

SENATE
STATE OF MINNESOTA
NINETY-THIRD SESSION

S.F. No. 2449

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DATE	D-PG	OFFICIAL STATUS
03/02/2023	1278	Introduction and first reading Referred to Health and Human Services See SF2744, SF2995

1.1 A bill for an act

1.2 relating to behavioral health; modifying mental health provider staffing,

1.3 documentation, and diagnostic assessment requirements; requiring the commissioner

1.4 of human services to establish a medical assistance mental health service provider

1.5 certification process; modifying assertive community treatment staff requirements;

1.6 modifying adult rehabilitative mental health services provider entity standards;

1.7 modifying behavioral health home services staff qualifications; modifying managed

1.8 care contract requirements for mental health and substance use disorder treatment

1.9 services; requiring a report; amending Minnesota Statutes 2022, sections 245I.05,

1.10 subdivision 3; 245I.08, subdivision 3; 245I.10, subdivisions 2, 6; 245I.11,

1.11 subdivision 3; 245I.20, subdivision 5; 256B.0622, subdivision 7a; 256B.0623,

1.12 subdivision 4; 256B.0757, subdivision 4c; 256B.69, subdivision 5a; proposing

1.13 coding for new law in Minnesota Statutes, chapter 256B.

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

1.15 Section 1. Minnesota Statutes 2022, section 245I.05, subdivision 3, is amended to read:

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

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

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

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

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

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

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

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

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

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

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

2.12 (1) mental illnesses;

2.13 (2) client recovery and resiliency;

2.14 (3) mental health de-escalation techniques;

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

2.16 (5) psychotropic medications and medication side effects.

2.17 (d) Within 90 days of first providing direct contact services to an adult client, a ~~clinical~~
2.18 ~~trainee~~, mental health practitioner, mental health certified peer specialist, or mental health
2.19 rehabilitation worker must receive training about:

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

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

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

2.24 (4) culturally responsive treatment practices.

2.25 (e) Within 90 days of first providing direct contact services to a child client, a ~~clinical~~
2.26 ~~trainee~~, mental health practitioner, mental health certified family peer specialist, mental
2.27 health certified peer specialist, or mental health behavioral aide must receive training about
2.28 the topics in clauses (1) to (5). This training must address the developmental characteristics
2.29 of each child served by the license holder and address the needs of each child in the context
2.30 of the child's family, support system, and culture. Training topics must include:

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

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

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

3.6 (4) culturally responsive treatment practices; and

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

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

3.10 Sec. 2. Minnesota Statutes 2022, section 245I.08, subdivision 3, is amended to read:

3.11 Subd. 3. **Documenting approval.** A license holder must ensure that all diagnostic
3.12 assessments, functional assessments, level of care assessments, and treatment plans completed
3.13 by a clinical trainee or mental health practitioner contain documentation of approval by a
3.14 treatment supervisor within ~~five~~ 30 business days of initial completion by the staff person
3.15 under treatment supervision.

3.16 Sec. 3. Minnesota Statutes 2022, section 245I.10, subdivision 2, is amended to read:

3.17 Subd. 2. **Generally.** (a) A license holder must use a client's diagnostic assessment or
3.18 crisis assessment to determine a client's eligibility for mental health services, except as
3.19 provided in this section.

3.20 (b) Prior to completing a client's initial diagnostic assessment, a license holder may
3.21 provide a client with the following services:

3.22 (1) an explanation of findings;

3.23 (2) neuropsychological testing, neuropsychological assessment, and psychological
3.24 testing;

3.25 (3) any combination of psychotherapy sessions, family psychotherapy sessions, and
3.26 family psychoeducation sessions not to exceed three sessions;

3.27 (4) crisis assessment services according to section 256B.0624; and

3.28 (5) ten days of intensive residential treatment services according to the assessment and
3.29 treatment planning standards in section 245I.23, subdivision 7.

4.1 (c) Based on the client's needs that a crisis assessment identifies under section 256B.0624,
4.2 a license holder may provide a client with the following services:

4.3 (1) crisis intervention and stabilization services under section 245I.23 or 256B.0624;
4.4 and

4.5 (2) any combination of psychotherapy sessions, group psychotherapy sessions, family
4.6 psychotherapy sessions, and family psychoeducation sessions not to exceed ten sessions
4.7 within a 12-month period without prior authorization.

4.8 (d) Based on the client's needs in the client's brief diagnostic assessment, a license holder
4.9 may provide a client with any combination of psychotherapy sessions, group psychotherapy
4.10 sessions, family psychotherapy sessions, and family psychoeducation sessions not to exceed
4.11 ten sessions within a 12-month period without prior authorization for any new client or for
4.12 an existing client who the license holder projects will need fewer than ten sessions during
4.13 the next 12 months.

4.14 (e) Based on the client's needs that a hospital's medical history and presentation
4.15 examination identifies, a license holder may provide a client with:

4.16 (1) any combination of psychotherapy sessions, group psychotherapy sessions, family
4.17 psychotherapy sessions, and family psychoeducation sessions not to exceed ten sessions
4.18 within a 12-month period without prior authorization for any new client or for an existing
4.19 client who the license holder projects will need fewer than ten sessions during the next 12
4.20 months; and

4.21 (2) up to five days of day treatment services or partial hospitalization.

4.22 (f) A license holder must update a client's standard diagnostic assessment or complete
4.23 a new standard diagnostic assessment of a client:

4.24 (1) when the client requires services of a greater number or intensity than the services
4.25 that paragraphs (b) to (e) describe;

4.26 (2) ~~at least annually following the client's initial diagnostic assessment~~ if the client needs
4.27 additional mental health services and the client does not meet the criteria for a brief
4.28 assessment;

4.29 (3) when the client's mental health condition has changed markedly since the client's
4.30 most recent diagnostic assessment; ~~or~~

4.31 (4) when the client's current mental health condition does not meet the criteria of the
4.32 client's current diagnosis; or

5.1 (5) upon the client's request.

5.2 (g) For an existing client, the license holder must ensure that a new standard diagnostic
5.3 assessment includes a written update containing all significant new or changed information
5.4 about the client, ~~and an update regarding what information has not significantly changed,~~
5.5 ~~including a discussion with the client about changes in the client's life situation, functioning,~~
5.6 ~~presenting problems, and progress with achieving treatment goals since the client's last~~
5.7 ~~diagnostic assessment was completed.~~

5.8 Sec. 4. Minnesota Statutes 2022, section 245I.10, subdivision 6, is amended to read:

5.9 Subd. 6. **Standard diagnostic assessment; required elements.** (a) Only a mental health
5.10 professional or a clinical trainee may complete a standard diagnostic assessment of a client.
5.11 A standard diagnostic assessment of a client must include a face-to-face interview with a
5.12 client and a written evaluation of the client. The assessor must complete a client's standard
5.13 diagnostic assessment within the client's cultural context.

5.14 (b) When completing a standard diagnostic assessment of a client, the assessor must
5.15 gather and document information about the client's current life situation, including the
5.16 following information:

5.17 (1) the client's age;

5.18 (2) the client's current living situation, including the client's housing status and household
5.19 members;

5.20 (3) the status of the client's basic needs;

5.21 (4) the client's education level and employment status;

5.22 (5) the client's current medications;

5.23 (6) any immediate risks to the client's health and safety;

5.24 (7) the client's perceptions of the client's condition;

5.25 (8) the client's description of the client's symptoms, including the reason for the client's
5.26 referral;

5.27 (9) the client's history of mental health treatment; and

5.28 (10) cultural influences on the client.

5.29 (c) If the assessor cannot obtain the information that this paragraph requires without
5.30 retraumatizing the client or harming the client's willingness to engage in treatment, the
5.31 assessor must identify which topics will require further assessment during the course of the

6.1 client's treatment. The assessor must gather and document information related to the following
6.2 topics:

6.3 (1) the client's relationship with the client's family and other significant personal
6.4 relationships, including the client's evaluation of the quality of each relationship;

6.5 (2) the client's strengths and resources, including the extent and quality of the client's
6.6 social networks;

6.7 (3) important developmental incidents in the client's life;

6.8 (4) maltreatment, trauma, potential brain injuries, and abuse that the client has suffered;

6.9 (5) the client's history of or exposure to alcohol and drug usage and treatment; and

6.10 (6) the client's health history and the client's family health history, including the client's
6.11 physical, chemical, and mental health history.

6.12 (d) When completing a standard diagnostic assessment of a client, an assessor must use
6.13 a recognized diagnostic framework.

6.14 (1) When completing a standard diagnostic assessment of a client who is five years of
6.15 age or younger, the assessor must use the current edition of the DC: 0-5 Diagnostic
6.16 Classification of Mental Health and Development Disorders of Infancy and Early Childhood
6.17 published by Zero to Three.

6.18 (2) When completing a standard diagnostic assessment of a client who is six years of
6.19 age or older, the assessor must use the current edition of the Diagnostic and Statistical
6.20 Manual of Mental Disorders published by the American Psychiatric Association.

6.21 ~~(3) When completing a standard diagnostic assessment of a client who is five years of~~
6.22 ~~age or younger, an assessor must administer the Early Childhood Service Intensity Instrument~~
6.23 ~~(ECSII) to the client and include the results in the client's assessment.~~

6.24 ~~(4) When completing a standard diagnostic assessment of a client who is six to 17 years~~
6.25 ~~of age, an assessor must administer the Child and Adolescent Service Intensity Instrument~~
6.26 ~~(CASH) to the client and include the results in the client's assessment.~~

6.27 ~~(5)~~ (3) When completing a standard diagnostic assessment of a client who is 18 years
6.28 of age or older, an assessor must use either (i) the CAGE-AID Questionnaire or (ii) the
6.29 criteria in the most recent edition of the Diagnostic and Statistical Manual of Mental
6.30 Disorders published by the American Psychiatric Association to screen and assess the client
6.31 for a substance use disorder.

7.1 (e) When completing a standard diagnostic assessment of a client, the assessor must
7.2 include and document the following components of the assessment:

7.3 (1) the client's mental status examination;

7.4 (2) the client's baseline measurements; symptoms; behavior; skills; abilities; resources;
7.5 vulnerabilities; safety needs, including client information that supports the assessor's findings
7.6 after applying a recognized diagnostic framework from paragraph (d); and any differential
7.7 diagnosis of the client;

7.8 (3) an explanation of: (i) how the assessor diagnosed the client using the information
7.9 from the client's interview, assessment, psychological testing, and collateral information
7.10 about the client; (ii) the client's needs; (iii) the client's risk factors; (iv) the client's strengths;
7.11 and (v) the client's responsivity factors.

7.12 (f) When completing a standard diagnostic assessment of a client, the assessor must
7.13 consult the client and the client's family about which services that the client and the family
7.14 prefer to treat the client. The assessor must make referrals for the client as to services required
7.15 by law.

7.16 Sec. 5. Minnesota Statutes 2022, section 245I.11, subdivision 3, is amended to read:

7.17 Subd. 3. **Storing and accounting for medications.** (a) If a license holder stores client
7.18 medications, the license holder must:

7.19 (1) store client medications in original containers in a locked location;

7.20 (2) store refrigerated client medications in special trays or containers that are separate
7.21 from food;

7.22 (3) store client medications marked "for external use only" in a compartment that is
7.23 separate from other client medications;

7.24 (4) store Schedule II to IV drugs listed in section 152.02, subdivisions 3 to 5, in a
7.25 compartment that is locked separately from other medications;

7.26 (5) ensure that only authorized staff persons have access to stored client medications;

7.27 (6) for a license holder providing residential services, follow a documentation procedure
7.28 on each shift, and for a license holder providing nonresidential services, follow a
7.29 documentation procedure once every 30 days to account for all scheduled drugs; and

7.30 (7) record each incident when a staff person accepts a supply of client medications and
7.31 destroy discontinued, outdated, or deteriorated client medications.

8.1 (b) If a license holder is licensed as a residential program, the license holder must allow
 8.2 clients who self-administer medications to keep a private medication supply. The license
 8.3 holder must ensure that the client stores all private medication in a locked container in the
 8.4 client's private living area, unless the private medication supply poses a health and safety
 8.5 risk to any clients. A client must not maintain a private medication supply of a prescription
 8.6 medication without a written medication order from a licensed prescriber and a prescription
 8.7 label that includes the client's name.

8.8 Sec. 6. Minnesota Statutes 2022, section 245I.20, subdivision 5, is amended to read:

8.9 Subd. 5. **Treatment supervision specified.** (a) A mental health professional must remain
 8.10 responsible for each client's case. The certification holder must document the name of the
 8.11 mental health professional responsible for each case and the dates that the mental health
 8.12 professional is responsible for the client's case from beginning date to end date. The
 8.13 certification holder must assign each client's case for assessment, diagnosis, and treatment
 8.14 services to a treatment team member who is competent in the assigned clinical service, the
 8.15 recommended treatment strategy, and in treating the client's characteristics.

8.16 ~~(b) Treatment supervision of mental health practitioners and clinical trainees required~~
 8.17 ~~by section 245I.06 must include case reviews as described in this paragraph. Every two~~
 8.18 ~~months, a mental health professional must complete and document a case review of each~~
 8.19 ~~client assigned to the mental health professional when the client is receiving clinical services~~
 8.20 ~~from a mental health practitioner or clinical trainee. The case review must include a~~
 8.21 ~~consultation process that thoroughly examines the client's condition and treatment, including:~~
 8.22 ~~(1) a review of the client's reason for seeking treatment, diagnoses and assessments, and~~
 8.23 ~~the individual treatment plan; (2) a review of the appropriateness, duration, and outcome~~
 8.24 ~~of treatment provided to the client; and (3) treatment recommendations.~~

8.25 Sec. 7. **[256B.0617] MENTAL HEALTH SERVICES PROVIDER CERTIFICATION.**

8.26 (a) The commissioner of human services shall establish an initial provider entity
 8.27 application and certification process and recertification process to determine whether a
 8.28 provider entity has administrative and clinical infrastructures that meet the requirements to
 8.29 be certified, for the following services:

8.30 (1) assertive community treatment under section 256B.0622, subdivision 3a;

8.31 (2) adult rehabilitative mental health services under section 256B.0623;

8.32 (3) mobile crisis team services under section 256B.0624;

- 9.1 (4) children's therapeutic services and supports under section 256B.0943;
 9.2 (5) children's intensive behavioral health services under section 256B.0946; and
 9.3 (6) intensive nonresidential rehabilitative mental health services under section 256B.0947.

9.4 (b) The commissioner shall recertify a provider entity every three years using the
 9.5 individual provider's certification anniversary or the calendar year end. The commissioner
 9.6 may approve a recertification extension in the interest of sustaining services when a certain
 9.7 date for recertification is identified.

9.8 (c) The commissioner shall establish a process for decertification of a provider entity
 9.9 and shall require corrective action, medical assistance repayment, or decertification of a
 9.10 provider entity that no longer meets the requirements in this section or that fails to meet the
 9.11 clinical quality standards or administrative standards provided by the commissioner in the
 9.12 application and certification process.

9.13 (d) The commissioner must provide the following to provider entities for the certification,
 9.14 recertification, and decertification processes:

9.15 (1) a structured listing of required provider certification criteria;

9.16 (2) a formal written letter with a determination of certification, recertification, or
 9.17 decertification, signed by the commissioner or the appropriate division director; and

9.18 (3) a formal written communication outlining the process for necessary corrective action
 9.19 and follow-up by the commissioner signed by the commissioner or appropriate division
 9.20 director, if applicable.

9.21 **EFFECTIVE DATE.** This section is effective July 1, 2023, and the commissioner of
 9.22 human services must implement all requirements of this section by September 1, 2023.

9.23 Sec. 8. Minnesota Statutes 2022, section 256B.0622, subdivision 7a, is amended to read:

9.24 Subd. 7a. **Assertive community treatment team staff requirements and roles.** (a)

9.25 The required treatment staff qualifications and roles for an ACT team are:

9.26 (1) the team leader:

9.27 (i) shall be a mental health professional. Individuals who are not licensed but who are
 9.28 eligible for licensure and are otherwise qualified may also fulfill this role ~~but must obtain~~
 9.29 ~~full licensure within 24 months of assuming the role of team leader;~~

9.30 (ii) must be an active member of the ACT team and provide some direct services to
 9.31 clients;

10.1 (iii) must be a single full-time staff member, dedicated to the ACT team, who is
10.2 responsible for overseeing the administrative operations of the team, ~~providing treatment~~
10.3 ~~supervision of services in conjunction with the psychiatrist or psychiatric care provider~~, and
10.4 supervising team members to ensure delivery of best and ethical practices; and

10.5 (iv) must be available to provide overall treatment supervision to the ACT team after
10.6 regular business hours and on weekends and holidays. The team leader may at any time
10.7 delegate this duty to another qualified ~~member of the ACT team~~ licensed professional;

10.8 (2) the psychiatric care provider:

10.9 (i) must be a mental health professional permitted to prescribe psychiatric medications
10.10 as part of the mental health professional's scope of practice. The psychiatric care provider
10.11 must have demonstrated clinical experience working with individuals with serious and
10.12 persistent mental illness;

10.13 (ii) shall collaborate with the team leader in sharing overall clinical responsibility for
10.14 screening and admitting clients; monitoring clients' treatment and team member service
10.15 delivery; educating staff on psychiatric and nonpsychiatric medications, their side effects,
10.16 and health-related conditions; actively collaborating with nurses; and helping provide
10.17 treatment supervision to the team;

10.18 (iii) shall fulfill the following functions for assertive community treatment clients:
10.19 provide assessment and treatment of clients' symptoms and response to medications, including
10.20 side effects; provide brief therapy to clients; provide diagnostic and medication education
10.21 to clients, with medication decisions based on shared decision making; monitor clients'
10.22 nonpsychiatric medical conditions and nonpsychiatric medications; and conduct home and
10.23 community visits;

10.24 (iv) shall serve as the point of contact for psychiatric treatment if a client is hospitalized
10.25 for mental health treatment and shall communicate directly with the client's inpatient
10.26 psychiatric care providers to ensure continuity of care;

10.27 (v) shall have a minimum full-time equivalency that is prorated at a rate of 16 hours per
10.28 50 clients. Part-time psychiatric care providers shall have designated hours to work on the
10.29 team, with sufficient blocks of time on consistent days to carry out the provider's clinical,
10.30 supervisory, and administrative responsibilities. No more than two psychiatric care providers
10.31 may share this role; and

11.1 (vi) shall provide psychiatric backup to the program after regular business hours and on
11.2 weekends and holidays. The psychiatric care provider may delegate this duty to another
11.3 qualified psychiatric provider;

11.4 (3) the nursing staff:

11.5 (i) shall consist of one to three registered nurses or advanced practice registered nurses,
11.6 of whom at least one has a minimum of one-year experience working with adults with
11.7 serious mental illness and a working knowledge of psychiatric medications. No more than
11.8 two individuals can share a full-time equivalent position;

11.9 (ii) are responsible for managing medication, administering and documenting medication
11.10 treatment, and managing a secure medication room; and

11.11 (iii) shall develop strategies, in collaboration with clients, to maximize taking medications
11.12 as prescribed; screen and monitor clients' mental and physical health conditions and
11.13 medication side effects; engage in health promotion, prevention, and education activities;
11.14 communicate and coordinate services with other medical providers; facilitate the development
11.15 of the individual treatment plan for clients assigned; and educate the ACT team in monitoring
11.16 psychiatric and physical health symptoms and medication side effects;

11.17 (4) the co-occurring disorder specialist:

11.18 (i) shall be a full-time equivalent co-occurring disorder specialist who has received
11.19 specific training on co-occurring disorders that is consistent with national evidence-based
11.20 practices. The training must include practical knowledge of common substances and how
11.21 they affect mental illnesses, the ability to assess substance use disorders and the client's
11.22 stage of treatment, motivational interviewing, and skills necessary to provide counseling to
11.23 clients at all different stages of change and treatment. The co-occurring disorder specialist
11.24 may also be an individual who is a licensed alcohol and drug counselor as described in
11.25 section 148F.01, subdivision 5, or a counselor who otherwise meets the training, experience,
11.26 and other requirements in section 245G.11, subdivision 5. No more than two co-occurring
11.27 disorder specialists may occupy this role; and

11.28 (ii) shall provide or facilitate the provision of co-occurring disorder treatment to clients.
11.29 The co-occurring disorder specialist shall serve as a consultant and educator to fellow ACT
11.30 team members on co-occurring disorders;

11.31 (5) the vocational specialist:

11.32 (i) shall be a full-time vocational specialist who has at least one-year experience providing
11.33 employment services or advanced education that involved field training in vocational services

12.1 to individuals with mental illness. An individual who does not meet these qualifications
12.2 may also serve as the vocational specialist upon completing a training plan approved by the
12.3 commissioner;

12.4 (ii) shall provide or facilitate the provision of vocational services to clients. The vocational
12.5 specialist serves as a consultant and educator to fellow ACT team members on these services;
12.6 and

12.7 (iii) must not refer individuals to receive any type of vocational services or linkage by
12.8 providers outside of the ACT team;

12.9 (6) the mental health certified peer specialist:

12.10 (i) shall be a full-time equivalent. No more than two individuals can share this position.
12.11 The mental health certified peer specialist is a fully integrated team member who provides
12.12 highly individualized services in the community and promotes the self-determination and
12.13 shared decision-making abilities of clients. This requirement may be waived due to workforce
12.14 shortages upon approval of the commissioner;

12.15 (ii) must provide coaching, mentoring, and consultation to the clients to promote recovery,
12.16 self-advocacy, and self-direction, promote wellness management strategies, and assist clients
12.17 in developing advance directives; and

12.18 (iii) must model recovery values, attitudes, beliefs, and personal action to encourage
12.19 wellness and resilience, provide consultation to team members, promote a culture where
12.20 the clients' points of view and preferences are recognized, understood, respected, and
12.21 integrated into treatment, and serve in a manner equivalent to other team members;

12.22 (7) the program administrative assistant shall be a full-time office-based program
12.23 administrative assistant position assigned to solely work with the ACT team, providing a
12.24 range of supports to the team, clients, and families; and

12.25 (8) additional staff:

12.26 (i) shall be based on team size. Additional treatment team staff may include mental
12.27 health professionals; clinical trainees; certified rehabilitation specialists; mental health
12.28 practitioners; or mental health rehabilitation workers. These individuals shall have the
12.29 knowledge, skills, and abilities required by the population served to carry out rehabilitation
12.30 and support functions; and

12.31 (ii) shall be selected based on specific program needs or the population served.

12.32 (b) Each ACT team must clearly document schedules for all ACT team members.

13.1 (c) Each ACT team member must serve as a primary team member for clients assigned
 13.2 by the team leader and are responsible for facilitating the individual treatment plan process
 13.3 for those clients. The primary team member for a client is the responsible team member
 13.4 knowledgeable about the client's life and circumstances and writes the individual treatment
 13.5 plan. The primary team member provides individual supportive therapy or counseling, and
 13.6 provides primary support and education to the client's family and support system.

13.7 (d) Members of the ACT team must have strong clinical skills, professional qualifications,
 13.8 experience, and competency to provide a full breadth of rehabilitation services. Each staff
 13.9 member shall be proficient in their respective discipline and be able to work collaboratively
 13.10 as a member of a multidisciplinary team to deliver the majority of the treatment,
 13.11 rehabilitation, and support services clients require to fully benefit from receiving assertive
 13.12 community treatment.

13.13 (e) Each ACT team member must fulfill training requirements established by the
 13.14 commissioner.

13.15 Sec. 9. Minnesota Statutes 2022, section 256B.0623, subdivision 4, is amended to read:

13.16 Subd. 4. **Provider entity standards.** (a) The provider entity must be certified by the
 13.17 state following the certification process and procedures developed by the commissioner.

13.18 (b) The certification process is a determination as to whether the entity meets the standards
 13.19 in this section and chapter 245I, as required in section 245I.011, subdivision 5. The
 13.20 certification must specify which adult rehabilitative mental health services the entity is
 13.21 qualified to provide.

13.22 ~~(e) A nonecounty provider entity must obtain additional certification from each county~~
 13.23 ~~in which it will provide services. The additional certification must be based on the adequacy~~
 13.24 ~~of the entity's knowledge of that county's local health and human service system, and the~~
 13.25 ~~ability of the entity to coordinate its services with the other services available in that county.~~
 13.26 ~~A county-operated entity must obtain this additional certification from any other county in~~
 13.27 ~~which it will provide services.~~

13.28 ~~(d)~~ (c) State-level recertification must occur at least every three years.

13.29 ~~(e)~~ (d) The commissioner may intervene at any time and decertify providers with cause.
 13.30 The decertification is subject to appeal to the state. A county board may recommend that
 13.31 the state decertify a provider for cause.

13.32 ~~(f)~~ (e) The adult rehabilitative mental health services provider entity must meet the
 13.33 following standards:

- 14.1 (1) have capacity to recruit, hire, manage, and train qualified staff;
- 14.2 (2) have adequate administrative ability to ensure availability of services;
- 14.3 (3) ensure that staff are skilled in the delivery of the specific adult rehabilitative mental
- 14.4 health services provided to the individual eligible recipient;
- 14.5 (4) ensure enough flexibility in service delivery to respond to the changing and
- 14.6 intermittent care needs of a recipient as identified by the recipient and the individual treatment
- 14.7 plan;
- 14.8 (5) assist the recipient in arranging needed crisis assessment, intervention, and
- 14.9 stabilization services;
- 14.10 (6) ensure that services are coordinated with other recipient mental health services
- 14.11 providers and the county mental health authority and the federally recognized American
- 14.12 Indian authority and necessary others after obtaining the consent of the recipient. Services
- 14.13 must also be coordinated with the recipient's case manager or care coordinator if the recipient
- 14.14 is receiving case management or care coordination services;
- 14.15 (7) keep all necessary records required by law;
- 14.16 (8) deliver services as required by section 245.461;
- 14.17 (9) be an enrolled Medicaid provider; and
- 14.18 (10) maintain a quality assurance plan to determine specific service outcomes and the
- 14.19 recipient's satisfaction with services.

14.20 Sec. 10. Minnesota Statutes 2022, section 256B.0757, subdivision 4c, is amended to read:

14.21 Subd. 4c. **Behavioral health home services staff qualifications.** (a) A behavioral health

14.22 home services provider must maintain staff with required professional qualifications

14.23 appropriate to the setting.

14.24 (b) If behavioral health home services are offered in a mental health setting, the

14.25 integration specialist must be a registered licensed nurse licensed under the Minnesota Nurse

14.26 Practice Act, sections 148.171 to 148.285, as defined in section 148.171, subdivision 9.

14.27 (c) If behavioral health home services are offered in a primary care setting, the integration

14.28 specialist must be a mental health professional who is qualified according to section 245I.04,

14.29 subdivision 2.

14.30 (d) If behavioral health home services are offered in either a primary care setting or

14.31 mental health setting, the systems navigator must be a mental health practitioner who is

15.1 qualified according to section 245I.04, subdivision 4, or a community health worker as
15.2 defined in section 256B.0625, subdivision 49.

15.3 (e) If behavioral health home services are offered in either a primary care setting or
15.4 mental health setting, the qualified health home specialist must be one of the following:

15.5 (1) a mental health certified peer specialist who is qualified according to section 245I.04,
15.6 subdivision 10;

15.7 (2) a mental health certified family peer specialist who is qualified according to section
15.8 245I.04, subdivision 12;

15.9 (3) a case management associate as defined in section 245.462, subdivision 4, paragraph
15.10 (g), or 245.4871, subdivision 4, paragraph (j);

15.11 (4) a mental health rehabilitation worker who is qualified according to section 245I.04,
15.12 subdivision 14;

15.13 (5) a community paramedic as defined in section 144E.28, subdivision 9;

15.14 (6) a peer recovery specialist as defined in section 245G.07, subdivision 1, clause (5);

15.15 or

15.16 (7) a community health worker as defined in section 256B.0625, subdivision 49.

15.17 Sec. 11. Minnesota Statutes 2022, section 256B.69, subdivision 5a, is amended to read:

15.18 Subd. 5a. **Managed care contracts.** (a) Managed care contracts under this section and
15.19 section 256L.12 shall be entered into or renewed on a calendar year basis. The commissioner
15.20 may issue separate contracts with requirements specific to services to medical assistance
15.21 recipients age 65 and older.

15.22 (b) A prepaid health plan providing covered health services for eligible persons pursuant
15.23 to chapters 256B and 256L is responsible for complying with the terms of its contract with
15.24 the commissioner. Requirements applicable to managed care programs under chapters 256B
15.25 and 256L established after the effective date of a contract with the commissioner take effect
15.26 when the contract is next issued or renewed.

15.27 (c) The commissioner shall withhold five percent of managed care plan payments under
15.28 this section and county-based purchasing plan payments under section 256B.692 for the
15.29 prepaid medical assistance program pending completion of performance targets. Each
15.30 performance target must be quantifiable, objective, measurable, and reasonably attainable,
15.31 except in the case of a performance target based on a federal or state law or rule. Criteria
15.32 for assessment of each performance target must be outlined in writing prior to the contract

16.1 effective date. Clinical or utilization performance targets and their related criteria must
16.2 consider evidence-based research and reasonable interventions when available or applicable
16.3 to the populations served, and must be developed with input from external clinical experts
16.4 and stakeholders, including managed care plans, county-based purchasing plans, and
16.5 providers. The managed care or county-based purchasing plan must demonstrate, to the
16.6 commissioner's satisfaction, that the data submitted regarding attainment of the performance
16.7 target is accurate. The commissioner shall periodically change the administrative measures
16.8 used as performance targets in order to improve plan performance across a broader range
16.9 of administrative services. The performance targets must include measurement of plan
16.10 efforts to contain spending on health care services and administrative activities. The
16.11 commissioner may adopt plan-specific performance targets that take into account factors
16.12 affecting only one plan, including characteristics of the plan's enrollee population. The
16.13 withheld funds must be returned no sooner than July of the following year if performance
16.14 targets in the contract are achieved. The commissioner may exclude special demonstration
16.15 projects under subdivision 23.

16.16 (d) The commissioner shall require that managed care plans:

16.17 (1) use the assessment and authorization processes, forms, timelines, standards,
16.18 documentation, and data reporting requirements, protocols, billing processes, and policies
16.19 consistent with medical assistance fee-for-service or the Department of Human Services
16.20 contract requirements for all personal care assistance services under section 256B.0659 and
16.21 community first services and supports under section 256B.85; and

16.22 (2) by January 30 of each year that follows a rate increase for any aspect of services
16.23 under section 256B.0659 or 256B.85, inform the commissioner and the chairs and ranking
16.24 minority members of the legislative committees with jurisdiction over rates determined
16.25 under section 256B.851 of the amount of the rate increase that is paid to each personal care
16.26 assistance provider agency with which the plan has a contract.

16.27 (e) Effective for services rendered on or after January 1, 2012, the commissioner shall
16.28 include as part of the performance targets described in paragraph (c) a reduction in the health
16.29 plan's emergency department utilization rate for medical assistance and MinnesotaCare
16.30 enrollees, as determined by the commissioner. For 2012, the reduction shall be based on
16.31 the health plan's utilization in 2009. To earn the return of the withhold each subsequent
16.32 year, the managed care plan or county-based purchasing plan must achieve a qualifying
16.33 reduction of no less than ten percent of the plan's emergency department utilization rate for
16.34 medical assistance and MinnesotaCare enrollees, excluding enrollees in programs described
16.35 in subdivisions 23 and 28, compared to the previous measurement year until the final

17.1 performance target is reached. When measuring performance, the commissioner must
17.2 consider the difference in health risk in a managed care or county-based purchasing plan's
17.3 membership in the baseline year compared to the measurement year, and work with the
17.4 managed care or county-based purchasing plan to account for differences that they agree
17.5 are significant.

17.6 The withheld funds must be returned no sooner than July 1 and no later than July 31 of
17.7 the following calendar year if the managed care plan or county-based purchasing plan
17.8 demonstrates to the satisfaction of the commissioner that a reduction in the utilization rate
17.9 was achieved. The commissioner shall structure the withhold so that the commissioner
17.10 returns a portion of the withheld funds in amounts commensurate with achieved reductions
17.11 in utilization less than the targeted amount.

17.12 The withhold described in this paragraph shall continue for each consecutive contract
17.13 period until the plan's emergency room utilization rate for state health care program enrollees
17.14 is reduced by 25 percent of the plan's emergency room utilization rate for medical assistance
17.15 and MinnesotaCare enrollees for calendar year 2009. Hospitals shall cooperate with the
17.16 health plans in meeting this performance target and shall accept payment withholds that
17.17 may be returned to the hospitals if the performance target is achieved.

17.18 (f) Effective for services rendered on or after January 1, 2012, the commissioner shall
17.19 include as part of the performance targets described in paragraph (c) a reduction in the plan's
17.20 hospitalization admission rate for medical assistance and MinnesotaCare enrollees, as
17.21 determined by the commissioner. To earn the return of the withhold each year, the managed
17.22 care plan or county-based purchasing plan must achieve a qualifying reduction of no less
17.23 than five percent of the plan's hospital admission rate for medical assistance and
17.24 MinnesotaCare enrollees, excluding enrollees in programs described in subdivisions 23 and
17.25 28, compared to the previous calendar year until the final performance target is reached.
17.26 When measuring performance, the commissioner must consider the difference in health risk
17.27 in a managed care or county-based purchasing plan's membership in the baseline year
17.28 compared to the measurement year, and work with the managed care or county-based
17.29 purchasing plan to account for differences that they agree are significant.

17.30 The withheld funds must be returned no sooner than July 1 and no later than July 31 of
17.31 the following calendar year if the managed care plan or county-based purchasing plan
17.32 demonstrates to the satisfaction of the commissioner that this reduction in the hospitalization
17.33 rate was achieved. The commissioner shall structure the withhold so that the commissioner
17.34 returns a portion of the withheld funds in amounts commensurate with achieved reductions
17.35 in utilization less than the targeted amount.

18.1 The withhold described in this paragraph shall continue until there is a 25 percent
18.2 reduction in the hospital admission rate compared to the hospital admission rates in calendar
18.3 year 2011, as determined by the commissioner. The hospital admissions in this performance
18.4 target do not include the admissions applicable to the subsequent hospital admission
18.5 performance target under paragraph (g). Hospitals shall cooperate with the plans in meeting
18.6 this performance target and shall accept payment withholds that may be returned to the
18.7 hospitals if the performance target is achieved.

18.8 (g) Effective for services rendered on or after January 1, 2012, the commissioner shall
18.9 include as part of the performance targets described in paragraph (c) a reduction in the plan's
18.10 hospitalization admission rates for subsequent hospitalizations within 30 days of a previous
18.11 hospitalization of a patient regardless of the reason, for medical assistance and MinnesotaCare
18.12 enrollees, as determined by the commissioner. To earn the return of the withhold each year,
18.13 the managed care plan or county-based purchasing plan must achieve a qualifying reduction
18.14 of the subsequent hospitalization rate for medical assistance and MinnesotaCare enrollees,
18.15 excluding enrollees in programs described in subdivisions 23 and 28, of no less than five
18.16 percent compared to the previous calendar year until the final performance target is reached.

18.17 The withheld funds must be returned no sooner than July 1 and no later than July 31 of
18.18 the following calendar year if the managed care plan or county-based purchasing plan
18.19 demonstrates to the satisfaction of the commissioner that a qualifying reduction in the
18.20 subsequent hospitalization rate was achieved. The commissioner shall structure the withhold
18.21 so that the commissioner returns a portion of the withheld funds in amounts commensurate
18.22 with achieved reductions in utilization less than the targeted amount.

18.23 The withhold described in this paragraph must continue for each consecutive contract
18.24 period until the plan's subsequent hospitalization rate for medical assistance and
18.25 MinnesotaCare enrollees, excluding enrollees in programs described in subdivisions 23 and
18.26 28, is reduced by 25 percent of the plan's subsequent hospitalization rate for calendar year
18.27 2011. Hospitals shall cooperate with the plans in meeting this performance target and shall
18.28 accept payment withholds that must be returned to the hospitals if the performance target
18.29 is achieved.

18.30 (h) Effective for services rendered on or after January 1, 2013, through December 31,
18.31 2013, the commissioner shall withhold 4.5 percent of managed care plan payments under
18.32 this section and county-based purchasing plan payments under section 256B.692 for the
18.33 prepaid medical assistance program. The withheld funds must be returned no sooner than
18.34 July 1 and no later than July 31 of the following year. The commissioner may exclude
18.35 special demonstration projects under subdivision 23.

19.1 (i) Effective for services rendered on or after January 1, 2014, the commissioner shall
19.2 withhold three percent of managed care plan payments under this section and county-based
19.3 purchasing plan payments under section 256B.692 for the prepaid medical assistance
19.4 program. The withheld funds must be returned no sooner than July 1 and no later than July
19.5 31 of the following year. The commissioner may exclude special demonstration projects
19.6 under subdivision 23.

19.7 (j) A managed care plan or a county-based purchasing plan under section 256B.692 may
19.8 include as admitted assets under section 62D.044 any amount withheld under this section
19.9 that is reasonably expected to be returned.

19.10 (k) Contracts between the commissioner and a prepaid health plan are exempt from the
19.11 set-aside and preference provisions of section 16C.16, subdivisions 6, paragraph (a), and
19.12 7.

19.13 (l) The return of the withhold under paragraphs (h) and (i) is not subject to the
19.14 requirements of paragraph (c).

19.15 (m) Managed care plans and county-based purchasing plans shall maintain current and
19.16 fully executed agreements for all subcontractors, including bargaining groups, for
19.17 administrative services that are expensed to the state's public health care programs.
19.18 Subcontractor agreements determined to be material, as defined by the commissioner after
19.19 taking into account state contracting and relevant statutory requirements, must be in the
19.20 form of a written instrument or electronic document containing the elements of offer,
19.21 acceptance, consideration, payment terms, scope, duration of the contract, and how the
19.22 subcontractor services relate to state public health care programs. Upon request, the
19.23 commissioner shall have access to all subcontractor documentation under this paragraph.
19.24 Nothing in this paragraph shall allow release of information that is nonpublic data pursuant
19.25 to section 13.02.

19.26 (n) Effective for services rendered on or after January 1, 2024, the commissioner shall
19.27 require, as part of a contract, that all managed care and county-based purchasing plans use
19.28 timely claim filing timelines of twelve months and use remittance advice and prior
19.29 authorizations timelines consistent with those used under medical assistance fee-for-service
19.30 for mental health and substance use disorder treatment services. A managed care plan under
19.31 this section may not take back funds the managed care plan paid to a mental health and
19.32 substance use disorder treatment provider once six months have elapsed from the date the
19.33 funds were paid.

20.1 Sec. 12. **DIRECTION TO THE COMMISSIONER.**

20.2 By October 1, 2023, the commissioner of human services shall report to the chairs and
20.3 ranking minority members of the committees with jurisdiction over behavioral health on
20.4 the completed implementation of the requirements under Minnesota Statutes, section
20.5 256B.0617. The report shall outline the completed components related to certification,
20.6 recertification, and decertification and provide templates of all required documents developed
20.7 pursuant to that section.