting people to resources to meet their basic needs;

(3) finding, securing, and supporting people in their housing;

(4) attaining and maintaining health insurance benefits;

(5) assisting with job applications, finding and maintaining employment, and securing a stable financial situation;

(6) fostering social support, including support groups, mentoring, peer support, and other efforts to prevent isolation and promote recovery; and

(7) educating about mental illness, treatment, and recovery.

(c) Community support services shall use all available funding streams. The county shall maintain the level of expenditures for this program, as required under section 245.4835. County boards must continue to provide funds for those services not covered by other funding streams and to maintain an infrastructure to carry out these services. The county is encouraged to fund evidence-based practices such as Individual Placement and Supported Employment and Illness Management and Recovery.

(d) The commissioner shall collect data on community support services programs, including, but not limited to, demographic information such as age, sex, race, the number of people served, and information related to housing, employment, hospitalization, symptoms, and satisfaction with services.

EFFECTIVE DATE. This section is effective upon federal approval. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 6. Minnesota Statutes 2024, section 245.4712, subdivision 3, is amended to read:

Subd. 3. **Benefits assistance.** The county board must offer to help adults with serious and persistent mental illness or a complex post-traumatic stress disorder in applying for state and federal benefits, including Supplemental Security Income, medical assistance, Medicare, general assistance, and Minnesota supplemental aid. The help must be offered as part of the community support program available to adults with serious and persistent mental illness or a complex post-traumatic stress disorder for whom the county is financially responsible and who may qualify for these benefits.

Sec. 7. Minnesota Statutes 2024, section 245.4889, subdivision 1, is amended to read:

Subdivision 1. **Establishment and authority.** (a) The commissioner is authorized to make grants from available appropriations to assist:

(1) counties;

(2) Indian tribes;

(3) children's collaboratives under section 142D.15 or 245.493; or

(4) mental health service providers.

(b) The following services are eligible for grants under this section:

(1) services to children with emotional disturbances as defined in section 245.4871, subdivision 15, and their families;

(2) transition services under section 245.4875, subdivision 8, for young adults under age 21 and their families;

(3) respite care services for children with emotional disturbances or severe emotional disturbances who are at risk of residential treatment or hospitalization, who are already in out-of-home placement in family foster settings as defined in chapter 142B and at risk of change in out-of-home placement or placement in a residential facility or other higher level of care, who have utilized crisis services or emergency room services, or who have experienced a loss of in-home staffing support. Allowable activities and expenses for respite care services are defined under subdivision 4. A child is not required to have case management services to receive respite care services. Counties must work to provide access to regularly scheduled respite care;

(4) children's mental health crisis services;

(5) child-, youth-, and family-specific mobile response and stabilization services models;

(6) mental health services for people from cultural and ethnic minorities, including supervision of clinical trainees who are Black, indigenous, or people of color;

(7) children's mental health screening and follow-up diagnostic assessment and treatment;

(8) services to promote and develop the capacity of providers to use evidence-based practices in providing children's mental health services;

(9) school-linked mental health services under section 245.4901;

(10) building evidence-based mental health intervention capacity for children birth to age five;

(11) suicide prevention and counseling services that use text messaging statewide;

(12) mental health first aid training;

(13) training for parents, collaborative partners, and mental health providers on the impact of adverse childhood experiences and trauma and development of an interactive website to share information and strategies to promote resilience and prevent trauma;

(14) transition age services to develop or expand mental health treatment and supports for adolescents and young adults 26 years of age or younger;

(15) early childhood mental health consultation;

(16) evidence-based interventions for youth at risk of developing or experiencing a first episode of psychosis, and a public awareness campaign on the signs and symptoms of psychosis;

(17) psychiatric consultation for primary care practitioners; ~~and~~

(18) providers to begin operations and meet program requirements when establishing a new children's mental health program. These may be start-up grants; and

(19) evidence-based interventions for youth and young adults at risk of developing or experiencing an early episode of bipolar disorder.

(c) Services under paragraph (b) must be designed to help each child to function and remain with the child's family in the community and delivered consistent with the child's treatment plan. Transition services to eligible young adults under this paragraph must be designed to foster independent living in the community.

(d) As a condition of receiving grant funds, a grantee shall obtain all available third-party reimbursement sources, if applicable.

(e) The commissioner may establish and design a pilot program to expand the mobile response and stabilization services model for children, youth, and families. The commissioner may use grant funding to consult with a qualified expert entity to assist in the formulation of measurable outcomes and explore and position the state to submit a Medicaid state plan amendment to scale the model statewide.

Sec. 8. **[245.4904] EARLY EPISODE OF BIPOLAR DISORDER GRANT PROGRAM.**

Subdivision 1. Establishment. The commissioner of human services must establish an early episode of bipolar disorder grant program within the department to fund evidence-based interventions for youth and young adults at risk of developing or experiencing an early episode of bipolar disorder.

Subd. 2. Definitions. For the purposes of this section, "youth and young adults" means individuals who are 15 years of age or older and under 41 years of age.

Subd. 3. Activities. (a) All grantees must:

(1) provide intensive treatment and support for youth and young adults experiencing or at risk of experiencing early episodes of bipolar disorder. Intensive treatment and support may include medication management, psychoeducation for an individual and the individual's family, case management, employment support, education support, cognitive behavioral

9.1 approaches, social skills training, peer and family peer support, crisis planning, and stress
9.2 management;

9.3 (2) conduct outreach and provide training and guidance to mental health and health care
9.4 professionals, including postsecondary health clinicians, on bipolar disorder symptoms,
9.5 screening tools, the early episode of bipolar disorder grant program, and best practices; and

9.6 (3) use all available funding streams.

9.7 (b) Grant money may be used to pay for housing or travel expenses for individuals
9.8 receiving services or to address other barriers that prevent individuals and their families
9.9 from participating in early episode of bipolar disorder services.

9.10 (c) Program activities must only be provided to youth and young adults experiencing
9.11 bipolar disorder or early episodes of bipolar disorder.

9.12 Subd. 4. **Outcomes and report.** (a) The commissioner must annually evaluate the early
9.13 episode of bipolar grant program.

9.14 (b) The evaluation must utilize evidence-based practices and must include the following
9.15 outcome evaluation criteria:

9.16 (1) whether individuals experience a reduction in symptoms;

9.17 (2) whether individuals experience a decrease in inpatient mental health hospitalizations
9.18 or interactions with the criminal justice system; and

9.19 (3) whether individuals experience an increase in educational attainment or employment.

9.20 (c) By July 1, 2026, and every July 1 thereafter, the commissioner must provide a report
9.21 to the chairs and ranking minority members of the legislative committees with jurisdiction
9.22 over mental health, along with the chairs and ranking minority members of the senate finance
9.23 committee and house of representatives ways and means committee. The report must include
9.24 the number of grantees receiving funds under this section, the number of individuals served
9.25 under this section, data from the evaluation conducted under this subdivision, and information
9.26 on the use of state and federal funds for the services provided under this section.

9.27 Subd. 5. **Funding.** Early episode of bipolar disorder services are eligible for children's
9.28 mental health grants as specified in section 245.4889, subdivision 1, paragraph (b), clause
9.29 (19).

9.30 Subd. 6. **Federal aid or grants.** The commissioner of human services must comply with
9.31 all conditions and requirements necessary to receive federal aid or grants.

10.1 Sec. 9. Minnesota Statutes 2024, section 245I.05, subdivision 3, is amended to read:

10.2 Subd. 3. **Initial training.** (a) A staff person must receive training about:

10.3 (1) vulnerable adult maltreatment under section 245A.65, subdivision 3; and

10.4 (2) the maltreatment of minor reporting requirements and definitions in chapter 260E
10.5 within 72 hours of first providing direct contact services to a client.

10.6 (b) Before providing direct contact services to a client, a staff person must receive training
10.7 about:

10.8 (1) client rights and protections under section 245I.12;

10.9 (2) the Minnesota Health Records Act, including client confidentiality, family engagement
10.10 under section 144.294, and client privacy;

10.11 (3) emergency procedures that the staff person must follow when responding to a fire,
10.12 inclement weather, a report of a missing person, and a behavioral or medical emergency;

10.13 (4) specific activities and job functions for which the staff person is responsible, including
10.14 the license holder's program policies and procedures applicable to the staff person's position;

10.15 (5) professional boundaries that the staff person must maintain; and

10.16 (6) specific needs of each client to whom the staff person will be providing direct contact
10.17 services, including each client's developmental status, cognitive functioning, and physical
10.18 and mental abilities.

10.19 (c) Before providing direct contact services to a client, a mental health rehabilitation
10.20 worker, mental health behavioral aide, or mental health practitioner required to receive the
10.21 training according to section 245I.04, subdivision 4, must receive 30 hours of training about:

10.22 (1) mental illnesses;

10.23 (2) client recovery and resiliency;

10.24 (3) mental health de-escalation techniques;

10.25 (4) co-occurring mental illness and substance use disorders; and

10.26 (5) psychotropic medications and medication side effects, including tardive dyskinesia.

10.27 (d) Within 90 days of first providing direct contact services to an adult client, mental
10.28 health practitioner, mental health certified peer specialist, or mental health rehabilitation
10.29 worker must receive training about:

10.30 (1) trauma-informed care and secondary trauma;

11.1 (2) person-centered individual treatment plans, including seeking partnerships with
11.2 family and other natural supports;

11.3 (3) co-occurring substance use disorders; and

11.4 (4) culturally responsive treatment practices.

11.5 (e) Within 90 days of first providing direct contact services to a child client, mental
11.6 health practitioner, mental health certified family peer specialist, mental health certified
11.7 peer specialist, or mental health behavioral aide must receive training about the topics in
11.8 clauses (1) to (5). This training must address the developmental characteristics of each child
11.9 served by the license holder and address the needs of each child in the context of the child's
11.10 family, support system, and culture. Training topics must include:

11.11 (1) trauma-informed care and secondary trauma, including adverse childhood experiences
11.12 (ACEs);

11.13 (2) family-centered treatment plan development, including seeking partnership with a
11.14 child client's family and other natural supports;

11.15 (3) mental illness and co-occurring substance use disorders in family systems;

11.16 (4) culturally responsive treatment practices; and

11.17 (5) child development, including cognitive functioning, and physical and mental abilities.

11.18 (f) For a mental health behavioral aide, the training under paragraph (e) must include
11.19 parent team training using a curriculum approved by the commissioner.

11.20 Sec. 10. Minnesota Statutes 2024, section 245I.05, subdivision 5, is amended to read:

11.21 Subd. 5. **Additional training for medication administration.** (a) Prior to administering
11.22 medications to a client under delegated authority or observing a client self-administer
11.23 medications, a staff person who is not a licensed prescriber, registered nurse, or licensed
11.24 practical nurse qualified under section 148.171, subdivision 8, must receive training about
11.25 psychotropic medications, side effects including tardive dyskinesia, and medication
11.26 management.

11.27 (b) Prior to administering medications to a client under delegated authority, a staff person
11.28 must successfully complete a:

11.29 (1) medication administration training program for unlicensed personnel through an
11.30 accredited Minnesota postsecondary educational institution with completion of the course
11.31 documented in writing and placed in the staff person's personnel file; or

12.1 (2) formalized training program taught by a registered nurse or licensed prescriber that
12.2 is offered by the license holder. A staff person's successful completion of the formalized
12.3 training program must include direct observation of the staff person to determine the staff
12.4 person's areas of competency.

12.5 Sec. 11. Minnesota Statutes 2024, section 245I.11, subdivision 5, is amended to read:

12.6 Subd. 5. **Medication administration in residential programs.** If a license holder is
12.7 licensed as a residential program, the license holder must:

12.8 (1) assess and document each client's ability to self-administer medication. In the
12.9 assessment, the license holder must evaluate the client's ability to: (i) comply with prescribed
12.10 medication regimens; and (ii) store the client's medications safely and in a manner that
12.11 protects other individuals in the facility. Through the assessment process, the license holder
12.12 must assist the client in developing the skills necessary to safely self-administer medication;

12.13 (2) monitor the effectiveness of medications, side effects of medications, and adverse
12.14 reactions to medications, including symptoms and signs of tardive dyskinesia, for each
12.15 client. The license holder must address and document any concerns about a client's
12.16 medications;

12.17 (3) ensure that no staff person or client gives a legend drug supply for one client to
12.18 another client;

12.19 (4) have policies and procedures for: (i) keeping a record of each client's medication
12.20 orders; (ii) keeping a record of any incident of deferring a client's medications; (iii)
12.21 documenting any incident when a client's medication is omitted; and (iv) documenting when
12.22 a client refuses to take medications as prescribed; and

12.23 (5) document and track medication errors, document whether the license holder notified
12.24 anyone about the medication error, determine if the license holder must take any follow-up
12.25 actions, and identify the staff persons who are responsible for taking follow-up actions.

12.26 Sec. 12. Minnesota Statutes 2024, section 256B.0625, subdivision 3b, is amended to read:

12.27 Subd. 3b. **Telehealth services.** (a) Medical assistance covers medically necessary services
12.28 and consultations delivered by a health care provider through telehealth in the same manner
12.29 as if the service or consultation was delivered through in-person contact. Services or
12.30 consultations delivered through telehealth shall be paid at the full allowable rate.

13.1 (b) The commissioner may establish criteria that a health care provider must attest to in
13.2 order to demonstrate the safety or efficacy of delivering a particular service through
13.3 telehealth. The attestation may include that the health care provider:

13.4 (1) has identified the categories or types of services the health care provider will provide
13.5 through telehealth;

13.6 (2) has written policies and procedures specific to services delivered through telehealth
13.7 that are regularly reviewed and updated;

13.8 (3) has policies and procedures that adequately address patient safety before, during,
13.9 and after the service is delivered through telehealth;

13.10 (4) has established protocols addressing how and when to discontinue telehealth services;
13.11 and

13.12 (5) has an established quality assurance process related to delivering services through
13.13 telehealth.

13.14 (c) As a condition of payment, a licensed health care provider must document each
13.15 occurrence of a health service delivered through telehealth to a medical assistance enrollee.
13.16 Health care service records for services delivered through telehealth must meet the
13.17 requirements set forth in Minnesota Rules, part 9505.2175, subparts 1 and 2, and must
13.18 document:

13.19 (1) the type of service delivered through telehealth;

13.20 (2) the time the service began and the time the service ended, including an a.m. and p.m.
13.21 designation;

13.22 (3) the health care provider's basis for determining that telehealth is an appropriate and
13.23 effective means for delivering the service to the enrollee;

13.24 (4) the mode of transmission used to deliver the service through telehealth and records
13.25 evidencing that a particular mode of transmission was utilized;

13.26 (5) the location of the originating site and the distant site;

13.27 (6) if the claim for payment is based on a physician's consultation with another physician
13.28 through telehealth, the written opinion from the consulting physician providing the telehealth
13.29 consultation; and

13.30 (7) compliance with the criteria attested to by the health care provider in accordance
13.31 with paragraph (b).

(d) Telehealth visits provided through audio and visual communication or accessible video-based platforms may be used to satisfy the face-to-face requirement for reimbursement under the payment methods that apply to a federally qualified health center, rural health clinic, Indian health service, 638 tribal clinic, and certified community behavioral health clinic, if the service would have otherwise qualified for payment if performed in person.

(e) For purposes of this subdivision, unless otherwise covered under this chapter:

(1) "telehealth" means the delivery of health care services or consultations using real-time two-way interactive audio and visual communication or accessible telehealth video-based platforms to provide or support health care delivery and facilitate the assessment, diagnosis, consultation, treatment, education, and care management of a patient's health care. Telehealth includes: the application of secure video conferencing consisting of a real-time, full-motion synchronized video; store-and-forward technology; and synchronous interactions, between a patient located at an originating site and a health care provider located at a distant site. Telehealth does not include communication between health care providers, or between a health care provider and a patient that consists solely of an audio-only communication, email, or facsimile transmission or as specified by law, except that between January 1, 2026, and January 1, 2029, telehealth includes communication between a health care provider and a patient that solely consists of audio-only communication;

(2) "health care provider" means a health care provider as defined under section 62A.673; a community paramedic as defined under section 144E.001, subdivision 5f; a community health worker who meets the criteria under subdivision 49, paragraph (a); a mental health certified peer specialist under section 245I.04, subdivision 10; a mental health certified family peer specialist under section 245I.04, subdivision 12; a mental health rehabilitation worker under section 245I.04, subdivision 14; a mental health behavioral aide under section 245I.04, subdivision 16; a treatment coordinator under section 245G.11, subdivision 7; an alcohol and drug counselor under section 245G.11, subdivision 5; or a recovery peer under section 245G.11, subdivision 8; and

(3) "originating site," "distant site," and "store-and-forward technology" have the meanings given in section 62A.673, subdivision 2.

EFFECTIVE DATE. This section is effective January 1, 2026, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

15.1 Sec. 13. Minnesota Statutes 2024, section 256B.0625, subdivision 17, is amended to read:

15.2 Subd. 17. **Transportation costs.** (a) "Nonemergency medical transportation service"
15.3 means motor vehicle transportation provided by a public or private person that serves
15.4 Minnesota health care program beneficiaries who do not require emergency ambulance
15.5 service, as defined in section 144E.001, subdivision 3, to obtain covered medical services.

15.6 (b) For purposes of this subdivision, "rural urban commuting area" or "RUCA" means
15.7 a census-tract based classification system under which a geographical area is determined
15.8 to be urban, rural, or super rural.

15.9 (c) Medical assistance covers medical transportation costs incurred solely for obtaining
15.10 emergency medical care or transportation costs incurred by eligible persons in obtaining
15.11 emergency or nonemergency medical care when paid directly to an ambulance company,
15.12 nonemergency medical transportation company, or other recognized providers of
15.13 transportation services. Medical transportation must be provided by:

15.14 (1) nonemergency medical transportation providers who meet the requirements of this
15.15 subdivision;

15.16 (2) ambulances, as defined in section 144E.001, subdivision 2;

15.17 (3) taxicabs that meet the requirements of this subdivision;

15.18 (4) public transportation, within the meaning of "public transportation" as defined in
15.19 section 174.22, subdivision 7; or

15.20 (5) not-for-hire vehicles, including volunteer drivers, as defined in section 65B.472,
15.21 subdivision 1, paragraph (p).

15.22 (d) Medical assistance covers nonemergency medical transportation provided by
15.23 nonemergency medical transportation providers enrolled in the Minnesota health care
15.24 programs. All nonemergency medical transportation providers must comply with the
15.25 operating standards for special transportation service as defined in sections 174.29 to 174.30
15.26 and Minnesota Rules, chapter 8840, and all drivers must be individually enrolled with the
15.27 commissioner and reported on the claim as the individual who provided the service. All
15.28 nonemergency medical transportation providers shall bill for nonemergency medical
15.29 transportation services in accordance with Minnesota health care programs criteria. Publicly
15.30 operated transit systems, volunteers, and not-for-hire vehicles are exempt from the
15.31 requirements outlined in this paragraph.

15.32 (e) An organization may be terminated, denied, or suspended from enrollment if:

16.1 (1) the provider has not initiated background studies on the individuals specified in
16.2 section 174.30, subdivision 10, paragraph (a), clauses (1) to (3); or

16.3 (2) the provider has initiated background studies on the individuals specified in section
16.4 174.30, subdivision 10, paragraph (a), clauses (1) to (3), and:

16.5 (i) the commissioner has sent the provider a notice that the individual has been
16.6 disqualified under section 245C.14; and

16.7 (ii) the individual has not received a disqualification set-aside specific to the special
16.8 transportation services provider under sections 245C.22 and 245C.23.

16.9 (f) The administrative agency of nonemergency medical transportation must:

16.10 (1) adhere to the policies defined by the commissioner;

16.11 (2) pay nonemergency medical transportation providers for services provided to
16.12 Minnesota health care programs beneficiaries to obtain covered medical services;

16.13 (3) provide data monthly to the commissioner on appeals, complaints, no-shows, canceled
16.14 trips, and number of trips by mode; and

16.15 (4) by July 1, 2016, in accordance with subdivision 18e, utilize a web-based single
16.16 administrative structure assessment tool that meets the technical requirements established
16.17 by the commissioner, reconciles trip information with claims being submitted by providers,
16.18 and ensures prompt payment for nonemergency medical transportation services.

16.19 (g) Until the commissioner implements the single administrative structure and delivery
16.20 system under subdivision 18e, clients shall obtain their level-of-service certificate from the
16.21 commissioner or an entity approved by the commissioner that does not dispatch rides for
16.22 clients using modes of transportation under paragraph (l), clauses (4), (5), (6), and (7).

16.23 (h) The commissioner may use an order by the recipient's attending physician, advanced
16.24 practice registered nurse, physician assistant, or a medical or mental health professional to
16.25 certify that the recipient requires nonemergency medical transportation services.

16.26 Nonemergency medical transportation providers shall perform driver-assisted services for
16.27 eligible individuals, when appropriate. Driver-assisted service includes passenger pickup
16.28 at and return to the individual's residence or place of business, assistance with admittance
16.29 of the individual to the medical facility, and assistance in passenger securement or in securing
16.30 of wheelchairs, child seats, or stretchers in the vehicle.

16.31 (i) Nonemergency medical transportation providers must take clients to the health care
16.32 provider using the most direct route, and must not exceed 30 miles for a trip to a primary

17.1 care provider or 60 miles for a trip to a specialty care provider, unless the client receives
17.2 authorization from the local agency.

17.3 (j) Nonemergency medical transportation providers may not bill for separate base rates
17.4 for the continuation of a trip beyond the original destination. Nonemergency medical
17.5 transportation providers must maintain trip logs, which include pickup and drop-off times,
17.6 signed by the medical provider or client, whichever is deemed most appropriate, attesting
17.7 to mileage traveled to obtain covered medical services. Clients requesting client mileage
17.8 reimbursement must sign the trip log attesting mileage traveled to obtain covered medical
17.9 services.

17.10 (k) The administrative agency shall use the level of service process established by the
17.11 commissioner to determine the client's most appropriate mode of transportation. If public
17.12 transit or a certified transportation provider is not available to provide the appropriate service
17.13 mode for the client, the client may receive a onetime service upgrade.

17.14 (l) The covered modes of transportation are:

17.15 (1) client reimbursement, which includes client mileage reimbursement provided to
17.16 clients who have their own transportation, or to family or an acquaintance who provides
17.17 transportation to the client;

17.18 (2) volunteer transport, which includes transportation by volunteers using their own
17.19 vehicle;

17.20 (3) unassisted transport, which includes transportation provided to a client by a taxicab
17.21 or public transit. If a taxicab or public transit is not available, the client can receive
17.22 transportation from another nonemergency medical transportation provider;

17.23 (4) assisted transport, which includes transport provided to clients who require assistance
17.24 by a nonemergency medical transportation provider;

17.25 (5) lift-equipped/ramp transport, which includes transport provided to a client who is
17.26 dependent on a device and requires a nonemergency medical transportation provider with
17.27 a vehicle containing a lift or ramp;

17.28 (6) protected transport, which includes transport provided to a client who has received
17.29 a prescreening that has deemed other forms of transportation inappropriate and who requires
17.30 a provider: (i) with a protected vehicle that is not an ambulance or police car and has safety
17.31 locks, a video recorder, and a transparent thermoplastic partition between the passenger and
17.32 the vehicle driver; and (ii) who is certified as a protected transport provider; and

18.1 (7) stretcher transport, which includes transport for a client in a prone or supine position
18.2 and requires a nonemergency medical transportation provider with a vehicle that can transport
18.3 a client in a prone or supine position.

18.4 (m) The local agency shall be the single administrative agency and shall administer and
18.5 reimburse for modes defined in paragraph (l) according to paragraphs (p) and (q) when the
18.6 commissioner has developed, made available, and funded the web-based single administrative
18.7 structure, assessment tool, and level of need assessment under subdivision 18e. The local
18.8 agency's financial obligation is limited to funds provided by the state or federal government.

18.9 (n) The commissioner shall:

18.10 (1) verify that the mode and use of nonemergency medical transportation is appropriate;

18.11 (2) verify that the client is going to an approved medical appointment; and

18.12 (3) investigate all complaints and appeals.

18.13 (o) The administrative agency shall pay for the services provided in this subdivision and
18.14 seek reimbursement from the commissioner, if appropriate. As vendors of medical care,
18.15 local agencies are subject to the provisions in section 256B.041, the sanctions and monetary
18.16 recovery actions in section 256B.064, and Minnesota Rules, parts 9505.2160 to 9505.2245.

18.17 (p) Payments for nonemergency medical transportation must be paid based on the client's
18.18 assessed mode under paragraph (k), not the type of vehicle used to provide the service. The
18.19 medical assistance reimbursement rates for nonemergency medical transportation services
18.20 that are payable by or on behalf of the commissioner for nonemergency medical
18.21 transportation services are:

18.22 (1) \$0.22 per mile for client reimbursement;

18.23 (2) up to 100 percent of the Internal Revenue Service business deduction rate for volunteer
18.24 transport;

18.25 (3) equivalent to the standard fare for unassisted transport when provided by public
18.26 transit, and \$12.10 for the base rate and \$1.43 per mile when provided by a nonemergency
18.27 medical transportation provider;

18.28 (4) \$14.30 for the base rate and \$1.43 per mile for assisted transport;

18.29 (5) \$19.80 for the base rate and \$1.70 per mile for lift-equipped/ramp transport;

18.30 (6) \$75 for the base rate for the first 100 miles and an additional \$75 for trips over 100
18.31 miles and \$2.40 per mile for protected transport; and

19.1 (7) \$60 for the base rate and \$2.40 per mile for stretcher transport, and \$9 per trip for
19.2 an additional attendant if deemed medically necessary.

19.3 (q) The base rate for nonemergency medical transportation services in areas defined
19.4 under RUCA to be super rural is equal to 111.3 percent of the respective base rate in
19.5 paragraph (p), clauses (1) to (7). The mileage rate for nonemergency medical transportation
19.6 services in areas defined under RUCA to be rural or super rural areas is:

19.7 (1) for a trip equal to 17 miles or less, equal to 125 percent of the respective mileage
19.8 rate in paragraph (p), clauses (1) to (7); and

19.9 (2) for a trip between 18 and 50 miles, equal to 112.5 percent of the respective mileage
19.10 rate in paragraph (p), clauses (1) to (7).

19.11 (r) For purposes of reimbursement rates for nonemergency medical transportation services
19.12 under paragraphs (p) and (q), the zip code of the recipient's place of residence shall determine
19.13 whether the urban, rural, or super rural reimbursement rate applies.

19.14 (s) The commissioner, when determining reimbursement rates for nonemergency medical
19.15 transportation under paragraphs (p) and (q), shall exempt all modes of transportation listed
19.16 under paragraph (l) from Minnesota Rules, part 9505.0445, item R, subitem (2).

19.17 (t) Effective for the first day of each calendar quarter in which the price of gasoline as
19.18 posted publicly by the United States Energy Information Administration exceeds \$3.00 per
19.19 gallon, the commissioner shall adjust the rate paid per mile in paragraph (p) by one percent
19.20 up or down for every increase or decrease of ten cents for the price of gasoline. The increase
19.21 or decrease must be calculated using a base gasoline price of \$3.00. The percentage increase
19.22 or decrease must be calculated using the average of the most recently available price of all
19.23 grades of gasoline for Minnesota as posted publicly by the United States Energy Information
19.24 Administration.

19.25 Sec. 14. Minnesota Statutes 2024, section 256B.0625, subdivision 20, is amended to read:

19.26 Subd. 20. **Mental health case management.** (a) To the extent authorized by rule of the
19.27 state agency, medical assistance covers case management services to persons with serious
19.28 and persistent mental illness, persons with a complex post-traumatic stress disorder, and
19.29 children with severe emotional disturbance. Services provided under this section must meet
19.30 the relevant standards in sections 245.461 to 245.4887, the Comprehensive Adult and
19.31 Children's Mental Health Acts, Minnesota Rules, parts 9520.0900 to 9520.0926, and
19.32 9505.0322, excluding subpart 10.

20.1 (b) Entities meeting program standards set out in rules governing family community
20.2 support services as defined in section 245.4871, subdivision 17, are eligible for medical
20.3 assistance reimbursement for case management services for children with severe emotional
20.4 disturbance when these services meet the program standards in Minnesota Rules, parts
20.5 9520.0900 to 9520.0926 and 9505.0322, excluding subparts 6 and 10.

20.6 (c) Medical assistance and MinnesotaCare payment for mental health case management
20.7 shall be made on a monthly basis. In order to receive payment for an eligible child, the
20.8 provider must document at least a face-to-face contact either in person or by interactive
20.9 video that meets the requirements of subdivision 20b with the child, the child's parents, or
20.10 the child's legal representative. To receive payment for an eligible adult, the provider must
20.11 document:

20.12 (1) at least a face-to-face contact with the adult or the adult's legal representative either
20.13 in person or by interactive video that meets the requirements of subdivision 20b; or

20.14 (2) at least a telephone contact with the adult or the adult's legal representative and
20.15 document a face-to-face contact either in person or by interactive video that meets the
20.16 requirements of subdivision 20b with the adult or the adult's legal representative within the
20.17 preceding two months.

20.18 (d) Payment for mental health case management provided by county or state staff shall
20.19 be based on the monthly rate methodology under section 256B.094, subdivision 6, paragraph
20.20 (b), with separate rates calculated for child welfare and mental health, and within mental
20.21 health, separate rates for children and adults.

20.22 (e) Payment for mental health case management provided by Indian health services or
20.23 by agencies operated by Indian tribes may be made according to this section or other relevant
20.24 federally approved rate setting methodology.

20.25 (f) Payment for mental health case management provided by vendors who contract with
20.26 a county must be calculated in accordance with section 256B.076, subdivision 2. Payment
20.27 for mental health case management provided by vendors who contract with a Tribe must
20.28 be based on a monthly rate negotiated by the Tribe. The rate must not exceed the rate charged
20.29 by the vendor for the same service to other payers. If the service is provided by a team of
20.30 contracted vendors, the team shall determine how to distribute the rate among its members.
20.31 No reimbursement received by contracted vendors shall be returned to the county or tribe,
20.32 except to reimburse the county or tribe for advance funding provided by the county or tribe
20.33 to the vendor.

(g) If the service is provided by a team which includes contracted vendors, tribal staff, and county or state staff, the costs for county or state staff participation in the team shall be included in the rate for county-provided services. In this case, the contracted vendor, the tribal agency, and the county may each receive separate payment for services provided by each entity in the same month. In order to prevent duplication of services, each entity must document, in the recipient's file, the need for team case management and a description of the roles of the team members.

(h) Notwithstanding section 256B.19, subdivision 1, the nonfederal share of costs for mental health case management shall be provided by the recipient's county of responsibility, as defined in sections 256G.01 to 256G.12, from sources other than federal funds or funds used to match other federal funds. If the service is provided by a tribal agency, the nonfederal share, if any, shall be provided by the recipient's tribe. When this service is paid by the state without a federal share through fee-for-service, 50 percent of the cost shall be provided by the recipient's county of responsibility.

(i) Notwithstanding any administrative rule to the contrary, prepaid medical assistance and MinnesotaCare include mental health case management. When the service is provided through prepaid capitation, the nonfederal share is paid by the state and the county pays no share.

(j) The commissioner may suspend, reduce, or terminate the reimbursement to a provider that does not meet the reporting or other requirements of this section. The county of responsibility, as defined in sections 256G.01 to 256G.12, or, if applicable, the tribal agency, is responsible for any federal disallowances. The county or tribe may share this responsibility with its contracted vendors.

(k) The commissioner shall set aside a portion of the federal funds earned for county expenditures under this section to repay the special revenue maximization account under section 256.01, subdivision 2, paragraph (n). The repayment is limited to:

(1) the costs of developing and implementing this section; and

(2) programming the information systems.

(l) Payments to counties and tribal agencies for case management expenditures under this section shall only be made from federal earnings from services provided under this section. When this service is paid by the state without a federal share through fee-for-service, 50 percent of the cost shall be provided by the state. Payments to county-contracted vendors shall include the federal earnings, the state share, and the county share.

22.1 (m) Case management services under this subdivision do not include therapy, treatment,
22.2 legal, or outreach services.

22.3 (n) If the recipient is a resident of a nursing facility, intermediate care facility, or hospital,
22.4 and the recipient's institutional care is paid by medical assistance, payment for case
22.5 management services under this subdivision is limited to the lesser of:

22.6 (1) the last 180 days of the recipient's residency in that facility and may not exceed more
22.7 than six months in a calendar year; or

22.8 (2) the limits and conditions which apply to federal Medicaid funding for this service.

22.9 (o) Payment for case management services under this subdivision shall not duplicate
22.10 payments made under other program authorities for the same purpose.

22.11 (p) If the recipient is receiving care in a hospital, nursing facility, or residential setting
22.12 licensed under chapter 245A or 245D that is staffed 24 hours a day, seven days a week,
22.13 mental health targeted case management services must actively support identification of
22.14 community alternatives for the recipient and discharge planning.

22.15 **EFFECTIVE DATE.** This section is effective upon federal approval. The commissioner
22.16 of human services shall notify the revisor of statutes when federal approval is obtained.

22.17 Sec. 15. **APPROPRIATION; EARLY EPISODE OF BIPOLAR DISORDER GRANT**
22.18 **PROGRAM.**

22.19 \$..... in fiscal year 2026 and \$..... in fiscal year 2027 are appropriated from the general
22.20 fund to the commissioner of human services for the early episode of bipolar disorder grant
22.21 program under Minnesota Statutes, section 245.4904.

22.22 Sec. 16. **APPROPRIATION; FIRST EPISODE OF PSYCHOSIS GRANT**
22.23 **PROGRAM.**

22.24 (a) \$..... in fiscal year 2026 and \$..... in fiscal year 2027 are appropriated from the
22.25 general fund to the commissioner of human services for the first episode of psychosis grant
22.26 program under Minnesota Statutes, section 245.4905. This amount is added to the base.

22.27 (b) The commissioner of human services must fund current programs to ensure stability
22.28 and continuity of care, as long as the program has met the requirements for past usage of
22.29 funds. Funds may be used to fully fund current programs, increase a current program's
22.30 capacity, and expand programs to outside the seven-county metropolitan area.