# SENATE
## STATE OF MINNESOTA
## EIGHTY-SEVENTH LEGISLATURE

# S.F. No. 1285

**(SENATE AUTHORS: NEWMAN and Hann)**

| DATE | D-PG | OFFICIAL STATUS |
|---|---|---|
| 04/26/2011 | 1407 | Introduction and first reading<br>Referred to Health and Human Services |
| 04/27/2011 | 1435 | Chief author stricken, shown as co-author Hann<br>Chief author added Newman |
| 04/28/2011 | 1480a | Comm report: To pass as amended |
| | 1539 | Second reading |
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| 05/21/2011 | 3041 | Returned from House with amendment |
| | 3041 | Laid on table |
| | 3246 | Taken from table<br>Senate concurred and repassed bill |
| | 3246 | Third reading |

A bill for an act

relating to human services; making changes to chemical and mental health services; making rate reforms; amending Minnesota Statutes 2010, sections 245.462, subdivision 8; 245.467, subdivision 2; 245A.03, subdivision 7; 253B.02, subdivision 9; 254B.03, subdivisions 5, 9; 254B.05; 254B.12; 254B.13, subdivision 3; 256.9693; 256B.0622, subdivision 8; 256B.0623, subdivisions 3, 8; 256B.0624, subdivisions 2, 4, 6; 256B.0625, subdivisions 23, 38; 256B.0926, subdivision 2; 256B.0947; repealing Minnesota Statutes 2010, sections 254B.01, subdivision 7; 256B.0622, subdivision 8a.

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

Section 1. Minnesota Statutes 2010, section 245.462, subdivision 8, is amended to read:

Subd. 8. **Day treatment services.** "Day treatment," "day treatment services," or "day treatment program" means a structured program of treatment and care provided to an adult in or by: (1) a hospital accredited by the joint commission on accreditation of health organizations and licensed under sections 144.50 to 144.55; (2) a community mental health center under section 245.62; or (3) an entity that is under contract with the county board to operate a program that meets the requirements of section 245.4712, subdivision 2, and Minnesota Rules, parts 9505.0170 to 9505.0475. Day treatment consists of group psychotherapy and other intensive therapeutic services that are provided at least one day a week by a multidisciplinary staff under the clinical supervision of a mental health professional. Day treatment may include education and consultation provided to families and other individuals as part of the treatment process. The services are aimed at stabilizing the adult's mental health status, providing mental health services, and developing and improving the adult's independent living and socialization skills. The goal of day treatment is to reduce or relieve mental illness and to enable the adult to live in the community. Day treatment services are not a part of inpatient or residential treatment

services. Day treatment services are distinguished from day care by their structured therapeutic program of psychotherapy services. The commissioner may limit medical assistance reimbursement for day treatment to 15 hours per week per person ~~instead of the three hours per day per person specified in Minnesota Rules, part 9505.0323, subpart 15~~.

Sec. 2. Minnesota Statutes 2010, section 245.467, subdivision 2, is amended to read:

Subd. 2. **Diagnostic assessment.** All providers of residential, acute care hospital inpatient, and regional treatment centers must complete a diagnostic assessment for each of their clients within five days of admission. Providers of outpatient and day treatment services must complete a diagnostic assessment within five days after the adult's second visit or within 30 days after intake, whichever occurs first. In cases where a diagnostic assessment is available and has been completed within ~~180 days~~ three years preceding admission, only ~~updating~~ an adult diagnostic assessment update is necessary. ~~"Updating"~~ An "adult diagnostic assessment update" means a written summary by a mental health professional of the adult's current mental health status and service needs and includes a face-to-face interview with the adult. If the adult's mental health status has changed markedly since the adult's most recent diagnostic assessment, a new diagnostic assessment is required. Compliance with the provisions of this subdivision does not ensure eligibility for medical assistance or general assistance medical care reimbursement under chapters 256B and 256D.

Sec. 3. Minnesota Statutes 2010, section 245A.03, subdivision 7, is amended to read:

Subd. 7. **Licensing moratorium.** (a) The commissioner shall not issue an initial license for child foster care licensed under Minnesota Rules, parts 2960.3000 to 2960.3340, or adult foster care licensed under Minnesota Rules, parts 9555.5105 to 9555.6265, under this chapter for a physical location that will not be the primary residence of the license holder for the entire period of licensure. If a license is issued during this moratorium, and the license holder changes the license holder's primary residence away from the physical location of the foster care license, the commissioner shall revoke the license according to section 245A.07. Exceptions to the moratorium include:

(1) foster care settings that are required to be registered under chapter 144D;

(2) foster care licenses replacing foster care licenses in existence on May 15, 2009, and determined to be needed by the commissioner under paragraph (b);

(3) new foster care licenses determined to be needed by the commissioner under paragraph (b) for the closure of a nursing facility, ICF/MR, or regional treatment center, or restructuring of state-operated services that limits the capacity of state-operated facilities;

(4) new foster care licenses determined to be needed by the commissioner under paragraph (b) for persons requiring hospital level care; or

(5) new foster care licenses determined to be needed by the commissioner for the transition of people from personal care assistance to the home and community-based services.

(b) The commissioner shall determine the need for newly licensed foster care homes as defined under this subdivision. As part of the determination, the commissioner shall consider the availability of foster care capacity in the area in which the licensee seeks to operate, and the recommendation of the local county board. The determination by the commissioner must be final. A determination of need is not required for a change in ownership at the same address.

(c) Residential settings that would otherwise be subject to the moratorium established in paragraph (a), that are in the process of receiving an adult or child foster care license as of July 1, 2009, shall be allowed to continue to complete the process of receiving an adult or child foster care license. For this paragraph, all of the following conditions must be met to be considered in the process of receiving an adult or child foster care license:

(1) participants have made decisions to move into the residential setting, including documentation in each participant's care plan;

(2) the provider has purchased housing or has made a financial investment in the property;

(3) the lead agency has approved the plans, including costs for the residential setting for each individual;

(4) the completion of the licensing process, including all necessary inspections, is the only remaining component prior to being able to provide services; and

(5) the needs of the individuals cannot be met within the existing capacity in that county.

To qualify for the process under this paragraph, the lead agency must submit documentation to the commissioner by August 1, 2009, that all of the above criteria are met.

(d) The commissioner shall study the effects of the license moratorium under this subdivision and shall report back to the legislature by January 15, 2011. This study shall include, but is not limited to the following:

(1) the overall capacity and utilization of foster care beds where the physical location is not the primary residence of the license holder prior to and after implementation of the moratorium;

(2) the overall capacity and utilization of foster care beds where the physical location is the primary residence of the license holder prior to and after implementation of the moratorium; and

(3) the number of licensed and occupied ICF/MR beds prior to and after implementation of the moratorium.

Sec. 4. Minnesota Statutes 2010, section 253B.02, subdivision 9, is amended to read:

Subd. 9. **Health officer.** "Health officer" means:

(1) a licensed physician~~.~~;

(2) a licensed psychologist~~.~~;

(3) a licensed social worker~~.~~;

(4) a registered nurse working in an emergency room of a hospital~~, or~~;

(5) a psychiatric or public health nurse as defined in section 145A.02, subdivision 18~~, or~~;

(6) an advanced practice registered nurse (APRN) as defined in section 148.171, subdivision 3~~, and~~;

(7) a mental health professional providing mental health mobile crisis intervention services as described under section 256B.0624; or

(8) a formally designated ~~members~~ member of a prepetition screening unit established by section 253B.07.

Sec. 5. Minnesota Statutes 2010, section 254B.03, subdivision 5, is amended to read:

Subd. 5. **Rules; appeal.** The commissioner shall adopt rules as necessary to implement ~~Laws 1986, chapter 394, sections 8 to 20. The commissioner shall ensure that the rules are effective on July 1, 1987~~ this chapter. The commissioner shall establish an appeals process for use by recipients when services certified by the county are disputed. The commissioner shall adopt rules and standards for the appeal process to assure adequate redress for persons referred to inappropriate services.

Sec. 6. Minnesota Statutes 2010, section 254B.03, subdivision 9, is amended to read:

Subd. 9. **Commissioner to select vendors and set rates.** (a) Effective July 1, 2011, the commissioner shall:

(1) enter into agreements with eligible vendors that:

(i) meet the standards in section 254B.05, subdivision 1;

(ii) have good standing in all applicable licensure; and

(iii) have a current approved provider agreement as a Minnesota health care program provider that contains program standards for each rate and rate enhancement defined by the commissioner; and

(2) set rates for services reimbursed under this chapter.

(b) When setting rates, the commissioner shall consider the complexity and the acuity of the problems presented by the client.

(c) When rates set under this section and rates set under section 254B.09, subdivision 8, apply to the same treatment placement, section 254B.09, subdivision 8, supersedes.

Sec. 7. Minnesota Statutes 2010, section 254B.05, is amended to read:

**254B.05 VENDOR ELIGIBILITY.**

Subdivision 1. **Licensure required.** Programs licensed by the commissioner are eligible vendors. Hospitals may apply for and receive licenses to be eligible vendors, notwithstanding the provisions of section 245A.03. American Indian programs that provide chemical dependency primary treatment, extended care, transitional residence, or outpatient treatment services, and are licensed by tribal government are eligible vendors. Detoxification programs are not eligible vendors. Programs that are not licensed as a chemical dependency residential or nonresidential treatment program by the commissioner or by tribal government or do not meet the requirements of subdivisions 1a and 1b are not eligible vendors. ~~To be eligible for payment under the Consolidated Chemical Dependency Treatment Fund, a vendor of a chemical dependency service must participate in the Drug and Alcohol Abuse Normative Evaluation System and the treatment accountability plan.~~

Subd. 1a. **Room and board provider requirements.** (a) Effective January 1, 2000, vendors of room and board are eligible for chemical dependency fund payment if the vendor:

(1) has rules prohibiting residents bringing chemicals into the facility or using chemicals while residing in the facility and provide consequences for infractions of those rules;

~~(2) has a current contract with a county or tribal governing body;~~

~~(3)~~ (2) is determined to meet applicable health and safety requirements;

~~(4)~~ (3) is not a jail or prison; ~~and~~

~~(5)~~ (4) is not concurrently receiving funds under chapter 256I for the recipient~~.~~;

(5) admits individuals who are 18 years of age or older;

(6) is registered as a board and lodging or lodging establishment according to section 157.17;

(7) has awake staff on site 24 hours per day;

(8) has staff who are at least 18 years of age and meet the requirements of Minnesota Rules, part 9530.6450, subpart 1, item A;

(9) has emergency behavioral procedures that meet the requirements of Minnesota Rules, part 9530.6475;

(10) meets the requirements of Minnesota Rules, part 9530.6435, subparts 3 and 4, items A and B, if administering medications to clients;

(11) meets the abuse prevention requirements of section 245A.65, including a policy on fraternization and the mandatory reporting requirements of section 626.557;

(12) document coordination with the treatment provider to assure compliance with section 254B.03, subdivision 2;

(13) protect client funds and ensure freedom from exploitation by meeting the provisions of section 245A.04, subdivision 13;

(14) has a grievance procedure that meets the requirements of Minnesota Rules, part 9530.6470, subpart 2; and

(15) has sleeping and bathroom facilities for men and women separated by a door that is locked, has an alarm, or is supervised by awake staff.

(b) Programs licensed according to Minnesota Rules, chapter 2960, are exempt from paragraph (a), clauses (5) to (13).

Subd. 1b. **Additional vendor requirements.** Vendors of room and board must comply with the following duties:

(1) maintain a provider agreement with the department;

(2) continually comply with the standards in the agreement;

(3) participate in the Drug and Alcohol Normative Evaluation System;

(4) submit an annual audit if the vendor receives $500,000 or more a year from the consolidated chemical dependency treatment fund; and

(5) submit an annual financial statement if the vendor receives less than $500,000 or more a year from the consolidated chemical dependency treatment fund.

Subd. 2. **Regulatory methods.** (a) Where appropriate and feasible, the commissioner shall identify and implement alternative methods of regulation and enforcement to the extent authorized in this subdivision. These methods shall include:

(1) expansion of the types and categories of licenses that may be granted;

(2) when the standards of an independent accreditation body have been shown to predict compliance with the rules, the commissioner shall consider compliance with the accreditation standards to be equivalent to partial compliance with the rules; and

(3) use of an abbreviated inspection that employs key standards that have been shown to predict full compliance with the rules.

If the commissioner determines that the methods in clause (2) or (3) can be used in licensing a program, the commissioner may reduce any fee set under section 254B.03, subdivision 3, by up to 50 percent.

(b) The commissioner shall work with the commissioners of health, public safety, administration, and education in consolidating duplicative licensing and certification rules and standards if the commissioner determines that consolidation is administratively feasible, would significantly reduce the cost of licensing, and would not reduce the protection given to persons receiving services in licensed programs. Where administratively feasible and appropriate, the commissioner shall work with the commissioners of health, public safety, administration, and education in conducting joint agency inspections of programs.

(c) The commissioner shall work with the commissioners of health, public safety, administration, and education in establishing a single point of application for applicants who are required to obtain concurrent licensure from more than one of the commissioners listed in this clause.

Subd. 3. **Fee reductions.** If the commissioner determines that the methods in subdivision 2, clause (2) or (3), can be used in licensing a program, the commissioner shall reduce licensure fees by up to 50 percent. The commissioner may adopt rules to provide for the reduction of fees when a license holder substantially exceeds the basic standards for licensure.

Subd. 4. **Regional treatment centers.** Regional treatment center chemical dependency treatment units are eligible vendors. The commissioner may expand the capacity of chemical dependency treatment units beyond the capacity funded by direct legislative appropriation to serve individuals who are referred for treatment by counties and whose treatment will be paid for by funding under this chapter or other funding sources. Notwithstanding the provisions of sections 254B.03 to 254B.041, payment for any person committed at county request to a regional treatment center under chapter 253B for chemical dependency treatment and determined to be ineligible under the chemical dependency consolidated treatment fund, shall become the responsibility of the county.

Subd. 5. **Rate requirements.** (a) The commissioner shall establish rates for chemical dependency services and service enhancements funded under this chapter.

(b) Eligible chemical dependency treatment services include:

(1) outpatient treatment services that are licensed according to Minnesota Rules, parts 9530.6405 to 9530.6480, or applicable tribal license;

(2) medication assisted therapy services that are licensed according to Minnesota Rules, parts 9530.6405 to 9530.6480 and 9530.6500, or applicable tribal license;

(3) medication assisted therapy plus enhanced treatment services that meet the requirements of clause (2) and provide nine hours of clinical services each week;

(4) high, medium, and low intensity residential treatment services that are licensed according to Minnesota Rules, parts 9530.6405 to 9530.6480 and 9530.6505, or applicable tribal license which provide, respectively, 30, 15, and five hours of clinical services each week;

(5) hospital-based treatment services that are licensed according to Minnesota Rules, parts 9530.6405 to 9530.6480, or applicable tribal license and licensed as a hospital under sections 144.50 to 144.56;

(6) adolescent treatment programs that are licensed as outpatient treatment programs according to Minnesota Rules, parts 9530.6405 to 9530.6485, or as residential treatment programs according to Minnesota Rules, chapter 2960, or applicable tribal license; and

(7) room and board facilities that meet the requirements of section 254B.05, subdivision 1a.

(c) The commissioner shall establish higher rates for programs that meet the requirements of paragraph (b) and the following additional requirements:

(1) programs that serve parents with their children if the program meets the additional licensing requirement in Minnesota Rules, part 9530.6490, and provides child care that meets the requirements of section 245A.03, subdivision 2, during hours of treatment activity;

(2) programs serving special populations if the program meets the requirements in Minnesota Rules, part 9530.6605, subpart 13;

(3) programs that offer medical services delivered by appropriately credentialed health care staff in an amount equal to two hours per client per week; and

(4) programs that offer services to individuals co-occurring mental health and chemical dependency problems if:

(i) the program meets the co-occurring requirements in Minnesota Rules, part 9530.6495;

(ii) 25 percent of the counseling staff are mental health professionals, as defined in section 245.462, subdivision 18, clauses (1) to (6), or are students or licensing candidates under appropriate supervision preparing to become mental health professionals, except that no more than 50 percent of the mental health staff may be students or licensing candidates;

(iii) clients scoring positive on a standardized mental health screen receive a mental health diagnostic assessment within ten days of admission;

(iv) the program has standards for multidisciplinary case review that include a monthly review for each client; and

(v) family education is offered that addresses mental health and substance abuse disorders and the interaction between the two.

(d) Adolescent residential programs that meet the requirements of Minnesota Rules, parts 2960.0580 to 2960.0700, are exempt from the requirements in paragraph (c), clause (4), items (i) to (iv).

Sec. 8. Minnesota Statutes 2010, section 254B.12, is amended to read:

**254B.12 RATE METHODOLOGY.**

The commissioner shall~~, with broad-based stakeholder input, develop a recommendation and present a report to the 2011 legislature, including proposed legislation for a new~~ establish a new rate methodology for the consolidated chemical dependency treatment fund. The new methodology must replace county-negotiated rates with a uniform statewide methodology that must include a graduated reimbursement scale based on the patients' level of acuity and complexity. At least biennially, the commissioner shall review the financial information provided by vendors to determine the need for rate adjustments.

Sec. 9. Minnesota Statutes 2010, section 254B.13, subdivision 3, is amended to read:

Subd. 3. **Program evaluation.** The commissioner shall evaluate pilot projects under this section and report the results of the evaluation to the chairs and ranking minority members of the legislative committees with jurisdiction over chemical health issues by January 15, ~~2013~~ 2014. Evaluation of the pilot projects must be based on outcome evaluation criteria negotiated with the pilot projects prior to implementation.

Sec. 10. Minnesota Statutes 2010, section 256.9693, is amended to read:

**256.9693 INPATIENT TREATMENT FOR MENTAL ILLNESS.**

Subdivision 1. **Continuing care benefit program.** The commissioner shall establish a continuing care benefit program for ~~persons~~ adults and children with mental illness in which ~~persons~~ adults and children with mental illness may obtain acute care hospital inpatient treatment for mental illness for up to 45 days beyond that allowed by section 256.969. The commissioner may authorize additional days beyond 45 based on an individual review of medical necessity. ~~Persons~~ Adults and children with mental illness who are eligible for medical assistance may obtain inpatient treatment under this program in hospital beds for which the commissioner contracts under this section. The commissioner may selectively contract with hospitals to provide this benefit through competitive bidding when reasonable geographic access by recipients can be

assured. Payments under this section shall not affect payments under section 256.969. The commissioner may contract externally with a utilization review organization to authorize persons with mental illness to access the continuing care benefit program. The commissioner, as part of the contracts with hospitals, shall establish admission criteria to allow persons with mental illness to access the continuing care benefit program. If a court orders acute care hospital inpatient treatment for mental illness for a person, the person may obtain the treatment under the continuing care benefit program. The commissioner shall not require, as part of the admission criteria, any commitment or petition under chapter 253B as a condition of accessing the program. This benefit is not available for people who are also eligible for Medicare and who have not exhausted their annual or lifetime inpatient psychiatric benefit under Medicare. If a recipient is enrolled in a prepaid plan, this program ~~is included in~~ must be covered by the plan's ~~coverage~~ capitation payments.

Subd. 2. **Transfer of funds.** The commissioner is authorized to transfer funds from the child and adolescent behavioral health services appropriation for the purpose of children and adolescent treatment under this section.

Sec. 11. Minnesota Statutes 2010, section 256B.0622, subdivision 8, is amended to read:

Subd. 8. **Medical assistance payment for intensive rehabilitative mental health services.** (a) Payment for residential and nonresidential services in this section shall be based on one daily rate per provider inclusive of the following services received by an eligible recipient in a given calendar day: all rehabilitative services under this section, staff travel time to provide rehabilitative services under this section, and nonresidential crisis stabilization services under section 256B.0624.

(b) Except as indicated in paragraph (c), payment will not be made to more than one entity for each recipient for services provided under this section on a given day. If services under this section are provided by a team that includes staff from more than one entity, the team must determine how to distribute the payment among the members.

(c) The ~~host county shall recommend to the~~ commissioner shall determine one rate for each ~~entity~~ provider that will bill medical assistance for residential services under this section and one rate for each nonresidential provider. If a single entity provides both services, one rate is established for the entity's residential services and another rate for the entity's nonresidential services under this section. ~~In developing these rates, the host county shall consider and document~~ A provider is not eligible for payment under this

section without authorization from the commissioner. The commissioner shall develop rates using the following criteria:

(1) the cost for similar services in the local trade area;

(2) the provider's cost for services, as determined as follows:

(i) the direct services portion of costs must be determined using actual costs of salaries, benefits, payroll taxes, and training of direct service staff and service-related transportation;

(ii) for other program costs not included in item (i), the rate must include a specified percentage to be paid beyond the direct services costs. The percentage used shall be determined by the commissioner based upon the average of percentages that represent the relationship of other program costs to direct services costs among the entities that provide similar services;

(iii) in situations where a provider of intensive residential services can demonstrate actual program-related physical plant costs in excess of the group residential housing reimbursement, the commissioner may include these costs in the program rate, so long as the additional reimbursement does not subsidize the room and board expenses of the program;

(iv) intensive nonresidential services physical plant costs must be reimbursed as part of the costs described in item (ii); and

(v) up to an additional five percent of the total rate may be added to the program rate as a return to agency quality incentive based upon the entity meeting specified performance criteria specified by the commissioner;

~~(2) that the proposed costs incurred by entities providing the services are~~ (3) actual cost is defined as costs approved by the commissioner which are allowable, allocable, and reasonable, and ~~are~~ consistent with federal reimbursement requirements ~~including~~ under Code of Federal Regulations, title 48, chapter 1, part 31, ~~as~~ relating to for-profit entities, and Office of Management and Budget Circular Number A-122, ~~as~~ relating to nonprofit entities;

~~(3)~~ (4) the ~~intensity and frequency of services to be provided to each recipient, including the proposed overall~~ number of service units ~~of service to be delivered~~;

~~(4)~~ (5) the degree to which recipients will receive services other than services under this section;

~~(5)~~ (6) the costs of other services that will be separately reimbursed; and

~~(6)~~ (7) input from the local planning process authorized by the adult mental health initiative under section 245.4661, regarding recipients' service needs.

(d) The rate for intensive rehabilitative mental health services must exclude room and board, as defined in section 256I.03, subdivision 6, and services not covered under this section, such as partial hospitalization, home care, and inpatient services. Physician services that are not separately billed may be included in the rate to the extent that a psychiatrist is a member of the treatment team. ~~The county's recommendation shall specify the period for which the rate will be applicable, not to exceed two years.~~

(e) When services under this section are provided by an intensive nonresidential service provider assertive community team, case management functions must be an integral part of the team.

(f) The rate for a provider must not exceed the rate charged by that provider for the same service to other payors.

(g) ~~The commissioner shall approve or reject the county's rate recommendation, based on the commissioner's own analysis of the criteria in paragraph (c)~~ The rates for existing programs must be established prospectively based upon the approved allowable expenditures and utilization over a prior 12-month period.

(h) ~~Paragraph (c), clause (2), is effective for services provided on or after January 1, 2010, to December 31, 2011, and does not change contracts or agreements relating to services provided before January 1, 2010~~ Entities who discontinue providing services must be subject to a settle-up process whereby actual costs and reimbursement for the previous 12 months are compared. In the event that the entity was paid more than the entity's actual costs plus any applicable performance-related funding due the provider, the excess payment must be reimbursed to the department. If a provider's revenue is less than actual allowed costs due to lower utilization than projected, the commissioner may reimburse the provider to recover their actual allowable costs. The resulting adjustments by the commissioner must be proportional to the percent of total units of service reimbursed by the commissioner.

Sec. 12. Minnesota Statutes 2010, section 256B.0623, subdivision 3, is amended to read:

Subd. 3. **Eligibility.** An eligible recipient is an individual who:

(1) is age 18 or older;

(2) is diagnosed with a medical condition, such as mental illness or traumatic brain injury, for which adult rehabilitative mental health services are needed;

(3) has substantial disability and functional impairment in three or more of the areas listed in section 245.462, subdivision 11a, so that self-sufficiency is markedly reduced; and

(4) has had a recent diagnostic assessment or an adult diagnostic assessment update by a qualified professional that documents adult rehabilitative mental health services are medically necessary to address identified disability and functional impairments and individual recipient goals.

Sec. 13. Minnesota Statutes 2010, section 256B.0623, subdivision 8, is amended to read:

Subd. 8. **Diagnostic assessment.** Providers of adult rehabilitative mental health services must complete a diagnostic assessment as defined in section 245.462, subdivision 9, within five days after the recipient's second visit or within 30 days after intake, whichever occurs first. In cases where a diagnostic assessment is available that reflects the recipient's current status, and has been completed within ~~180 days~~ three years preceding admission, an adult diagnostic assessment update must be completed. An update shall include a face-to-face interview with the recipient and a written summary by a mental health professional of the recipient's current mental health status and service needs. If the recipient's mental health status has changed significantly since the adult's most recent diagnostic assessment, a new diagnostic assessment is required. ~~For initial implementation of adult rehabilitative mental health services, until June 30, 2005, a diagnostic assessment that reflects the recipient's current status and has been completed within the past three years preceding admission is acceptable.~~

Sec. 14. Minnesota Statutes 2010, section 256B.0624, subdivision 2, is amended to read:

Subd. 2. **Definitions.** For purposes of this section, the following terms have the meanings given them.

(a) "Mental health crisis" is an adult behavioral, emotional, or psychiatric situation which, but for the provision of crisis response services, would likely result in significantly reduced levels of functioning in primary activities of daily living, or in an emergency situation, or in the placement of the recipient in a more restrictive setting, including, but not limited to, inpatient hospitalization.

(b) "Mental health emergency" is an adult behavioral, emotional, or psychiatric situation which causes an immediate need for mental health services and is consistent with section 62Q.55.

A mental health crisis or emergency is determined for medical assistance service reimbursement by a physician, a mental health professional, or crisis mental health practitioner with input from the recipient whenever possible.

(c) "Mental health crisis assessment" means an immediate face-to-face assessment by a physician, a mental health professional, or mental health practitioner under the clinical supervision of a mental health professional, following a screening that suggests that the adult may be experiencing a mental health crisis or mental health emergency situation.

(d) "Mental health mobile crisis intervention services" means face-to-face, short-term intensive mental health services initiated during a mental health crisis or mental health emergency to help the recipient cope with immediate stressors, identify and utilize available resources and strengths, and begin to return to the recipient's baseline level of functioning.

(1) This service is provided on site by a mobile crisis intervention team outside of an inpatient hospital setting. Mental health mobile crisis intervention services must be available 24 hours a day, seven days a week.

(2) The initial screening must consider other available services to determine which service intervention would best address the recipient's needs and circumstances.

(3) The mobile crisis intervention team must be available to meet promptly face-to-face with a person in mental health crisis or emergency in a community setting or hospital emergency room.

(4) The intervention must consist of a mental health crisis assessment and a crisis treatment plan.

(5) The treatment plan must include recommendations for any needed crisis stabilization services for the recipient.

(e) "Mental health crisis stabilization services" means individualized mental health services provided to a recipient following crisis intervention services which are designed to restore the recipient to the recipient's prior functional level. Mental health crisis stabilization services may be provided in the recipient's home, the home of a family member or friend of the recipient, another community setting, or a short-term supervised, licensed residential program. Mental health crisis stabilization does not include partial hospitalization or day treatment.

Sec. 15. Minnesota Statutes 2010, section 256B.0624, subdivision 4, is amended to read:

Subd. 4. **Provider entity standards.** (a) A provider entity is an entity that meets the standards listed in paragraph (b) and:

(1) is a county board operated entity; or

(2) is a provider entity that is under contract with the county board in the county where the potential crisis or emergency is occurring. To provide services under this

section, the provider entity must directly provide the services; or if services are subcontracted, the provider entity must maintain responsibility for services and billing.

(b) The adult mental health crisis response services provider entity must have the capacity to meet and carry out the following standards:

(1) has the capacity to recruit, hire, and manage and train mental health professionals, practitioners, and rehabilitation workers;

(2) has adequate administrative ability to ensure availability of services;

(3) is able to ensure adequate preservice and in-service training;

(4) is able to ensure that staff providing these services are skilled in the delivery of mental health crisis response services to recipients;

(5) is able to ensure that staff are capable of implementing culturally specific treatment identified in the individual treatment plan that is meaningful and appropriate as determined by the recipient's culture, beliefs, values, and language;

(6) is able to ensure enough flexibility to respond to the changing intervention and care needs of a recipient as identified by the recipient during the service partnership between the recipient and providers;

(7) is able to ensure that mental health professionals and mental health practitioners have the communication tools and procedures to communicate and consult promptly about crisis assessment and interventions as services occur;

(8) is able to coordinate these services with county emergency services, community hospitals, ambulance, transportation services, social services, law enforcement, and mental health crisis services through regularly scheduled interagency meetings;

(9) is able to ensure that mental health crisis assessment and mobile crisis intervention services are available 24 hours a day, seven days a week;

(10) is able to ensure that services are coordinated with other mental health service providers, county mental health authorities, or federally recognized American Indian authorities and others as necessary, with the consent of the adult. Services must also be coordinated with the recipient's case manager if the adult is receiving case management services;

(11) is able to ensure that crisis intervention services are provided in a manner consistent with sections 245.461 to 245.486;

(12) is able to submit information as required by the state;

(13) maintains staff training and personnel files;

(14) is able to establish and maintain a quality assurance and evaluation plan to evaluate the outcomes of services and recipient satisfaction;

(15) is able to keep records as required by applicable laws;

(16) is able to comply with all applicable laws and statutes;

(17) is an enrolled medical assistance provider; and

(18) develops and maintains written policies and procedures regarding service provision and administration of the provider entity, including safety of staff and recipients in high-risk situations.

Sec. 16. Minnesota Statutes 2010, section 256B.0624, subdivision 6, is amended to read:

Subd. 6. **Crisis assessment and mobile intervention treatment planning.** (a) Prior to initiating mobile crisis intervention services, a screening of the potential crisis situation must be conducted. The screening may use the resources of crisis assistance and emergency services as defined in sections 245.462, subdivision 6, and 245.469, subdivisions 1 and 2. The screening must gather information, determine whether a crisis situation exists, identify parties involved, and determine an appropriate response.

(b) If a crisis exists, a crisis assessment must be completed. A crisis assessment evaluates any immediate needs for which emergency services are needed and, as time permits, the recipient's current life situation, sources of stress, mental health problems and symptoms, strengths, cultural considerations, support network, vulnerabilities, ~~and~~ current functioning, and the recipient's preferences as communicated verbally by the recipient, or as communicated in: a health care directive as described in chapters 145C and 253B, the treatment plan described under paragraph (d), a crisis prevention plan, or wellness recovery action plan.

(c) If the crisis assessment determines mobile crisis intervention services are needed, the intervention services must be provided promptly. As opportunity presents during the intervention, at least two members of the mobile crisis intervention team must confer directly or by telephone about the assessment, treatment plan, and actions taken and needed. At least one of the team members must be on site providing crisis intervention services. If providing on-site crisis intervention services, a mental health practitioner must seek clinical supervision as required in subdivision 9.

(d) The mobile crisis intervention team must develop an initial, brief crisis treatment plan as soon as appropriate but no later than 24 hours after the initial face-to-face intervention. The plan must address the needs and problems noted in the crisis assessment and include measurable short-term goals, cultural considerations, and frequency and type of services to be provided to achieve the goals and reduce or eliminate the crisis. The treatment plan must be updated as needed to reflect current goals and services.

(e) The team must document which short-term goals have been met and when no further crisis intervention services are required.

(f) If the recipient's crisis is stabilized, but the recipient needs a referral to other services, the team must provide referrals to these services. If the recipient has a case manager, planning for other services must be coordinated with the case manager.

Sec. 17. Minnesota Statutes 2010, section 256B.0625, subdivision 23, is amended to read:

Subd. 23. **Day treatment services.** Medical assistance covers day treatment services as specified in sections 245.462, subdivision 8, and 245.4871, subdivision 10, that are provided under contract with the county board. ~~Notwithstanding Minnesota Rules, part 9505.0323, subpart 15,~~ The commissioner may set authorization thresholds for day treatment for adults according to subdivision 25. ~~Notwithstanding Minnesota Rules, part 9505.0323, subpart 15, effective July 1, 2004,~~ Medical assistance covers day treatment services for children as specified under section 256B.0943.

Sec. 18. Minnesota Statutes 2010, section 256B.0625, subdivision 38, is amended to read:

Subd. 38. **Payments for mental health services.** Payments for mental health services covered under the medical assistance program that are provided by masters-prepared mental health professionals shall be 80 percent of the rate paid to doctoral-prepared professionals. Payments for mental health services covered under the medical assistance program that are provided by masters-prepared mental health professionals employed by community mental health centers shall be 100 percent of the rate paid to doctoral-prepared professionals. ~~For purposes of reimbursement of mental health professionals under the medical assistance program, all social workers who:~~

~~(1) have received a master's degree in social work from a program accredited by the Council on Social Work Education;~~

~~(2) are licensed at the level of graduate social worker or independent social worker; and~~

~~(3) are practicing clinical social work under appropriate supervision, as defined by chapter 148D, meet all requirements under Minnesota Rules, part 9505.0323, subpart 24, and shall be paid accordingly.~~

Sec. 19. Minnesota Statutes 2010, section 256B.0926, subdivision 2, is amended to read:

Subd. 2. **Admission review team; responsibilities; composition.** (a) Before a person is admitted to a facility, an admission review team must assure that the provider can meet the needs of the person as identified in the person's individual service plan required under section 256B.092, subdivision 1, unless authorized by the commissioner for admittance to a state-operated services facility.

(b) The admission review team must be assembled pursuant to Code of Federal Regulations, title 42, section 483.440(b)(2). The composition of the admission review team must meet the definition of an interdisciplinary team in Code of Federal Regulations, title 42, section 483.440. In addition, the admission review team must meet any conditions agreed to by the provider and the county where services are to be provided.

(c) The county in which the facility is located may establish an admission review team which includes at least the following:

(1) a qualified developmental disability professional, as defined in Code of Federal Regulations, title 42, section 483.440;

(2) a representative of the county in which the provider is located;

(3) at least one professional representing one of the following professions: nursing, psychology, physical therapy, or occupational therapy; and

(4) a representative of the provider.

If the county in which the facility is located does not establish an admission review team, the provider shall establish a team whose composition meets the definition of an interdisciplinary team in Code of Federal Regulations, title 42, section 483.440. The provider shall invite a representative of the county agency where the facility is located to be a member of the admission review team.

Sec. 20. Minnesota Statutes 2010, section 256B.0947, is amended to read:

**256B.0947 INTENSIVE REHABILITATIVE MENTAL HEALTH SERVICES.**

Subdivision 1. **Scope.** Effective November 1, 2011, and subject to federal approval, medical assistance covers medically necessary, intensive nonresidential rehabilitative mental health services as defined in subdivision 2, for recipients as defined in subdivision 3, when the services are provided by an entity meeting the standards in this section.

Subd. 2. **Definitions.** For purposes of this section, the following terms have the meanings given them.

(a) "Intensive nonresidential rehabilitative mental health services" means child rehabilitative mental health services as defined in section 256B.0943, except that these services are provided by a multidisciplinary staff using a total team approach consistent with assertive community treatment, ~~or other evidence-based practices~~ as adapted for

youth, and are directed to recipients ages 16 to 21 with a serious mental illness or co-occurring mental illness and substance abuse addiction who require intensive services to prevent admission to an inpatient psychiatric hospital or placement in a residential treatment facility or who require intensive services to step down from inpatient or residential care to community-based care.

(b) ~~"Evidence-based practices" are nationally recognized mental health services that are proven by substantial research to be effective in helping individuals with serious mental illness obtain specific treatment goals~~ "Co-occurring mental illness and substance abuse addiction" means a dual diagnosis of at least one form of mental illness and at least one substance use disorder. Substance use disorders include alcohol or drug abuse or dependence, excluding nicotine use.

(c) "Diagnostic assessment" has the meaning given to it in Minnesota Rules, part 9505.0370, subpart 11. A diagnostic assessment must be provided according to Minnesota Rules, part 9505.0372, subpart 1, and for this section must incorporate a determination of the youth's necessary level of care using a standardized functional assessment instrument approved and periodically updated by the commissioner.

(d) "Education specialist" means an individual with knowledge and experience working with youth regarding special education requirements and goals, special education plans, and coordination of educational activities with health care activities.

(e) "Housing access support" means an ancillary activity to help an individual find, obtain, retain, and move to safe and adequate housing. Housing access support does not provide monetary assistance for rent, damage deposits, or application fees.

(f) "Integrated dual disorders treatment" means the integrated treatment of co-occurring mental illness and substance use disorders by a team of cross-trained clinicians within the same program, and is characterized by assertive outreach, stage-wise comprehensive treatment, treatment goal setting, and flexibility to work within each stage of treatment.

(g) "Medication education services" means services provided individually or in groups, which focus on:

(1) educating the client and client's family or significant nonfamilial supporters about mental illness and symptoms;

(2) the role and effects of medications in treating symptoms of mental illness; and

(3) the side effects of medications.

Medication education is coordinated with medication management services and does not duplicate it. Medication education services are provided by physicians, pharmacists, or registered nurses with certification in psychiatric and mental health care.

(h) "Peer specialist" means an employed team member who is a certified peer specialist and also a former children's mental health consumer who:

(1) provides direct services to clients including social, emotional, and instrumental support and outreach;

(2) assists younger peers to identify and achieve specific life goals;

(3) works directly with clients to promote the client's self-determination, personal responsibility, and empowerment;

(4) assists youth with mental illness to regain control over their lives and their developmental process in order to move effectively into adulthood;

(5) provides training and education to other team members, consumer advocacy organizations, and clients on resiliency and peer support; and

(6) meets the following criteria:

(i) is at least 22 years of age;

(ii) has had a diagnosis of mental illness, as defined in Minnesota Rules, part 9505.0370, subpart 20, or co-occurring mental illness and substance abuse addiction;

(iii) is a former consumer of child and adolescent mental health services, or a former or current consumer of adult mental health services;

(iv) has at least a high school diploma or equivalent;

(v) has successfully completed training requirements determined and periodically updated by the commissioner; and

(vi) is willing to disclose the individual's own mental health history to team members and clients.

(i) "Provider agency" means a for-profit or nonprofit organization established to administer an assertive community treatment for youth team.

(j) "Substance use disorders" means one or more of the disorders defined in the diagnostic and statistical manual of mental disorders, current edition, that include:

(1) alcohol or drug abuse, which is indicated by harmful effects on a person's life including work, relationship, and legal problems; and

(2) dependence on drugs or alcohol which is indicated by tolerance, withdrawal, or inability to reduce using more than intended.

(k) "Transition services" means:

(1) activities, materials, consultation, and coordination that ensures continuity of the client's care in advance of and in preparation for the client's move from one stage of care or life to another by maintaining contact with the client and assisting the client to establish provider relationships;

(2) providing the client with knowledge and skills needed posttransition;

(3) establishing communication between sending and receiving entities;

(4) supporting a client's request for service authorization and enrollment; and

(5) establishing and enforcing procedures and schedules.

A youth's transition from the children's mental health system and services to the adult mental health system and services and return to the client's home and entry or re-entry into community-based mental health services following discharge from an out-of-home placement or inpatient hospital stay.

~~(c)~~ (l) "Treatment team" means all staff who provide services to recipients under this section. ~~At a minimum, this includes the clinical supervisor, mental health professionals, mental health practitioners, mental health behavioral aides, and a school representative familiar with the recipient's individual education plan (IEP) if applicable.~~

Subd. 3. **Client eligibility.** An eligible recipient ~~under the age of 18~~ is an individual who:

(1) is age 16 ~~or~~, 17, 18, 19, or 20; and

(2) is diagnosed with a ~~medical condition, such as an emotional disturbance or traumatic brain injury~~ serious mental illness or co-occurring mental illness and substance abuse addiction, for which intensive nonresidential rehabilitative mental health services are needed;

(3) has received a level-of-care determination, using an instrument approved by the commissioner, that indicates a need for intensive integrated intervention without 24-hour medical monitoring and a need for extensive collaboration among multiple providers;

~~(3)~~ (4) has ~~substantial disability and~~ a functional impairment ~~in three or more of the areas listed in section 245.462, subdivision 11a, so that self-sufficiency upon adulthood or emancipation is unlikely~~ and a history of difficulty in functioning safely and successfully in the community, school, home, or job; or who is likely to need services from the adult mental health system within the next two years; and

~~(4)~~ (5) has had a recent diagnostic assessment, as provided in Minnesota Rules, part 9505.0372, subpart 1, by a ~~qualified~~ mental health professional who is qualified under Minnesota Rules, part 9505.0371, subpart 5, item A, that documents that intensive nonresidential rehabilitative mental health services are medically necessary to ~~address~~ ameliorate identified ~~disability and~~ symptoms and functional impairments and to achieve individual ~~recipient~~ transition goals.

Subd. 3a. **Required service components.** (a) Subject to federal approval, medical assistance covers all medically necessary intensive nonresidential rehabilitative mental health services and supports, as defined in this section, under a single daily rate per client.

Services and supports must be delivered by an eligible provider under subdivision 5 to an eligible client under subdivision 3.

(b) Intensive nonresidential rehabilitative mental health services, supports, and ancillary activities covered by the single daily rate per client must include the following, as needed by the individual client:

(1) individual, family, and group psychotherapy;

(2) individual, family, and group skills training, as defined in section 256B.0943, subdivision 1, paragraph (p);

(3) crisis assistance as defined in section 245.4871, subdivision 9a, which includes recognition of factors precipitating a mental health crisis, identification of behaviors related to the crisis, and the development of a plan to address prevention, intervention, and follow-up strategies to be used in the lead-up to or onset of, and conclusion of, a mental health crisis; crisis assistance does not mean crisis response services or crisis intervention services provided in section 256B.0944;

(4) medication management provided by a physician or an advanced practice registered nurse with certification in psychiatric and mental health care;

(5) mental health case management as provided in section 256B.0625, subdivision 20;

(6) medication education services as defined in this section;

(7) care coordination by a client-specific lead worker assigned by and responsible to the treatment team;

(8) psychoeducation of and consultation and coordination with the client's biological, adoptive, or foster family and, in the case of a youth living independently, the client's immediate nonfamilial support network;

(9) clinical consultation to a client's employer or school or to other service agencies or to the courts to assist in managing the mental illness or co-occurring disorder and to develop client support systems;

(10) coordination with, or performance of, crisis intervention and stabilization services as defined in section 256B.0944;

(11) assessment of a client's treatment progress and effectiveness of services using standardized outcome measures published by the commissioner;

(12) transition services as defined in this section;

(13) integrated dual disorders treatment as defined in this section; and

(14) housing access support.

(c) The provider shall ensure and document the following by means of performing the required function or by contracting with a qualified person or entity:

(1) client access to crisis intervention services, as defined in section 256B.0944, and available 24 hours per day and seven days per week;

(2) completion of an extended diagnostic assessment, as defined in Minnesota Rules, part 9505.0372, subpart 1, item C; and

(3) determination of the client's needed level of care using an instrument approved and periodically updated by the commissioner.

Subd. 4. **Provider ~~certification and~~ contract requirements.** (a) The intensive nonresidential rehabilitative mental health services provider ~~must:~~ agency shall

~~(1)~~ have a contract with the ~~host county~~ commissioner to provide intensive transition youth rehabilitative mental health services~~; and~~.

~~(2) be certified by the commissioner as being in compliance with this section and section 256B.0943.~~

(b) The commissioner shall develop ~~procedures~~ administrative and clinical contract standards and performance evaluation criteria for ~~counties and~~ providers, including county providers, and may require applicants to submit ~~contracts and other~~ documentation as needed to allow the commissioner to determine whether the standards ~~in this section~~ are met.

Subd. 5. **Standards for intensive nonresidential rehabilitative providers.** (a) Services must be provided by a ~~certified~~ provider entity as ~~defined in section 256B.0943, subdivision 4 that meets the requirements in section 245B.0943, subdivisions 5 and 6~~ provided in subdivision 4.

(b) The treatment team for intensive nonresidential rehabilitative mental health services comprises both permanently employed core team members and client-specific team members as follows:

(1) The core treatment team is an entity that operates under the direction of an independently licensed mental health professional, who is qualified under Minnesota Rules, part 9505.0371, subpart 5, item A, and that assumes comprehensive clinical responsibility for clients. Based on professional qualifications and client needs, clinically qualified core team members are assigned on a rotating basis as the client's lead worker to coordinate a client's care. The core team must comprise at least four full-time equivalent direct care staff and must include, but is not limited to:

(i) an independently licensed mental health professional, qualified under Minnesota Rules, part 9505.0371, subpart 5, item A, who serves as team leader to provide administrative direction and clinical supervision to the team;

(ii) an advanced-practice registered nurse with certification in psychiatric or mental health care or a board-certified child and adolescent psychiatrist, either of which must be credentialed to prescribe medications;

(iii) a licensed alcohol and drug counselor who is also trained in mental health interventions; and

(iv) a peer specialist as defined in subdivision 2, paragraph (h).

(2) The core team may also include any of the following:

(i) additional mental health professionals;

(ii) a vocational specialist;

(iii) an educational specialist;

(iv) a child and adolescent psychiatrist who may be retained on a consultant basis;

(v) a mental health practitioner, as defined in section 245.4871, subdivision 26;

(vi) a mental health manager, as defined in section 245.4871, subdivision 4; and

(vii) a housing access specialist.

(3) A treatment team may include, in addition to those in clause (1) or (2), ad hoc members not employed by the team who consult on a specific client and who must accept overall clinical direction from the treatment team for the duration of the client's placement with the treatment team and must be paid by the provider agency at the rate for a typical session by that provider with that client or at a rate negotiated with the client-specific member. Client-specific treatment team members may include:

(i) the mental health professional treating the client prior to placement with the treatment team;

(ii) the client's current substance abuse counselor, if applicable;

(iii) a lead member of the client's individual education planning team or school-based mental health provider, if applicable;

(iv) a representative from the client's health care home or primary care clinic, as needed to ensure integration of medical and behavioral health care;

(v) the client's probation officer or other juvenile justice representative, if applicable; and

(vi) the client's current vocational or employment counselor, if applicable.

~~(b)~~ (c) The clinical supervisor ~~must~~ shall be an active member of the treatment team and shall function as a practicing clinician at least on a part-time basis. The treatment team ~~must~~ shall meet with the clinical supervisor at least weekly to discuss recipients' progress and make rapid adjustments to meet recipients' needs. The team meeting ~~shall~~ must include ~~recipient-specific~~ client-specific case reviews and general treatment discussions

among team members. ~~Recipient-specific~~ Client-specific case reviews and planning must be documented in the individual ~~recipient's~~ client's treatment record.

(d) The staffing ratio must not exceed ten clients to one full-time equivalent treatment team position.

(e) The treatment team shall serve no more than 80 clients at any one time. Should local demand exceed the team's capacity, an additional team must be established rather than exceed this limit.

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

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

~~(e) The initial individual treatment plan must be completed within ten days of intake and reviewed and updated at least monthly with the recipient.~~

(g) The intensive nonresidential rehabilitative mental health services provider shall participate in evaluation of the assertive community treatment for youth (Youth ACT) model as conducted by the commissioner, including the collection and reporting of data and the reporting of performance measures as specified by contract with the commissioner.

(h) A regional treatment team may serve multiple counties.

Subd. 6. **~~Additional~~ Service standards.** The standards in this subdivision apply to intensive nonresidential rehabilitative mental health services.

~~(1)~~ (a) The treatment team ~~must~~ shall use team treatment, not an individual treatment model.

~~(2) The clinical supervisor must function as a practicing clinician at least on a part-time basis.~~

~~(3) The staffing ratio must not exceed ten recipients to one full-time equivalent treatment team position.~~

~~(4)~~ (b) Services must be available at times that meet client needs.

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

(d) An individual treatment plan must be completed for each client, according to criteria specified in section 256B.0943, subdivision 6, paragraph (b), clause (2), and, additionally, must:

(1) be completed in consultation with the client's current therapist and key providers and provide for ongoing consultation with the client's current therapist to ensure therapeutic continuity and to facilitate the client's return to the community;

(2) if a need for substance use disorder treatment is indicated by validated assessment:

(i) identify goals, objectives, and strategies of substance use disorder treatment; develop a schedule for accomplishing treatment goals and objectives; and identify the individuals responsible for providing treatment services and supports;

(ii) be reviewed at least once every 90 days and revised, if necessary;

(3) be signed by the clinical supervisor and by the client and, if the client is a minor, by the client's parent or other person authorized by statute to consent to mental health treatment and substance use disorder treatment for the client; and

(4) provide for the client's transition out of intensive nonresidential rehabilitative mental health services by defining the team's actions to assist the client and subsequent providers in the transition to less intensive or "stepped down" services.

~~(5)~~ (e) The treatment team ~~must~~ shall actively and assertively engage ~~and reach out to~~ the ~~recipient's~~ client's family members and significant others~~, after obtaining the recipient's permission~~ by establishing communication and collaboration with the family and significant others and educating the family and significant others about the client's mental illness, symptom management, and the family's role in treatment, unless the team knows or has reason to suspect that the client has suffered or faces a threat of suffering any physical or mental injury, abuse, or neglect from a family member or significant other.

(f) For a client age 18 or older, the treatment team may disclose to a family member, other relative, or a close personal friend of the client, or other person identified by the client, the protected health information directly relevant to such person's involvement with the client's care, as provided in Code of Federal Regulations, title 45, part 164.502(b). If the client is present, the treatment team shall obtain the client's agreement, provide the client with an opportunity to object, or reasonably infer from the circumstances, based on the exercise of professional judgment, that the client does not object. If the client is not present or is unable, by incapacity or emergency circumstances, to agree or object, the treatment team may, in the exercise of professional judgment, determine whether the disclosure is in the best interests of the client and, if so, disclose only the protected health information that is directly relevant to the family member's, relative's, friend's, or client-identified person's involvement with the client's health care. The client may orally agree or object to the disclosure and may prohibit or restrict disclosure to specific individuals.

~~(6) The treatment team must establish ongoing communication and collaboration between the team, family, and significant others and educate the family and significant others about mental illness, symptom management, and the family's role in treatment.~~

~~(7)~~ (g) The treatment team ~~must~~ shall provide interventions to promote positive interpersonal relationships.

Subd. 7. **Medical assistance payment and rate setting.** (a) Payment for ~~nonresidential~~ services in this section ~~shall~~ must be based on one daily encounter rate per provider inclusive of the following services received by an eligible ~~recipient~~ client in a given calendar day: all rehabilitative services, supports, and ancillary activities under this section, staff travel time to provide rehabilitative services under this section, and ~~nonresidential~~ crisis ~~stabilization~~ response services under section 256B.0944.

(b) ~~Except as indicated in paragraph (c),~~ Payment ~~will~~ must not be made to more than one entity for each ~~recipient~~ client for services provided under this section on a given day. If services under this section are provided by a team that includes staff from more than one entity, the team ~~must~~ shall determine how to distribute the payment among the members.

(c) The ~~host county shall recommend to the~~ commissioner ~~one rate for each entity~~ shall establish regional cost-based rates for entities that will bill medical assistance for nonresidential intensive rehabilitative mental health services. In developing these rates, the ~~host county~~ commissioner shall consider ~~and document~~:

(1) the cost for similar services in the ~~local~~ health care trade area;

(2) actual costs incurred by entities providing the services;

(3) the intensity and frequency of services to be provided to each ~~recipient~~ client;

(4) the degree to which ~~recipients~~ clients will receive services other than services under this section; and

(5) the costs of other services that will be separately reimbursed.

(d) The rate for a provider must not exceed the rate charged by that provider for the same service to other payors.

Subd. 7a. **Noncovered services.** (a) The rate for intensive rehabilitative mental health services must exclude medical assistance ~~room and board rate, as defined in section 256I.03, subdivision 6, and~~ payment for services not covered under this section~~, such as partial hospitalization and inpatient services~~. ~~Physician~~ Services ~~are~~ not ~~a component of the treatment team and~~ covered under this section may be billed separately. ~~The county's recommendation shall specify the period for which the rate will be applicable, not to exceed two years.~~

~~(e) When services under this section are provided by an assertive community team, case management functions must be an integral part of the team.~~

~~(f) The rate for a provider must not exceed the rate charged by that provider for the same service to other payors.~~

~~(g) The commissioner shall approve or reject the county's rate recommendation, based on the commissioner's own analysis of the criteria in paragraph (c).~~

(b) The following services are not covered under this section and are not eligible for medical assistance payment under the per-client, per-day payment:

(1) inpatient psychiatric hospital treatment;

(2) mental health residential treatment;

(3) partial hospitalization;

(4) physician services outside of care provided by a psychiatrist serving as a member of the treatment team;

(5) room and board costs, as defined in section 256I.03, subdivision 6;

(6) children's mental health day treatment services; and

(7) mental health behavioral aide services, as defined in section 256B.0943, subdivision 1, paragraph (m).

Subd. 8. **Provider enrollment ~~and rate setting~~.** ~~Counties that employ their own staff to provide services under this section~~ The commissioner shall establish and administer treatment teams with consideration given to regional distribution. Providers shall apply directly to the commissioner for enrollment and ~~rate setting~~ must be reimbursed at rates established by contract. ~~In this case, a county contract is not required and~~ The commissioner shall perform the program review ~~and rate setting duties which would otherwise be required of counties under this section~~.

Subd. 9. **Service authorization.** The commissioner shall publish prior authorization criteria and standards to be used for intensive nonresidential rehabilitative mental health services, as provided in section 256B.0625, subdivision 25.

Sec. 21. **REPEALER.**

Minnesota Statutes 2010, sections 254B.01, subdivision 7; and 256B.0622, subdivision 8a, are repealed.