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State of Minnesota
HOUSE OF REPRESENTATIVES
First Division Engrossment

NINETY-SECOND SESSION

H. F. No. **1495**

02/22/2021 Authored by Fischer, Franke and Vang
The bill was read for the first time and referred to the Committee on Human Services Finance and Policy

Division Action

02/23/2021 Referred by Chair to the Behavioral Health Policy Division
03/03/2021 Returned to the Committee on Human Services Finance and Policy as Amended

1.1 A bill for an act

1.2 relating to human services; modifying mental health services provisions; amending

1.3 Minnesota Statutes 2020, sections 62A.152, subdivision 3; 62A.3094, subdivision

1.4 1; 62Q.096; 144.651, subdivision 2; 144D.01, subdivision 4; 144G.08, subdivision

1.5 7, as amended; 148B.5301, subdivision 2; 148E.120, subdivision 2; 148F.11,

1.6 subdivision 1; 245.462, subdivisions 1, 6, 8, 9, 14, 16, 17, 18, 21, 23, by adding

1.7 a subdivision; 245.4661, subdivision 5; 245.4662, subdivision 1; 245.467,

1.8 subdivisions 2, 3; 245.469, subdivisions 1, 2; 245.470, subdivision 1; 245.4712,

1.9 subdivision 2; 245.472, subdivision 2; 245.4863; 245.4871, subdivisions 9a, 10,

1.10 11a, 17, 21, 26, 27, 29, 31, 32, 34, by adding a subdivision; 245.4876, subdivisions

1.11 2, 3; 245.4879, subdivision 1; 245.488, subdivision 1; 245.4901, subdivision 2;

1.12 245.62, subdivision 2; 245.735, subdivision 3; 245A.04, subdivision 5; 245A.10,

1.13 subdivision 4; 245A.65, subdivision 2; 245D.02, subdivision 20; 254B.05,

1.14 subdivision 5; 256B.0615, subdivisions 1, 5; 256B.0616, subdivisions 1, 3, 5;

1.15 256B.0622, subdivisions 1, 2, 3a, 4, 7, 7a, 7b, 7d; 256B.0623, subdivisions 1, 2,

1.16 3, 4, 5, 6, 9, 12; 256B.0624; 256B.0625, subdivisions 3b, 5, 19c, 28a, 42, 48, 49,

1.17 56a; 256B.0757, subdivision 4c; 256B.0941, subdivision 1; 256B.0943,

1.18 subdivisions 1, 2, 3, 4, 5, 5a, 6, 7, 9, 11; 256B.0946, subdivisions 1, 1a, 2, 3, 4, 6;

1.19 256B.0947, subdivisions 1, 2, 3, 3a, 5, 6, 7; 256B.0949, subdivisions 2, 4, 5a;

1.20 256B.25, subdivision 3; 256B.761; 256B.763; 256P.01, subdivision 6a; 295.50,

1.21 subdivision 9b; 325F.721, subdivision 1; proposing coding for new law in

1.22 Minnesota Statutes, chapter 256B; proposing coding for new law as Minnesota

1.23 Statutes, chapter 245I; repealing Minnesota Statutes 2020, sections 245.462,

1.24 subdivision 4a; 245.4879, subdivision 2; 245.62, subdivisions 3, 4; 245.69,

1.25 subdivision 2; 256B.0615, subdivision 2; 256B.0616, subdivision 2; 256B.0622,

1.26 subdivisions 3, 5a; 256B.0623, subdivisions 7, 8, 10, 11; 256B.0625, subdivisions

1.27 5l, 35a, 35b, 61, 62, 65; 256B.0943, subdivisions 8, 10; 256B.0944; 256B.0946,

1.28 subdivision 5; Minnesota Rules, parts 9505.0370; 9505.0371; 9505.0372;

1.29 9520.0010; 9520.0020; 9520.0030; 9520.0040; 9520.0050; 9520.0060; 9520.0070;

1.30 9520.0080; 9520.0090; 9520.0100; 9520.0110; 9520.0120; 9520.0130; 9520.0140;

1.31 9520.0150; 9520.0160; 9520.0170; 9520.0180; 9520.0190; 9520.0200; 9520.0210;

1.32 9520.0230; 9520.0750; 9520.0760; 9520.0770; 9520.0780; 9520.0790; 9520.0800;

1.33 9520.0810; 9520.0820; 9520.0830; 9520.0840; 9520.0850; 9520.0860; 9520.0870.

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

2.2 **ARTICLE 1**

2.3 **MENTAL HEALTH UNIFORM SERVICE STANDARDS**

2.4 Section 1. **[245I.01] PURPOSE AND CITATION.**

2.5 Subdivision 1. Citation. This chapter may be cited as the "Mental Health Uniform
2.6 Service Standards Act."

2.7 Subd. 2. Purpose. In accordance with sections 245.461 and 245.487, the purpose of this
2.8 chapter is to create a system of mental health care that is unified, accountable, and
2.9 comprehensive, and to promote the recovery and resiliency of Minnesotans who have mental
2.10 illnesses. The state's public policy is to support Minnesotans' access to quality outpatient
2.11 and residential mental health services. Further, the state's public policy is to protect the
2.12 health and safety, rights, and well-being of Minnesotans receiving mental health services.

2.13 Sec. 2. **[245I.011] APPLICABILITY.**

2.14 Subdivision 1. License requirements. A license holder under this chapter must comply
2.15 with the requirements in chapters 245A, 245C, and 260E; section 626.557; and Minnesota
2.16 Rules, chapter 9544.

2.17 Subd. 2. Variances. (a) The commissioner may grant a variance to an applicant, license
2.18 holder, or certification holder as long as the variance does not affect the staff qualifications
2.19 or the health or safety of any person in a licensed or certified program and the applicant,
2.20 license holder, or certification holder meets the following conditions:

2.21 (1) an applicant, license holder, or certification holder must request the variance on a
2.22 form approved by the commissioner and in a manner prescribed by the commissioner;

2.23 (2) the request for a variance must include the:

2.24 (i) reasons that the applicant, license holder, or certification holder cannot comply with
2.25 a requirement as stated in the law; and

2.26 (ii) alternative equivalent measures that the applicant, license holder, or certification
2.27 holder will follow to comply with the intent of the law; and

2.28 (3) the request for a variance must state the period of time when the variance is requested.

2.29 (b) The commissioner may grant a permanent variance when the conditions under which
2.30 the applicant, license holder, or certification holder requested the variance do not affect the
2.31 health or safety of any person whom the licensed or certified program serves, and when the

3.1 conditions of the variance do not compromise the qualifications of staff who provide services
3.2 to clients. A permanent variance expires when the conditions that warranted the variance
3.3 change in any way. Any applicant, license holder, or certification holder must inform the
3.4 commissioner of any changes to the conditions that warranted the permanent variance. If
3.5 an applicant, license holder, or certification holder fails to advise the commissioner of
3.6 changes to the conditions that warranted the variance, the commissioner must revoke the
3.7 permanent variance and may impose other sanctions under sections 245A.06 and 245A.07.

3.8 (c) The commissioner's decision to grant or deny a variance request is final and not
3.9 subject to appeal under the provisions of chapter 14.

3.10 Subd. 3. **Certification required.** (a) An individual, organization, or government entity
3.11 that is exempt from licensure under section 245A.03, subdivision 2, paragraph (a), clause
3.12 (19), and chooses to be identified as a certified mental health clinic must:

3.13 (1) be a mental health clinic that is certified under section 245I.20;

3.14 (2) comply with all of the responsibilities assigned to a license holder by this chapter
3.15 except subdivision 1; and

3.16 (3) comply with all of the responsibilities assigned to a certification holder by chapter
3.17 245A.

3.18 (b) An individual, organization, or government entity described by this subdivision must
3.19 obtain a criminal background study for each staff person or volunteer who provides direct
3.20 contact services to clients.

3.21 Subd. 4. **License required.** An individual, organization, or government entity providing
3.22 intensive residential treatment services or residential crisis stabilization to adults must be
3.23 licensed under section 245I.23.

3.24 Subd. 5. **Programs certified under chapter 256B.** (a) An individual, organization, or
3.25 government entity certified under the following sections must comply with all of the
3.26 responsibilities assigned to a license holder under this chapter except subdivision 1:

3.27 (1) an assertive community treatment provider under section 256B.0622, subdivision
3.28 3a;

3.29 (2) an adult rehabilitative mental health services provider under section 256B.0623;

3.30 (3) a mobile crisis team under section 256B.0624;

3.31 (4) a children's therapeutic services and supports provider under section 256B.0943;

3.32 (5) an intensive treatment in foster care provider under section 256B.0946; and

4.1 (6) an intensive nonresidential rehabilitative mental health services provider under section
4.2 256B.0947.

4.3 (b) An individual, organization, or government entity certified under the sections listed
4.4 in paragraph (a), clauses (1) to (6), must obtain a criminal background study for each staff
4.5 person and volunteer providing direct contact services to a client.

4.6 **EFFECTIVE DATE.** This section is effective upon federal approval or July 1, 2022,
4.7 whichever is later.

4.8 Sec. 3. **[245I.02] DEFINITIONS.**

4.9 Subdivision 1. **Scope.** For purposes of this chapter, the terms in this section have the
4.10 meanings given.

4.11 Subd. 2. **Approval.** "Approval" means the documented review of, opportunity to request
4.12 changes to, and agreement with a treatment document. An individual may demonstrate
4.13 approval with a written signature, secure electronic signature, or documented oral approval.

4.14 Subd. 3. **Behavioral sciences or related fields.** "Behavioral sciences or related fields"
4.15 means an education from an accredited college or university in social work, psychology,
4.16 sociology, community counseling, family social science, child development, child
4.17 psychology, community mental health, addiction counseling, counseling and guidance,
4.18 special education, nursing, and other similar fields approved by the commissioner.

4.19 Subd. 4. **Business day.** "Business day" means a weekday on which government offices
4.20 are open for business. Business day does not include state or federal holidays, Saturdays,
4.21 or Sundays.

4.22 Subd. 5. **Case manager.** "Case manager" means a client's case manager according to
4.23 section 256B.0596; 256B.0621; 256B.0625, subdivision 20; 256B.092, subdivision 1a;
4.24 256B.0924; 256B.093, subdivision 3a; 256B.094; or 256B.49.

4.25 Subd. 6. **Certified rehabilitation specialist.** "Certified rehabilitation specialist" means
4.26 a staff person who meets the qualifications of section 245I.04, subdivision 8.

4.27 Subd. 7. **Child.** "Child" means a client under the age of 18.

4.28 Subd. 8. **Client.** "Client" means a person who is seeking or receiving services regulated
4.29 by this chapter. For the purpose of a client's consent to services, client includes a parent,
4.30 guardian, or other individual legally authorized to consent on behalf of a client to services.

4.31 Subd. 9. **Clinical trainee.** "Clinical trainee" means a staff person who is qualified
4.32 according to section 245I.04, subdivision 6.

5.1 Subd. 10. **Commissioner.** "Commissioner" means the commissioner of human services
5.2 or the commissioner's designee.

5.3 Subd. 11. **Co-occurring substance use disorder treatment.** "Co-occurring substance
5.4 use disorder treatment" means the treatment of a person who has a co-occurring mental
5.5 illness and substance use disorder. Co-occurring substance use disorder treatment is
5.6 characterized by stage-wise comprehensive treatment, treatment goal setting, and flexibility
5.7 for clients at each stage of treatment. Co-occurring substance use disorder treatment includes
5.8 assessing and tracking each client's stage of change readiness and treatment using a treatment
5.9 approach based on a client's stage of change, such as motivational interviewing when working
5.10 with a client at an earlier stage of change readiness and a cognitive behavioral approach
5.11 and relapse prevention to work with a client at a later stage of change; and facilitating a
5.12 client's access to community supports.

5.13 Subd. 12. **Crisis plan.** "Crisis plan" means a plan to prevent and de-escalate a client's
5.14 future crisis situation, with the goal of preventing future crises for the client and the client's
5.15 family and other natural supports. Crisis plan includes a crisis plan developed according to
5.16 section 245.4871, subdivision 9a.

5.17 Subd. 13. **Critical incident.** "Critical incident" means an occurrence involving a client
5.18 that requires a license holder to respond in a manner that is not part of the license holder's
5.19 ordinary daily routine. Critical incident includes a client's suicide, attempted suicide, or
5.20 homicide; a client's death; an injury to a client or other person that is life-threatening or
5.21 requires medical treatment; a fire that requires a fire department's response; alleged
5.22 maltreatment of a client; an assault of a client; an assault by a client; or other situation that
5.23 requires a response by law enforcement, the fire department, an ambulance, or another
5.24 emergency response provider.

5.25 Subd. 14. **Diagnostic assessment.** "Diagnostic assessment" means the evaluation and
5.26 report of a client's potential diagnoses that a mental health professional or clinical trainee
5.27 completes under section 245I.10, subdivisions 4 to 6.

5.28 Subd. 15. **Direct contact.** "Direct contact" has the meaning given in section 245C.02,
5.29 subdivision 11.

5.30 Subd. 16. **Family and other natural supports.** "Family and other natural supports"
5.31 means the people whom a client identifies as having a high degree of importance to the
5.32 client. Family and other natural supports also means people that the client identifies as being
5.33 important to the client's mental health treatment, regardless of whether the person is related
5.34 to the client or lives in the same household as the client.

6.1 Subd. 17. **Functional assessment.** "Functional assessment" means the assessment of a
6.2 client's current level of functioning relative to functioning that is appropriate for someone
6.3 the client's age. For a client five years of age or younger, a functional assessment is the
6.4 Early Childhood Service Intensity Instrument (ESCII). For a client six to 17 years of age,
6.5 a functional assessment is the Child and Adolescent Service Intensity Instrument (CASII).
6.6 For a client 18 years of age or older, a functional assessment is the functional assessment
6.7 described in section 245I.10, subdivision 9.

6.8 Subd. 18. **Individual abuse prevention plan.** "Individual abuse prevention plan" means
6.9 a plan according to section 245A.65, subdivision 2, paragraph (b), and section 626.557,
6.10 subdivision 14.

6.11 Subd. 19. **Level of care assessment.** "Level of care assessment" means the level of care
6.12 decision support tool appropriate to the client's age. For a client five years of age or younger,
6.13 a level of care assessment is the Early Childhood Service Intensity Instrument (ESCII). For
6.14 a client six to 17 years of age, a level of care assessment is the Child and Adolescent Service
6.15 Intensity Instrument (CASII). For a client 18 years of age or older, a level of care assessment
6.16 is the Level of Care Utilization System for Psychiatric and Addiction Services (LOCUS).

6.17 Subd. 20. **License.** "License" has the meaning given in section 245A.02, subdivision 8.

6.18 Subd. 21. **License holder.** "License holder" has the meaning given in section 245A.02,
6.19 subdivision 9.

6.20 Subd. 22. **Licensed prescriber.** "Licensed prescriber" means an individual who is
6.21 authorized to prescribe legend drugs under section 151.37.

6.22 Subd. 23. **Mental health behavioral aide.** "Mental health behavioral aide" means a
6.23 staff person who is qualified under section 245I.04, subdivision 16.

6.24 Subd. 24. **Mental health certified family peer specialist.** "Mental health certified
6.25 family peer specialist" means a staff person who is qualified under section 245I.04,
6.26 subdivision 12.

6.27 Subd. 25. **Mental health certified peer specialist.** "Mental health certified peer
6.28 specialist" means a staff person who is qualified under section 245I.04, subdivision 10.

6.29 Subd. 26. **Mental health practitioner.** "Mental health practitioner" means a staff person
6.30 who is qualified under section 245I.04, subdivision 4.

6.31 Subd. 27. **Mental health professional.** "Mental health professional" means a staff person
6.32 who is qualified under section 245I.04, subdivision 2.

7.1 Subd. 28. **Mental health rehabilitation worker.** "Mental health rehabilitation worker"
7.2 means a staff person who is qualified under section 245I.04, subdivision 14.

7.3 Subd. 29. **Mental illness.** "Mental illness" means any of the conditions included in the
7.4 most recent editions of the DC: 0-5 Diagnostic Classification of Mental Health and
7.5 Development Disorders of Infancy and Early Childhood published by Zero to Three or the
7.6 Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric
7.7 Association.

7.8 Subd. 30. **Organization.** "Organization" has the meaning given in section 245A.02,
7.9 subdivision 10c.

7.10 Subd. 31. **Personnel file.** "Personnel file" means a set of records under section 245I.07,
7.11 paragraph (a). Personnel files excludes information related to a person's employment that
7.12 is not included in section 245I.07.

7.13 Subd. 32. **Registered nurse.** "Registered nurse" means a staff person who is qualified
7.14 under section 148.171, subdivision 20.

7.15 Subd. 33. **Rehabilitative mental health services.** "Rehabilitative mental health services"
7.16 means mental health services provided to an adult client that enable the client to develop
7.17 and achieve psychiatric stability, social competencies, personal and emotional adjustment,
7.18 independent living skills, family roles, and community skills when symptoms of mental
7.19 illness has impaired any of the client's abilities in these areas.

7.20 Subd. 34. **Residential program.** "Residential program" has the meaning given in section
7.21 245A.02, subdivision 14.

7.22 Subd. 35. **Signature.** "Signature" means a written signature or an electronic signature
7.23 defined in section 325L.02, paragraph (h).

7.24 Subd. 36. **Staff person.** "Staff person" means an individual who works under a license
7.25 holder's direction or under a contract with a license holder. Staff person includes an intern,
7.26 consultant, contractor, individual who works part-time, and an individual who does not
7.27 provide direct contact services to clients. Staff person includes a volunteer who provides
7.28 treatment services to a client or a volunteer whom the license holder regards as a staff person
7.29 for the purpose of meeting staffing or service delivery requirements. A staff person must
7.30 be 18 years of age or older.

7.31 Subd. 37. **Strengths.** "Strengths" means a person's inner characteristics, virtues, external
7.32 relationships, activities, and connections to resources that contribute to a client's resilience
7.33 and core competencies. A person can build on strengths to support recovery.

8.1 Subd. 38. **Trauma.** "Trauma" means an event, series of events, or set of circumstances
8.2 that is experienced by an individual as physically or emotionally harmful or life-threatening
8.3 that has lasting adverse effects on the individual's functioning and mental, physical, social,
8.4 emotional, or spiritual well-being. Trauma includes group traumatic experiences. Group
8.5 traumatic experiences are emotional or psychological harm that a group experiences. Group
8.6 traumatic experiences can be transmitted across generations within a community and are
8.7 often associated with racial and ethnic population groups who suffer major intergenerational
8.8 losses.

8.9 Subd. 39. **Treatment plan.** "Treatment plan" means services that a license holder
8.10 formulates to respond to a client's needs and goals. A treatment plan includes individual
8.11 treatment plans under section 245I.10, subdivisions 7 and 8; initial treatment plans under
8.12 section 245I.23, subdivision 7; and crisis treatment plans under sections 245I.23, subdivision
8.13 8, and 256B.0624, subdivision 11.

8.14 Subd. 40. **Treatment supervision.** "Treatment supervision" means a mental health
8.15 professional's or certified rehabilitation specialist's oversight, direction, and evaluation of
8.16 a staff person providing services to a client according to section 245I.06.

8.17 Subd. 41. **Volunteer.** "Volunteer" means an individual who, under the direction of the
8.18 license holder, provides services to or facilitates an activity for a client without compensation.

8.19 **Sec. 4. [245I.03] REQUIRED POLICIES AND PROCEDURES.**

8.20 Subdivision 1. **Generally.** A license holder must establish, enforce, and maintain policies
8.21 and procedures to comply with the requirements of this chapter and chapters 245A, 245C,
8.22 and 260E; sections 626.557 and 626.5572; and Minnesota Rules, chapter 9544. The license
8.23 holder must make all policies and procedures available in writing to each staff person. The
8.24 license holder must complete and document a review of policies and procedures every two
8.25 years and update policies and procedures as necessary. Each policy and procedure must
8.26 identify the date that it was initiated and the dates of all revisions. The license holder must
8.27 clearly communicate any policy and procedural change to each staff person and provide
8.28 necessary training to each staff person to implement any policy and procedural change.

8.29 Subd. 2. **Health and safety.** A license holder must have policies and procedures to
8.30 ensure the health and safety of each staff person and client during the provision of services,
8.31 including policies and procedures for services based in community settings.

9.1 Subd. 3. **Client rights.** A license holder must have policies and procedures to ensure
9.2 that each staff person complies with the client rights and protections requirements in section
9.3 245I.12.

9.4 Subd. 4. **Behavioral emergencies.** (a) A license holder must have procedures that each
9.5 staff person follows when responding to a client who exhibits behavior that threatens the
9.6 immediate safety of the client or others. A license holder's behavioral emergency procedures
9.7 must incorporate person-centered planning and trauma-informed care.

9.8 (b) A license holder's behavioral emergency procedures must include:

9.9 (1) a plan designed to prevent the client from inflicting self-harm and harming others;

9.10 (2) contact information for emergency resources that a staff person must use when the
9.11 license holder's behavioral emergency procedures are unsuccessful in controlling a client's
9.12 behavior;

9.13 (3) the types of behavioral emergency procedures that a staff person may use;

9.14 (4) the specific circumstances under which the program may use behavioral emergency
9.15 procedures; and

9.16 (5) the staff persons whom the license holder authorizes to implement behavioral
9.17 emergency procedures.

9.18 (c) The license holder's behavioral emergency procedures must not include secluding
9.19 or restraining a client except as allowed under section 245.8261.

9.20 (d) Staff persons must not use behavioral emergency procedures to enforce program
9.21 rules or for the convenience of staff persons. Behavioral emergency procedures must not
9.22 be part of any client's treatment plan. A staff person may not use behavioral emergency
9.23 procedures except in response to a client's current behavior that threatens the immediate
9.24 safety of the client or others.

9.25 Subd. 5. **Health services and medications.** If a license holder is licensed as a residential
9.26 program, stores or administers client medications, or observes clients self-administer
9.27 medications, the license holder must ensure that a staff person who is a registered nurse or
9.28 licensed prescriber reviews and approves of the license holder's policies and procedures to
9.29 comply with the health services and medications requirements in section 245I.11, the training
9.30 requirements in section 245I.05, subdivision 6, and the documentation requirements in
9.31 section 245I.08, subdivision 5.

10.1 Subd. 6. Reporting maltreatment. A license holder must have policies and procedures
10.2 for reporting a staff person's suspected maltreatment, abuse, or neglect of a client according
10.3 to chapter 260E and section 626.557.

10.4 Subd. 7. Critical incidents. If a license holder is licensed as a residential program, the
10.5 license holder must have policies and procedures for reporting and maintaining records of
10.6 critical incidents according to section 245I.13.

10.7 Subd. 8. Personnel. A license holder must have personnel policies and procedures that:

10.8 (1) include a chart or description of the organizational structure of the program that
10.9 indicates positions and lines of authority;

10.10 (2) ensure that it will not adversely affect a staff person's retention, promotion, job
10.11 assignment, or pay when a staff person communicates in good faith with the Department
10.12 of Human Services, the Office of Ombudsman for Mental Health and Developmental
10.13 Disabilities, the Department of Health, a health-related licensing board, a law enforcement
10.14 agency, or a local agency investigating a complaint regarding a client's rights, health, or
10.15 safety;

10.16 (3) prohibit a staff person from having sexual contact with a client in violation of chapter
10.17 604, sections 609.344 or 609.345;

10.18 (4) prohibit a staff person from neglecting, abusing, or maltreating a client as described
10.19 in chapter 260E and sections 626.557 and 626.5572;

10.20 (5) include the drug and alcohol policy described in section 245A.04, subdivision 1,
10.21 paragraph (c);

10.22 (6) describe the process for disciplinary action, suspension, or dismissal of a staff person
10.23 for violating a policy provision described in clauses (3) to (5);

10.24 (7) describe the license holder's response to a staff person who violates other program
10.25 policies or who has a behavioral problem that interferes with providing treatment services
10.26 to clients; and

10.27 (8) describe each staff person's position that includes the staff person's responsibilities,
10.28 authority to execute the responsibilities, and qualifications for the position.

10.29 Subd. 9. Volunteers. A license holder must have policies and procedures for using
10.30 volunteers, including when a license holder must submit a background study for a volunteer,
10.31 and the specific tasks that a volunteer may perform.

11.1 Subd. 10. **Data privacy.** (a) A license holder must have policies and procedures that
11.2 comply with all applicable state and federal law. A license holder's use of electronic record
11.3 keeping or electronic signatures does not alter a license holder's obligations to comply with
11.4 applicable state and federal law.

11.5 (b) A license holder must have policies and procedures for a staff person to promptly
11.6 document a client's revocation of consent to disclose the client's health record. The license
11.7 holder must verify that the license holder has permission to disclose a client's health record
11.8 before releasing any client data.

11.9 Sec. 5. **[245L.04] PROVIDER QUALIFICATIONS AND SCOPE OF PRACTICE.**

11.10 Subdivision 1. **Tribal providers.** For purposes of this section, a tribal entity may
11.11 credential an individual according to section 256B.02, subdivision 7, paragraphs (b) and
11.12 (c).

11.13 Subd. 2. **Mental health professional qualifications.** The following individuals may
11.14 provide services to a client as a mental health professional:

11.15 (1) a registered nurse who is licensed under sections 148.171 to 148.285 and is certified
11.16 as a: (i) clinical nurse specialist in child or adolescent, family, or adult psychiatric and
11.17 mental health nursing by a national certification organization; or (ii) nurse practitioner in
11.18 adult or family psychiatric and mental health nursing by a national nurse certification
11.19 organization;

11.20 (2) a licensed independent clinical social worker as defined in section 148E.050,
11.21 subdivision 5;

11.22 (3) a psychologist licensed by the Board of Psychology under sections 148.88 to 148.98;

11.23 (4) a physician licensed under chapter 147 if the physician is: (i) certified by the American
11.24 Board of Psychiatry and Neurology; (ii) certified by the American Osteopathic Board of
11.25 Neurology and Psychiatry; or (iii) eligible for board certification in psychiatry;

11.26 (5) a marriage and family therapist licensed under sections 148B.29 to 148B.392; or

11.27 (6) a licensed professional clinical counselor licensed under section 148B.5301.

11.28 Subd. 3. **Mental health professional scope of practice.** A mental health professional
11.29 must maintain a valid license with the mental health professional's governing health-related
11.30 licensing board and must only provide services to a client within the scope of practice
11.31 determined by the applicable health-related licensing board.

12.1 Subd. 4. Mental health practitioner qualifications. (a) An individual who is qualified
12.2 in at least one of the ways described in paragraph (b) to (d) may serve as a mental health
12.3 practitioner.

12.4 (b) An individual is qualified as a mental health practitioner through relevant coursework
12.5 if the individual completes at least 30 semester hours or 45 quarter hours in behavioral
12.6 sciences or related fields and:

12.7 (1) has at least 2,000 hours of experience providing services to individuals with:

12.8 (i) a mental illness or a substance use disorder; or

12.9 (ii) a traumatic brain injury or a developmental disability, and completes the additional
12.10 training described in section 245I.05, subdivision 3, paragraph (c), before providing direct
12.11 contact services to a client;

12.12 (2) is fluent in the non-English language of the ethnic group to which at least 50 percent
12.13 of the individual's clients belong, and completes the additional training described in section
12.14 245I.05, subdivision 3, paragraph (c), before providing direct contact services to a client;

12.15 (3) is working in a day treatment program under section 256B.0671, subdivision 3, or
12.16 256B.0943; or

12.17 (4) has completed a practicum or internship that (i) required direct interaction with adult
12.18 clients or child clients, and (ii) was focused on behavioral sciences or related fields.

12.19 (c) An individual is qualified as a mental health practitioner through work experience
12.20 if the individual:

12.21 (1) has at least 4,000 hours of experience in the delivery of services to individuals with:

12.22 (i) a mental illness or a substance use disorder; or

12.23 (ii) a traumatic brain injury or a developmental disability, and completes the additional
12.24 training described in section 245I.05, subdivision 3, paragraph (c), before providing direct
12.25 contact services to clients; or

12.26 (2) receives treatment supervision at least once per week until meeting the requirement
12.27 in clause (1) of 4,000 hours of experience and has at least 2,000 hours of experience providing
12.28 services to individuals with:

12.29 (i) a mental illness or a substance use disorder; or

13.1 (ii) a traumatic brain injury or a developmental disability, and completes the additional
13.2 training described in section 245I.05, subdivision 3, paragraph (c), before providing direct
13.3 contact services to clients.

13.4 (d) An individual is qualified as a mental health practitioner if the individual has a
13.5 master's or other graduate degree in behavioral sciences or related fields.

13.6 **Subd. 5. Mental health practitioner scope of practice.** (a) A mental health practitioner
13.7 under the treatment supervision of a mental health professional or certified rehabilitation
13.8 specialist may provide an adult client with client education, rehabilitative mental health
13.9 services, functional assessments, level of care assessments, and treatment plans. A mental
13.10 health practitioner under the treatment supervision of a mental health professional may
13.11 provide skill-building services to a child client and complete treatment plans for a child
13.12 client.

13.13 (b) A mental health practitioner must not provide treatment supervision to other staff
13.14 persons. A mental health practitioner may provide direction to mental health rehabilitation
13.15 workers and mental health behavioral aides.

13.16 (c) A mental health practitioner who provides services to clients according to section
13.17 256B.0624 or 256B.0944 may perform crisis assessments and interventions for a client.

13.18 **Subd. 6. Clinical trainee qualifications.** (a) A clinical trainee is a staff person who: (1)
13.19 is enrolled in an accredited graduate program of study to prepare the staff person for
13.20 independent licensure as a mental health professional and who is participating in a practicum
13.21 or internship with the license holder through the individual's graduate program; or (2) has
13.22 completed an accredited graduate program of study to prepare the staff person for independent
13.23 licensure as a mental health professional and who is in compliance with the requirements
13.24 of the applicable health-related licensing board, including requirements for supervised
13.25 practice.

13.26 (b) A clinical trainee is responsible for notifying and applying to a health-related licensing
13.27 board to ensure that the trainee meets the requirements of the health-related licensing board.
13.28 As permitted by a health-related licensing board, treatment supervision under this chapter
13.29 may be integrated into a plan to meet the supervisory requirements of the health-related
13.30 licensing board but does not supersede those requirements.

13.31 **Subd. 7. Clinical trainee scope of practice.** (a) A clinical trainee under the treatment
13.32 supervision of a mental health professional may provide a client with psychotherapy, client
13.33 education, rehabilitative mental health services, diagnostic assessments, functional
13.34 assessments, level of care assessments, and treatment plans.

14.1 (b) A clinical trainee must not provide treatment supervision to other staff persons. A
14.2 clinical trainee may provide direction to mental health behavioral aides and mental health
14.3 rehabilitation workers.

14.4 (c) A psychological clinical trainee under the treatment supervision of a psychologist
14.5 may perform psychological testing of clients.

14.6 (d) A clinical trainee must not provide services to clients that violate any practice act of
14.7 a health-related licensing board, including failure to obtain licensure if licensure is required.

14.8 Subd. 8. Certified rehabilitation specialist qualifications. A certified rehabilitation
14.9 specialist must have:

14.10 (1) a master's degree from an accredited college or university in behavioral sciences or
14.11 related fields;

14.12 (2) at least 4,000 hours of post-master's supervised experience providing mental health
14.13 services to clients; and

14.14 (3) a valid national certification as a certified rehabilitation counselor or certified
14.15 psychosocial rehabilitation practitioner.

14.16 Subd. 9. Certified rehabilitation specialist scope of practice. (a) A certified
14.17 rehabilitation specialist may provide an adult client with client education, rehabilitative
14.18 mental health services, functional assessments, level of care assessments, and treatment
14.19 plans.

14.20 (b) A certified rehabilitation specialist may provide treatment supervision to a mental
14.21 health certified peer specialist, mental health practitioner, and mental health rehabilitation
14.22 worker.

14.23 Subd. 10. Mental health certified peer specialist qualifications. A mental health
14.24 certified peer specialist must:

14.25 (1) have been diagnosed with a mental illness;

14.26 (2) be a current or former mental health services client; and

14.27 (3) have a valid certification as a mental health certified peer specialist under section
14.28 256B.0615.

14.29 Subd. 11. Mental health certified peer specialist scope of practice. A mental health
14.30 certified peer specialist under the treatment supervision of a mental health professional or
14.31 certified rehabilitation specialist must:

- 15.1 (1) provide individualized peer support to each client;
15.2 (2) promote a client's recovery goals, self-sufficiency, self-advocacy, and development
15.3 of natural supports; and
15.4 (3) support a client's maintenance of skills that the client has learned from other services.

15.5 Subd. 12. **Mental health certified family peer specialist qualifications.** A mental
15.6 health certified family peer specialist must:

- 15.7 (1) have raised or be currently raising a child with a mental illness;
15.8 (2) have experience navigating the children's mental health system; and
15.9 (3) have a valid certification as a mental health certified family peer specialist under
15.10 section 256B.0616.

15.11 Subd. 13. **Mental health certified family peer specialist scope of practice.** A mental
15.12 health certified family peer specialist under the treatment supervision of a mental health
15.13 professional must provide services to increase the child's ability to function in the child's
15.14 home, school, and community. The mental health certified family peer specialist must:

- 15.15 (1) provide family peer support to build on a client's family's strengths and help the
15.16 family achieve desired outcomes;
15.17 (2) provide nonadversarial advocacy to a child client and the child's family that
15.18 encourages partnership and promotes the child's positive change and growth;
15.19 (3) support families in advocating for culturally appropriate services for a child in each
15.20 treatment setting;
15.21 (4) promote resiliency, self-advocacy, and development of natural supports;
15.22 (5) support maintenance of skills learned from other services;
15.23 (6) establish and lead parent support groups;
15.24 (7) assist parents in developing coping and problem-solving skills; and
15.25 (8) educate parents about mental illnesses and community resources, including resources
15.26 that connect parents with similar experiences to one another.

15.27 Subd. 14. **Mental health rehabilitation worker qualifications.** (a) A mental health
15.28 rehabilitation worker must:

- 15.29 (1) have a high school diploma or equivalent; and
15.30 (2) meet one of the following qualification requirements:

16.1 (i) be fluent in the non-English language or competent in the culture of the ethnic group
16.2 to which at least 20 percent of the mental health rehabilitation worker's clients belong;

16.3 (ii) have an associate of arts degree;

16.4 (iii) have two years of full-time postsecondary education or a total of 15 semester hours
16.5 or 23 quarter hours in behavioral sciences or related fields;

16.6 (iv) be a registered nurse;

16.7 (v) have, within the previous ten years, three years of personal life experience with
16.8 mental illness;

16.9 (vi) have, within the previous ten years, three years of life experience as a primary
16.10 caregiver to an adult with a mental illness, traumatic brain injury, substance use disorder,
16.11 or developmental disability; or

16.12 (vii) have, within the previous ten years, 2,000 hours of work experience providing
16.13 health and human services to individuals.

16.14 (b) A mental health rehabilitation worker who is scheduled as an overnight staff person
16.15 and works alone is exempt from the additional qualification requirements in paragraph (a),
16.16 clause (2).

16.17 Subd. 15. **Mental health rehabilitation worker scope of practice.** A mental health
16.18 rehabilitation worker under the treatment supervision of a mental health professional or
16.19 certified rehabilitation specialist may provide rehabilitative mental health services to an
16.20 adult client according to the client's treatment plan.

16.21 Subd. 16. **Mental health behavioral aide qualifications.** (a) A level 1 mental health
16.22 behavioral aide must have: (1) a high school diploma or equivalent; or (2) two years of
16.23 experience as a primary caregiver to a child with mental illness within the previous ten
16.24 years.

16.25 (b) A level 2 mental health behavioral aide must: (1) have an associate or bachelor's
16.26 degree; or (2) be certified by a program under section 256B.0943, subdivision 8a.

16.27 Subd. 17. **Mental health behavioral aide scope of practice.** While under the treatment
16.28 supervision of a mental health professional, a mental health behavioral aide may practice
16.29 psychosocial skills with a child client according to the child's treatment plan and individual
16.30 behavior plan that a mental health professional, clinical trainee, or mental health practitioner
16.31 has previously taught to the child.

17.1 Sec. 6. **[245I.05] TRAINING REQUIRED.**

17.2 Subdivision 1. **Training plan.** A license holder must develop a training plan to ensure
17.3 that staff persons receive ongoing training according to this section. The training plan must
17.4 include:

17.5 (1) a formal process to evaluate the training needs of each staff person. An annual
17.6 performance evaluation of a staff person satisfies this requirement;

17.7 (2) a description of how the license holder conducts ongoing training of each staff person,
17.8 including whether ongoing training is based on a staff person's hire date or a specified annual
17.9 cycle determined by the program;

17.10 (3) a description of how the license holder verifies and documents each staff person's
17.11 previous training experience. A license holder may consider a staff person to have met a
17.12 training requirement in subdivision 3, paragraph (d) or (e), if the staff person has received
17.13 equivalent postsecondary education in the previous four years or training experience in the
17.14 previous two years; and

17.15 (4) a description of how the license holder determines when a staff person needs
17.16 additional training, including when the license holder will provide additional training.

17.17 Subd. 2. **Documentation of training.** (a) The license holder must provide training to
17.18 each staff person according to the training plan and must document that the license holder
17.19 provided the training to each staff person. The license holder must document the following
17.20 information for each staff person's training:

17.21 (1) the topics of the training;

17.22 (2) the name of the trainee;

17.23 (3) the name and credentials of the trainer;

17.24 (4) the license holder's method of evaluating the trainee's competency upon completion
17.25 of training;

17.26 (5) the date of the training; and

17.27 (6) the length of training in hours and minutes.

17.28 (b) Documentation of a staff person's continuing education credit accepted by the
17.29 governing health-related licensing board is sufficient to document training for purposes of
17.30 this subdivision.

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

- 18.1 (1) vulnerable adult maltreatment under section 245A.65, subdivision 3; and
- 18.2 (2) the maltreatment of minor reporting requirements and definitions in chapter 260E
- 18.3 within 72 hours of first providing direct contact services to a client.
- 18.4 (b) Before providing direct contact services to a client, a staff person must receive training
- 18.5 about:
- 18.6 (1) client rights and protections under section 245I.12;
- 18.7 (2) the Minnesota Health Records Act, including client confidentiality, family engagement
- 18.8 under section 144.294, and client privacy;
- 18.9 (3) emergency procedures that the staff person must follow when responding to a fire,
- 18.10 inclement weather, a report of a missing person, and a behavioral or medical emergency;
- 18.11 (4) specific activities and job functions for which the staff person is responsible, including
- 18.12 the license holder's program policies and procedures applicable to the staff person's position;
- 18.13 (5) professional boundaries that the staff person must maintain; and
- 18.14 (6) specific needs of each client to whom the staff person will be providing direct contact
- 18.15 services, including each client's developmental status, cognitive functioning, physical and
- 18.16 mental abilities.
- 18.17 (c) Before providing direct contact services to a client, a mental health rehabilitation
- 18.18 worker, mental health behavioral aide, or mental health practitioner qualified under section
- 18.19 245I.04, subdivision 4, must receive 30 hours of training about:
- 18.20 (1) mental illnesses;
- 18.21 (2) client recovery and resiliency;
- 18.22 (3) mental health de-escalation techniques;
- 18.23 (4) co-occurring mental illness and substance use disorders; and
- 18.24 (5) psychotropic medications and medication side effects.
- 18.25 (d) Within 90 days of first providing direct contact services to an adult client, a clinical
- 18.26 trainee, mental health practitioner, mental health certified peer specialist, or mental health
- 18.27 rehabilitation worker must receive training about:
- 18.28 (1) trauma-informed care and secondary trauma;
- 18.29 (2) person-centered individual treatment plans, including seeking partnerships with
- 18.30 family and other natural supports;

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

19.2 (4) culturally responsive treatment practices.

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

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

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

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

19.14 (4) culturally responsive treatment practices; and

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

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

19.18 Subd. 4. **Ongoing training.** (a) A license holder must ensure that staff persons who
19.19 provide direct contact services to clients receive annual training about the topics in
19.20 subdivision 3, paragraphs (a) and (b), clauses (1) to (3).

19.21 (b) A license holder must ensure that each staff person who is qualified under section
19.22 245I.04 who is not a mental health professional receives 30 hours of training every two
19.23 years. The training topics must be based on the program's needs and the staff person's areas
19.24 of competency.

19.25 Subd. 5. **Additional training for medication administration.** (a) Prior to administering
19.26 medications to a client under delegated authority or observing a client self-administer
19.27 medications, a staff person who is not a licensed prescriber, registered nurse, or licensed
19.28 practical nurse qualified under section 148.171, subdivision 8, must receive training about
19.29 psychotropic medications, side effects, and medication management.

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

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

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

20.8 **Sec. 7. [245I.06] TREATMENT SUPERVISION.**

20.9 Subdivision 1. **Generally.** (a) A license holder must ensure that a mental health
20.10 professional or certified rehabilitation specialist provides treatment supervision to each staff
20.11 person who provides services to a client and who is not a mental health professional or
20.12 certified rehabilitation specialist. When providing treatment supervision, a treatment
20.13 supervisor must follow a staff person's written treatment supervision plan.

20.14 (b) Treatment supervision must focus on each client's treatment needs and the ability of
20.15 the staff person under treatment supervision to provide services to each client, including
20.16 the following topics related to the staff person's current caseload:

20.17 (1) a review and evaluation of the interventions that the staff person delivers to each
20.18 client;

20.19 (2) instruction on alternative strategies if a client is not achieving treatment goals;

20.20 (3) a review and evaluation of each client's assessments, treatment plans, and progress
20.21 notes for accuracy and appropriateness;

20.22 (4) instruction on the cultural norms or values of the clients and communities that the
20.23 license holder serves and the impact that a client's culture has on providing treatment;

20.24 (5) evaluation of and feedback regarding a direct service staff person's areas of
20.25 competency; and

20.26 (6) coaching, teaching, and practicing skills with a staff person.

20.27 (c) A treatment supervisor must provide treatment supervision to a staff person using
20.28 methods that allow for immediate feedback, including in-person, telephone, and interactive
20.29 video supervision.

20.30 (d) A treatment supervisor's responsibility for a staff person receiving treatment
20.31 supervision is limited to the services provided by the associated license holder. If a staff
20.32 person receiving treatment supervision is employed by multiple license holders, each license

21.1 holder is responsible for providing treatment supervision related to the treatment of the
21.2 license holder's clients.

21.3 Subd. 2. **Treatment supervision planning.** (a) A treatment supervisor and the staff
21.4 person supervised by the treatment supervisor must develop a written treatment supervision
21.5 plan. The license holder must ensure that a new staff person's treatment supervision plan is
21.6 completed and implemented by a treatment supervisor and the new staff person within 30
21.7 days of the new staff person's first day of employment. The license holder must review and
21.8 update each staff person's treatment supervision plan annually.

21.9 (b) Each staff person's treatment supervision plan must include:

21.10 (1) the name and qualifications of the staff person receiving treatment supervision;

21.11 (2) the names and licensures of the treatment supervisors who are supervising the staff
21.12 person;

21.13 (3) how frequently the treatment supervisors must provide treatment supervision to the
21.14 staff person; and

21.15 (4) the staff person's authorized scope of practice, including a description of the client
21.16 population that the staff person serves, and a description of the treatment methods and
21.17 modalities that the staff person may use to provide services to clients.

21.18 Subd. 3. **Treatment supervision and direct observation of mental health**
21.19 **rehabilitation workers and mental health behavioral aides.** (a) A mental health behavioral
21.20 aide or a mental health rehabilitation worker must receive direct observation from a mental
21.21 health professional, clinical trainee, certified rehabilitation specialist, or mental health
21.22 practitioner while the mental health behavioral aide or mental health rehabilitation worker
21.23 provides treatment services to clients, no less than twice per month for the first six months
21.24 of employment and once per month thereafter. The staff person performing the direct
21.25 observation must approve of the progress note for the observed treatment service.

21.26 (b) For a mental health rehabilitation worker qualified under section 245I.04, subdivision
21.27 14, paragraph (a), clause (2), item (i), treatment supervision in the first 2,000 hours of work
21.28 must at a minimum consist of:

21.29 (1) monthly individual supervision; and

21.30 (2) direct observation twice per month.

21.31 Sec. 8. **[245I.07] PERSONNEL FILES.**

21.32 (a) For each staff person, a license holder must maintain a personnel file that includes:

22.1 (1) verification of the staff person's qualifications required for the position including
22.2 training, education, practicum or internship agreement, licensure, and any other required
22.3 qualifications;

22.4 (2) documentation related to the staff person's background study;

22.5 (3) the hiring date of the staff person;

22.6 (4) a description of the staff person's job responsibilities with the license holder;

22.7 (5) the date that the staff person's specific duties and responsibilities became effective,
22.8 including the date that the staff person began having direct contact with clients;

22.9 (6) documentation of the staff person's training as required by section 245I.05, subdivision
22.10 2;

22.11 (7) a verification copy of license renewals that the staff person completed during the
22.12 staff person's employment;

22.13 (8) annual job performance evaluations; and

22.14 (9) if applicable, the staff person's alleged and substantiated violations of the license
22.15 holder's policies under section 245I.03, subdivision 8, clauses (3) to (7), and the license
22.16 holder's response.

22.17 (b) The license holder must ensure that all personnel files are readily accessible for the
22.18 commissioner's review. The license holder is not required to keep personnel files in a single
22.19 location.

22.20 **Sec. 9. [245I.08] DOCUMENTATION STANDARDS.**

22.21 Subdivision 1. **Generally.** A license holder must ensure that all documentation required
22.22 by this chapter complies with this section.

22.23 Subd. 2. **Documentation standards.** A license holder must ensure that all documentation
22.24 required by this chapter:

22.25 (1) is legible;

22.26 (2) identifies the applicable client and staff person on each page; and

22.27 (3) is signed and dated by the staff persons who provided services to the client or
22.28 completed the documentation, including the staff persons' credentials.

22.29 Subd. 3. **Documenting approval.** A license holder must ensure that all diagnostic
22.30 assessments, functional assessments, level of care assessments, and treatment plans completed

23.1 by a clinical trainee or mental health practitioner contain documentation of approval by a
23.2 treatment supervisor within five business days of initial completion by the staff person under
23.3 treatment supervision.

23.4 Subd. 4. **Progress notes.** A license holder must use a progress note to document each
23.5 occurrence of a mental health service that a staff person provides to a client. A progress
23.6 note must include the following:

23.7 (1) the type of service;

23.8 (2) the date of service;

23.9 (3) the start and stop time of the service unless the license holder is licensed as a
23.10 residential program;

23.11 (4) the location of the service;

23.12 (5) the scope of the service, including: (i) the targeted goal and objective; (ii) the
23.13 intervention that the staff person provided to the client and the methods that the staff person
23.14 used; (iii) the client's response to the intervention; (iv) the staff person's plan to take future
23.15 actions, including changes in treatment that the staff person will implement if the intervention
23.16 was ineffective; and (v) the service modality;

23.17 (6) the signature, printed name, and credentials of the staff person who provided the
23.18 service to the client;

23.19 (7) the mental health provider travel documentation required by section 256B.0625, if
23.20 applicable; and

23.21 (8) significant observations by the staff person, if applicable, including: (i) the client's
23.22 current risk factors; (ii) emergency interventions by staff persons; (iii) consultations with
23.23 or referrals to other professionals, family, or significant others; and (iv) changes in the
23.24 client's mental or physical symptoms.

23.25 Subd. 5. **Medication administration record.** If a license holder administers or observes
23.26 a client self-administer medications, the license holder must maintain a medication
23.27 administration record for each client that contains the following, as applicable:

23.28 (1) the client's date of birth;

23.29 (2) the client's allergies;

23.30 (3) all medication orders for the client, including client-specific orders for
23.31 over-the-counter medications and approved condition-specific protocols;

24.1 (4) the name of each ordered medication, date of each medication's expiration, each
24.2 medication's dosage frequency, method of administration, and time;

24.3 (5) the licensed prescriber's name and telephone number;

24.4 (6) the date of initiation;

24.5 (7) the signature, printed name, and credentials of the staff person who administered the
24.6 medication or observed the client self-administer the medication; and

24.7 (8) the reason that the license holder did not administer the client's prescribed medication
24.8 or observe the client self-administer the client's prescribed medication.

24.9 Sec. 10. **[245I.09] CLIENT FILES.**

24.10 Subdivision 1. **Generally.** (a) A license holder must maintain a file for each client that
24.11 contains the client's current and accurate records. The license holder must store each client
24.12 file on the premises where the license holder provides or coordinates services for the client.
24.13 The license holder must ensure that all client files are readily accessible for the
24.14 commissioner's review. The license holder is not required to keep client files in a single
24.15 location.

24.16 (b) The license holder must protect client records against loss, tampering, or unauthorized
24.17 disclosure of confidential client data according to the Minnesota Government Data Practices
24.18 Act, chapter 13; the privacy provisions of the Minnesota health care programs provider
24.19 agreement; the Health Insurance Portability and Accountability Act of 1996 (HIPAA),
24.20 Public Law 104-191; and the Minnesota Health Records Act, sections 144.291 to 144.298.

24.21 Subd. 2. **Record retention.** A license holder must retain client records of a discharged
24.22 client for a minimum of five years from the date of the client's discharge. A license holder
24.23 who ceases to provide treatment services to a client must retain the client's records for a
24.24 minimum of five years from the date that the license holder stopped providing services to
24.25 the client and must notify the commissioner of the location of the client records and the
24.26 name of the individual responsible for storing and maintaining the client records.

24.27 Subd. 3. **Contents.** A license holder must retain a clear and complete record of the
24.28 information that the license holder receives regarding a client, and of the services that the
24.29 license holder provides to the client. If applicable, each client's file must include the following
24.30 information:

24.31 (1) the client's screenings, assessments, and testing;

24.32 (2) the client's treatment plans and reviews of the client's treatment plan;

- 25.1 (3) the client's individual abuse prevention plans;
- 25.2 (4) the client's health care directive under section 145C.01, subdivision 5a, and the
25.3 client's emergency contacts;
- 25.4 (5) the client's crisis plans;
- 25.5 (6) the client's consents for releases of information and documentation of the client's
25.6 releases of information;
- 25.7 (7) the client's significant medical and health-related information;
- 25.8 (8) a record of each communication that a staff person has with the client's other mental
25.9 health providers and persons interested in the client, including the client's case manager,
25.10 family members, primary caregiver, legal representatives, court representatives,
25.11 representatives from the correctional system, or school administration;
- 25.12 (9) written information by the client that the client requests to include in the client's file;
25.13 and
- 25.14 (10) the date of the client's discharge from the license holder's program, the reason that
25.15 the license holder discontinued services for the client, and the client's discharge summaries.

25.16 Sec. 11. **[245I.10] ASSESSMENT AND TREATMENT PLANNING.**

25.17 Subdivision 1. **Definitions.** (a) "Diagnostic formulation" means a written analysis and
25.18 explanation of a client's clinical assessment to develop a hypothesis about the cause and
25.19 nature of a client's presenting problems and to identify the most suitable approach for treating
25.20 the client.

25.21 (b) "Responsivity factors" means the factors other than the diagnostic formulation that
25.22 may modify a client's treatment needs. This includes a client's learning style, abilities,
25.23 cognitive functioning, cultural background, and personal circumstances. When documenting
25.24 a client's responsivity factors a mental health professional or clinical trainee must include
25.25 an analysis of how a client's strengths are reflected in the license holder's plan to deliver
25.26 services to the client.

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

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

- 26.1 (1) an explanation of findings;
- 26.2 (2) neuropsychological testing, neuropsychological assessment, and psychological
- 26.3 testing;
- 26.4 (3) any combination of psychotherapy sessions, family psychotherapy sessions, and
- 26.5 family psychoeducation sessions not to exceed three sessions;
- 26.6 (4) crisis assessment services according to section 256B.0624; and
- 26.7 (5) ten days of intensive residential treatment services according to the assessment and
- 26.8 treatment planning standards in section 245.23, subdivision 7.
- 26.9 (c) Based on the client's needs that a crisis assessment identifies under section 256B.0624,
- 26.10 a license holder may provide a client with the following services:
- 26.11 (1) crisis intervention and stabilization services under section 245I.23 or 256B.0624;
- 26.12 and
- 26.13 (2) any combination of psychotherapy sessions, group psychotherapy sessions, family
- 26.14 psychotherapy sessions, and family psychoeducation sessions not to exceed ten sessions
- 26.15 within a 12-month period without prior authorization.
- 26.16 (d) Based on the client's needs in the client's brief diagnostic assessment, a license holder
- 26.17 may provide a client with any combination of psychotherapy sessions, group psychotherapy
- 26.18 sessions, family psychotherapy sessions, and family psychoeducation sessions not to exceed
- 26.19 ten sessions within a 12-month period without prior authorization for any new client or for
- 26.20 an existing client who the license holder projects will need fewer than ten sessions during
- 26.21 the next 12 months.
- 26.22 (e) Based on the client's needs that a hospital's medical history and presentation
- 26.23 examination identifies, a license holder may provide a client with:
- 26.24 (1) any combination of psychotherapy sessions, group psychotherapy sessions, family
- 26.25 psychotherapy sessions, and family psychoeducation sessions not to exceed ten sessions
- 26.26 within a 12-month period without prior authorization for any new client or for an existing
- 26.27 client who the license holder projects will need fewer than ten sessions during the next 12
- 26.28 months; and
- 26.29 (2) up to five days of day treatment services or partial hospitalization.
- 26.30 (f) A license holder must complete a new standard diagnostic assessment of a client:
- 26.31 (1) when the client requires services of a greater number or intensity than the services
- 26.32 that paragraphs (b) to (e) describe;

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

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

27.6 (4) when the client's current mental health condition does not meet the criteria of the
27.7 client's current diagnosis.

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

27.14 Subd. 3. **Continuity of services.** (a) For any client with a diagnostic assessment
27.15 completed under Minnesota Rules, parts 9505.0370 to 9505.0372, before the effective date
27.16 of this section, the diagnostic assessment is valid for authorizing the client's treatment and
27.17 billing for one calendar year after the date that the assessment was completed.

27.18 (b) For any client with an individual treatment plan completed under section 256B.0622,
27.19 256B.0623, 256B.0943, 256B.0946, or 256B.0947 or Minnesota Rules, parts 9505.0370 to
27.20 9505.0372, the client's treatment plan is valid for authorizing treatment and billing until the
27.21 treatment plan's expiration date.

27.22 (c) This subdivision expires July 1, 2023.

27.23 Subd. 4. **Diagnostic assessment.** A client's diagnostic assessment must: (1) identify at
27.24 least one mental health diagnosis for which the client meets the diagnostic criteria and
27.25 recommend mental health services to develop the client's mental health services and treatment
27.26 plan; or (2) include a finding that the client does not meet the criteria for a mental health
27.27 disorder.

27.28 Subd. 5. **Brief diagnostic assessment; required elements.** (a) Only a mental health
27.29 professional or clinical trainee may complete a brief diagnostic assessment of a client. A
27.30 license holder may only use a brief diagnostic assessment for a client who is six years of
27.31 age or older.

27.32 (b) When conducting a brief diagnostic assessment of a client, the assessor must complete
27.33 a face-to-face interview with the client and a written evaluation of the client. The assessor

- 28.1 must gather and document initial components of the client's standard diagnostic assessment,
28.2 including the client's:
- 28.3 (1) age;
28.4 (2) description of symptoms, including the reason for the client's referral;
28.5 (3) history of mental health treatment;
28.6 (4) cultural influences on the client; and
28.7 (5) mental status examination.
- 28.8 (c) Based on the initial components of the assessment, the assessor must develop a
28.9 provisional diagnostic formulation about the client. The assessor may use the client's
28.10 provisional diagnostic formulation to address the client's immediate needs and presenting
28.11 problems.
- 28.12 (d) A mental health professional or clinical trainee may use treatment sessions with the
28.13 client authorized by a brief diagnostic assessment to gather additional information about
28.14 the client to complete the client's standard diagnostic assessment if the number of sessions
28.15 will exceed the coverage limits in subdivision 2.
- 28.16 **Subd. 6. Standard diagnostic assessment; required elements.** (a) Only a mental health
28.17 professional or a clinical trainee may complete a standard diagnostic assessment of a client.
28.18 A standard diagnostic assessment of a client must include a face-to-face interview with a
28.19 client and a written evaluation of the client. The assessor must complete a client's standard
28.20 diagnostic assessment within the client's cultural context.
- 28.21 (b) When completing a standard diagnostic assessment of a client, the assessor must
28.22 gather and document information about the client's current life situation, including the
28.23 following information:
- 28.24 (1) the client's age;
28.25 (2) the client's current living situation, including the client's housing status and household
28.26 members;
28.27 (3) the status of the client's basic needs;
28.28 (4) the client's education level and employment status;
28.29 (5) the client's current medications;
28.30 (6) any immediate risks to the client's health and safety;
28.31 (7) the client's perceptions of the client's condition;

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

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

29.4 (10) cultural influences on the client.

29.5 (c) If the assessor cannot obtain the information that this subdivision requires without
29.6 retraumatizing the client or harming the client's willingness to engage in treatment, the
29.7 assessor must identify which topics will require further assessment during the course of the
29.8 client's treatment. The assessor must gather and document information related to the following
29.9 topics:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

30.24 Subd. 7. **Individual treatment plan.** A license holder must follow each client's written
30.25 individual treatment plan when providing services to the client with the following exceptions:

30.26 (1) services that do not require that a license holder completes a standard diagnostic
30.27 assessment of a client before providing services to the client;

30.28 (2) when developing a service plan; and

30.29 (3) when a client re-engages in services under subdivision 8, paragraph (b).

30.30 Subd. 8. **Individual treatment plan; required elements.** (a) After completing a client's
30.31 diagnostic assessment and before providing services to the client, the license holder must
30.32 complete the client's individual treatment plan. The license holder must:

31.1 (1) base the client's individual treatment plan on the client's diagnostic assessment and
31.2 baseline measurements;

31.3 (2) for a child client, use a child-centered, family-driven, and culturally appropriate
31.4 planning process that allows the child's parents and guardians to observe and participate in
31.5 the child's individual and family treatment services, assessments, and treatment planning;

31.6 (3) for an adult client, use a person-centered, culturally appropriate planning process
31.7 that allows the client's family and other natural supports to observe and participate in the
31.8 client's treatment services, assessments, and treatment planning;

31.9 (4) identify the client's treatment goals, measureable treatment objectives, a schedule
31.10 for accomplishing the client's treatment goals and objectives, a treatment strategy, and the
31.11 individuals responsible for providing treatment services and supports to the client. The
31.12 license holder must have a treatment strategy to engage the client in treatment if the client:

31.13 (i) has a history of not engaging in treatment; and

31.14 (ii) is ordered by a court to participate in treatment services or to take neuroleptic
31.15 medications;

31.16 (5) identify the participants involved in the client's treatment planning. The client must
31.17 be a participant in the client's treatment planning. If applicable, the license holder must
31.18 document the reasons that the license holder did not involve the client's family or other
31.19 natural supports in the client's treatment planning;

31.20 (6) review the client's individual treatment plan every 180 days and update the client's
31.21 individual treatment plan with the client's treatment progress, new treatment objectives and
31.22 goals or, if the client has not made treatment progress, changes in the license holder's
31.23 approach to treatment; and

31.24 (7) ensure that the client approves of the client's individual treatment plan unless a court
31.25 orders the client's treatment plan under chapter 253B.

31.26 (b) If the client disagrees with the client's treatment plan, the license holder must
31.27 document in the client file the reasons why the client does not agree with the treatment plan.
31.28 If the license holder cannot obtain the client's approval of the treatment plan, a mental health
31.29 professional must make efforts to obtain approval from a person who is authorized to consent
31.30 on the client's behalf within 30 days after the client's previous individual treatment plan
31.31 expired. A license holder may not deny a client service during this time period solely because
31.32 the license holder could not obtain the client's approval of the client's individual treatment

32.1 plan. A license holder may continue to bill for the client's otherwise eligible services when
32.2 the client re-engages in services.

32.3 Subd. 9. **Functional assessment; required elements.** When a license holder is
32.4 completing a functional assessment for an adult client, the license holder must:

32.5 (1) complete a functional assessment of the client after completing the client's diagnostic
32.6 assessment;

32.7 (2) use a collaborative process that allows the client and the client's family and other
32.8 natural supports, the client's referral sources, and the client's providers to provide information
32.9 about how the client's symptoms of mental illness impact the client's functioning;

32.10 (3) if applicable, document the reasons that the license holder did not contact the client's
32.11 family and other natural supports;

32.12 (4) assess and document how the client's symptoms of mental illness impact the client's
32.13 functioning in the following areas:

32.14 (i) the client's mental health symptoms;

32.15 (ii) the client's mental health service needs;

32.16 (iii) the client's substance use;

32.17 (iv) the client's vocational and educational functioning;

32.18 (v) the client's social functioning, including the use of leisure time;

32.19 (vi) the client's interpersonal functioning, including relationships with the client's family
32.20 and other natural supports;

32.21 (vii) the client's ability to provide self-care and live independently;

32.22 (viii) the client's medical and dental health;

32.23 (ix) the client's financial assistance needs; and

32.24 (x) the client's housing and transportation needs;

32.25 (5) include a narrative summarizing the client's strengths, resources, and all areas of
32.26 functional impairment;

32.27 (6) complete the client's functional assessment before the client's initial individual
32.28 treatment plan unless a service specifies otherwise; and

33.1 (7) update the client's functional assessment with the client's current functioning whenever
33.2 there is a significant change in the client's functioning or at least every 180 days, unless a
33.3 service specifies otherwise.

33.4 Sec. 12. [245I.11] HEALTH SERVICES AND MEDICATIONS.

33.5 Subdivision 1. Generally. If a license holder is licensed as a residential program, stores
33.6 or administers client medications, or observes clients self-administer medications, the license
33.7 holder must ensure that a staff person who is a registered nurse or licensed prescriber is
33.8 responsible for overseeing storage and administration of client medications and observing
33.9 as a client self-administers medications, including training according to section 245I.05,
33.10 subdivision 6, and documenting the occurrence according to section 245I.08, subdivision
33.11 5.

33.12 Subd. 2. Health services. If a license holder is licensed as a residential program, the
33.13 license holder must:

33.14 (1) ensure that a client is screened for health issues within 72 hours of the client's
33.15 admission;

33.16 (2) monitor the physical health needs of each client on an ongoing basis;

33.17 (3) offer referrals to clients and coordinate each client's care with psychiatric and medical
33.18 services;

33.19 (4) identify circumstances in which a staff person must notify a registered nurse or
33.20 licensed prescriber of any of a client's health concerns and the process for providing
33.21 notification of client health concerns; and

33.22 (5) identify the circumstances in which the license holder must obtain medical care for
33.23 a client and the process for obtaining medical care for a client.

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

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

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

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

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

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

34.4 (6) follow a documentation procedure on each shift to account for all scheduled drugs;

34.5 and

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

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

34.15 Subd. 4. **Medication orders.** (a) If a license holder stores, prescribes, or administers
34.16 medications or observes a client self-administer medications, the license holder must:

34.17 (1) ensure that a licensed prescriber writes all orders to accept, administer, or discontinue
34.18 client medications;

34.19 (2) accept nonwritten orders to administer client medications in emergency circumstances
34.20 only;

34.21 (3) establish a timeline and process for obtaining a written order with the licensed
34.22 prescriber's signature when the license holder accepts a nonwritten order to administer client
34.23 medications;

34.24 (4) obtain prescription medication renewals from a licensed prescriber for each client
34.25 every 90 days for psychotropic medications and annually for all other medications; and

34.26 (5) maintain the client's right to privacy and dignity.

34.27 (b) If a license holder employs a licensed prescriber, the license holder must inform the
34.28 client about potential medication effects and side effects and obtain and document the client's
34.29 informed consent before the licensed prescriber prescribes a medication.

34.30 Subd. 5. **Medication administration.** If a license holder is licensed as a residential
34.31 program, the license holder must:

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

35.6 (2) monitor the effectiveness of medications, side effects of medications, and adverse
35.7 reactions to medications for each client. The license holder must address and document any
35.8 concerns about a client's medications;

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

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

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

35.18 **Sec. 13. [245L.12] CLIENT RIGHTS AND PROTECTIONS.**

35.19 Subdivision 1. **Client rights.** A license holder must ensure that all clients have the
35.20 following rights:

35.21 (1) the rights listed in the health care bill of rights in section 144.651;

35.22 (2) the right to be free from discrimination based on age, race, color, creed, religion,
35.23 national origin, gender, marital status, disability, sexual orientation, and status with regard
35.24 to public assistance. The license holder must follow all applicable state and federal laws
35.25 including the Minnesota Human Rights Act, chapter 363A; and

35.26 (3) the right to be informed prior to a photograph or audio or video recording being made
35.27 of the client. The client has the right to refuse to allow any recording or photograph of the
35.28 client that is not for the purposes of identification or supervision by the license holder.

35.29 Subd. 2. **Restrictions to client rights.** If the license holder restricts a client's right, the
35.30 license holder must document in the client file a mental health professional's approval of
35.31 the restriction and the reasons for the restriction.

36.1 Subd. 3. **Notice of rights.** The license holder must give a copy of the client's rights
36.2 according to this section to each client on the day of the client's admission. The license
36.3 holder must document that the license holder gave a copy of the client's rights to each client
36.4 on the day of the client's admission according to this section. The license holder must post
36.5 a copy of the client rights in an area visible or accessible to all clients. The license holder
36.6 must include the client rights in Minnesota Rules, chapter 9544, for applicable clients.

36.7 Subd. 4. **Client property.** (a) The license holder must meet the requirements of section
36.8 245A.04, subdivision 13.

36.9 (b) If the license holder is unable to obtain a client's signature acknowledging the receipt
36.10 or disbursement of the client's funds or property required by section 245A.04, subdivision
36.11 13, paragraph (c), clause (1), two staff persons must sign documentation acknowledging
36.12 that the staff persons witnessed the client's receipt or disbursement of the client's funds or
36.13 property.

36.14 (c) The license holder must return all of the client's funds and other property to the client
36.15 except for the following items:

36.16 (1) illicit drugs, drug paraphernalia, and drug containers that are subject to forfeiture
36.17 under section 609.5316. The license holder must give illicit drugs, drug paraphernalia, and
36.18 drug containers to a local law enforcement agency or destroy the items; and

36.19 (2) weapons, explosives, and other property that may cause serious harm to the client
36.20 or others. The license holder may give a client's weapons and explosives to a local law
36.21 enforcement agency. The license holder must notify the client that a local law enforcement
36.22 agency has the client's property and that the client has the right to reclaim the property if
36.23 the client has a legal right to possess the item.

36.24 (d) If a client leaves the license holder's program but abandons the client's funds or
36.25 property, the license holder must retain and store the client's funds or property, including
36.26 medications, for a minimum of 30 days after the client's discharge from the program.

36.27 Subd. 5. **Client grievances.** (a) The license holder must have a grievance procedure
36.28 that:

36.29 (1) describes to clients how the license holder will meet the requirements in this
36.30 subdivision; and

36.31 (2) contains the current telephone numbers, e-mail addresses, and mailing addresses of
36.32 the Department of Human Services, Licensing Division; the Office of Ombudsman for

37.1 Mental Health and Developmental Disabilities; the Department of Health, Office of Health
37.2 Facilities Complaints; and all applicable health-related licensing boards.

37.3 (b) On the day of each client's admission, the license holder must explain the grievance
37.4 procedure to the client.

37.5 (c) The license holder must:

37.6 (1) post the grievance procedure in a place visible to clients and provide a copy of the
37.7 grievance procedure upon request;

37.8 (2) allow clients, former clients, and their authorized representatives to submit a grievance
37.9 to the license holder;

37.10 (3) within three business days of receiving a client's grievance, acknowledge in writing
37.11 that the license holder received the client's grievance. If applicable, the license holder must
37.12 include a notice of the client's separate appeal rights for a managed care organization's
37.13 reduction, termination, or denial of a covered service;

37.14 (4) within 15 business days of receiving a client's grievance, provide a written final
37.15 response to the client's grievance containing the license holder's official response to the
37.16 grievance; and

37.17 (5) allow the client to bring a grievance to the person with the highest level of authority
37.18 in the program.

37.19 **Sec. 14. [245I.13] CRITICAL INCIDENTS.**

37.20 If a license holder is licensed as a residential program, the license holder must report all
37.21 critical incidents to the commissioner within ten days of learning of the incident on a form
37.22 approved by the commissioner. The license holder must keep a record of critical incidents
37.23 in a central location that is readily accessible to the commissioner for review upon the
37.24 commissioner's request for a minimum of two licensing periods.

37.25 **Sec. 15. [245I.20] MENTAL HEALTH CLINIC.**

37.26 Subdivision 1. **Purpose.** Certified mental health clinics provide clinical services for the
37.27 treatment of mental illnesses with a treatment team that reflects multiple disciplines and
37.28 areas of expertise.

37.29 Subd. 2. **Definitions.** (a) "Clinical services" means services provided to a client to
37.30 diagnose, describe, predict, and explain the client's status relative to a condition or problem
37.31 as described in the: (1) current edition of the Diagnostic and Statistical Manual of Mental

38.1 Disorders published by the American Psychiatric Association; or (2) current edition of the
38.2 DC: 0-5 Diagnostic Classification of Mental Health and Development Disorders of Infancy
38.3 and Early Childhood published by Zero to Three. Where necessary, clinical services includes
38.4 services to treat a client to reduce the client's impairment due to the client's condition.
38.5 Clinical services also includes individual treatment planning, case review, record-keeping
38.6 required for a client's treatment, and treatment supervision. For the purposes of this section,
38.7 clinical services excludes services delivered to a client under a separate license and services
38.8 listed under section 245I.011, subdivision 5.

38.9 (b) "Competent" means having professional education, training, continuing education,
38.10 consultation, supervision, experience, or a combination thereof necessary to demonstrate
38.11 sufficient knowledge of and proficiency in a specific clinical service.

38.12 (c) "Discipline" means a branch of professional knowledge or skill acquired through a
38.13 specific course of study, training, and supervised practice. Discipline is usually documented
38.14 by a specific educational degree, licensure, or certification of proficiency. Examples of the
38.15 mental health disciplines include but are not limited to psychiatry, psychology, clinical
38.16 social work, marriage and family therapy, clinical counseling, and psychiatric nursing.

38.17 (d) "Treatment team" means the mental health professionals, mental health practitioners,
38.18 and clinical trainees who provide clinical services to clients.

38.19 **Subd. 3. Organizational structure.** (a) A mental health clinic location must be an entire
38.20 facility or a clearly identified unit within a facility that is administratively and clinically
38.21 separate from the rest of the facility. The mental health clinic location may provide services
38.22 other than clinical services to clients, including medical services, substance use disorder
38.23 services, social services, training, and education.

38.24 (b) The certification holder must notify the commissioner of all mental health clinic
38.25 locations. If there is more than one mental health clinic location, the certification holder
38.26 must designate one location as the main location and all of the other locations as satellite
38.27 locations. The main location as a unit and the clinic as a whole must comply with the
38.28 minimum staffing standards in subdivision 4.

38.29 (c) The certification holder must ensure that each satellite location:

38.30 (1) adheres to the same policies and procedures as the main location;

38.31 (2) provides treatment team members with face-to-face or telephone access to a mental
38.32 health professional for the purposes of supervision whenever the satellite location is open.
38.33 The certification holder must maintain a schedule of the mental health professionals who

39.1 will be available and the contact information for each available mental health professional.
39.2 The schedule must be current and readily available to treatment team members; and
39.3 (3) enables clients to access all of the mental health clinic's clinical services and treatment
39.4 team members, as needed.

39.5 Subd. 4. **Minimum staffing standards.** (a) A certification holder's treatment team must
39.6 consist of at least four mental health professionals. At least two of the mental health
39.7 professionals must be employed by or under contract with the mental health clinic for a
39.8 minimum of 35 hours per week each. Each of the two mental health professionals must
39.9 specialize in a different mental health discipline.

39.10 (b) The treatment team must include:

39.11 (1) a physician qualified as a mental health professional according to section 245I.04,
39.12 subdivision 2, clause (4), or a nurse qualified as a mental health professional according to
39.13 section 245I.04, subdivision 2, clause (1); and

39.14 (2) a psychologist qualified as a mental health professional according to section 245I.04,
39.15 subdivision 2, clause (3).

39.16 (c) The staff persons fulfilling the requirement in paragraph (b) must provide clinical
39.17 services at least:

39.18 (1) eight hours every two weeks if the mental health clinic has over 25.0 full-time
39.19 equivalent treatment team members;

39.20 (2) eight hours each month if the mental health clinic has 15.1 to 25.0 full-time equivalent
39.21 treatment team members;

39.22 (3) four hours each month if the mental health clinic has 5.1 to 15.0 full-time equivalent
39.23 treatment team members; or

39.24 (4) two hours each month if the mental health clinic has 2.0 to 5.0 full-time equivalent
39.25 treatment team members or only provides in-home services to clients.

39.26 (d) The certification holder must maintain a record that demonstrates compliance with
39.27 this subdivision.

39.28 Subd. 5. **Treatment supervision specified.** (a) A mental health professional must remain
39.29 responsible for each client's case. The certification holder must document the name of the
39.30 mental health professional responsible for each case and the dates that the mental health
39.31 professional is responsible for the client's case from beginning date to end date. The
39.32 certification holder must assign each client's case for assessment, diagnosis, and treatment

40.1 services to a treatment team member who is competent in the assigned clinical service, the
40.2 recommended treatment strategy, and in treating the client's characteristics.

40.3 (b) Treatment supervision of mental health practitioners and clinical trainees required
40.4 by section 245I.06 must include case reviews as described in this paragraph. Every two
40.5 months, a mental health professional must complete a case review of each client assigned
40.6 to the mental health professional when the client is receiving clinical services from a mental
40.7 health practitioner or clinical trainee. The case review must include a consultation process
40.8 that thoroughly examines the client's condition and treatment, including: (1) a review of the
40.9 client's reason for seeking treatment, diagnoses and assessments, and the individual treatment
40.10 plan; (2) a review of the appropriateness, duration, and outcome of treatment provided to
40.11 the client; and (3) treatment recommendations.

40.12 Subd. 6. **Additional policy and procedure requirements.** (a) In addition to the policies
40.13 and procedures required by section 245I.03, the certification holder must establish, enforce,
40.14 and maintain the policies and procedures required by this subdivision.

40.15 (b) The certification holder must have a clinical evaluation procedure to identify and
40.16 document each treatment team member's areas of competence.

40.17 (c) The certification holder must have policies and procedures for client intake and case
40.18 assignment that:

40.19 (1) outline the client intake process;

40.20 (2) describe how the mental health clinic determines the appropriateness of accepting a
40.21 client into treatment by reviewing the client's condition and need for treatment, the clinical
40.22 services that the mental health clinic offers to clients, and other available resources; and

40.23 (3) contain a process for assigning a client's case to a mental health professional who is
40.24 responsible for the client's case and other treatment team members.

40.25 Subd. 7. **Referrals.** If necessary treatment for a client or treatment desired by a client
40.26 is not available at the mental health clinic, the certification holder must facilitate appropriate
40.27 referrals for the client. When making a referral for a client, the treatment team member must
40.28 document a discussion with the client that includes: (1) the reason for the client's referral;
40.29 (2) potential treatment resources for the client; and (3) the client's response to receiving a
40.30 referral.

40.31 Subd. 8. **Emergency service.** For the certification holder's telephone numbers that clients
40.32 regularly access, the certification holder must include the contact information for the area's

41.1 mental health crisis services as part of the certification holder's message when a live operator
41.2 is not available to answer clients' calls.

41.3 Subd. 9. **Quality assurance and improvement plan.** (a) At a minimum, a certification
41.4 holder must develop a written quality assurance and improvement plan that includes a plan
41.5 for:

41.6 (1) encouraging ongoing consultation among members of the treatment team;

41.7 (2) obtaining and evaluating feedback about services from clients, family and other
41.8 natural supports, referral sources, and staff persons;

41.9 (3) measuring and evaluating client outcomes;

41.10 (4) reviewing client suicide deaths and suicide attempts;

41.11 (5) examining the quality of clinical service delivery to clients; and

41.12 (6) self-monitoring of compliance with this chapter.

41.13 (b) At least annually, the certification holder must review, evaluate, and update the
41.14 quality assurance and improvement plan. The review must: (1) include documentation of
41.15 the actions that the certification holder will take as a result of information obtained from
41.16 monitoring activities in the plan; and (2) establish goals for improved service delivery to
41.17 clients for the next year.

41.18 Subd. 10. **Application procedures.** (a) The applicant for certification must submit any
41.19 documents that the commissioner requires on forms approved by the commissioner.

41.20 (b) Upon submitting an application for certification, an applicant must pay the application
41.21 fee required by section 245A.10, subdivision 3.

41.22 (c) The commissioner must act on an application within 90 working days of receiving
41.23 a completed application.

41.24 (d) When the commissioner receives an application for initial certification that is
41.25 incomplete because the applicant failed to submit required documents or is deficient because
41.26 the submitted documents do not meet certification requirements, the commissioner must
41.27 provide the applicant with written notice that the application is incomplete or deficient. In
41.28 the notice, the commissioner must identify the particular documents that are missing or
41.29 deficient and give the applicant 45 days to submit a second application that is complete. An
41.30 applicant's failure to submit a complete application within 45 days after receiving notice
41.31 from the commissioner is a basis for certification denial.

42.1 (e) The commissioner must give notice of a denial to an applicant when the commissioner
42.2 has made the decision to deny the certification application. In the notice of denial, the
42.3 commissioner must state the reasons for the denial in plain language. The commissioner
42.4 must send or deliver the notice of denial to an applicant by certified mail or personal service.
42.5 In the notice of denial, the commissioner must state the reasons that the commissioner denied
42.6 the application and must inform the applicant of the applicant's right to request a contested
42.7 case hearing under chapter 14 and Minnesota Rules, parts 1400.8505 to 1400.8612. The
42.8 applicant may appeal the denial by notifying the commissioner in writing by certified mail
42.9 or personal service. If mailed, the appeal must be postmarked and sent to the commissioner
42.10 within 20 calendar days after the applicant received the notice of denial. If an applicant
42.11 delivers an appeal by personal service, the commissioner must receive the appeal within 20
42.12 calendar days after the applicant received the notice of denial.

42.13 Subd. 11. **Commissioner's right of access.** (a) When the commissioner is exercising
42.14 the powers conferred to the commissioner by this chapter, if the mental health clinic is in
42.15 operation and the information is relevant to the commissioner's inspection or investigation,
42.16 the certification holder must provide the commissioner access to:

42.17 (1) the physical facility and grounds where the program is located;

42.18 (2) documentation and records, including electronically maintained records;

42.19 (3) clients served by the mental health clinic;

42.20 (4) staff persons of the mental health clinic; and

42.21 (5) personnel records of current and former staff of the mental health clinic.

42.22 (b) The certification holder must provide the commissioner with access to the facility
42.23 and grounds, documentation and records, clients, and staff without prior notice and as often
42.24 as the commissioner considers necessary if the commissioner is investigating alleged
42.25 maltreatment or a violation of a law or rule, or conducting an inspection. When conducting
42.26 an inspection, the commissioner may request and must receive assistance from other state,
42.27 county, and municipal governmental agencies and departments. The applicant or certification
42.28 holder must allow the commissioner, at the commissioner's expense, to photocopy,
42.29 photograph, and make audio and video recordings during an inspection.

42.30 Subd. 12. **Monitoring and inspections.** (a) The commissioner may conduct a certification
42.31 review of the certified mental health clinic every two years to determine the certification
42.32 holder's compliance with applicable rules and statutes.

43.1 (b) The commissioner must offer the certification holder a choice of dates for an
43.2 announced certification review. A certification review must occur during the clinic's normal
43.3 working hours.

43.4 (c) The commissioner must make the results of certification reviews and investigations
43.5 publicly available on the department's website.

43.6 Subd. 13. **Correction orders.** (a) If the applicant or certification holder fails to comply
43.7 with a law or rule, the commissioner may issue a correction order. The correction order
43.8 must state:

43.9 (1) the condition that constitutes a violation of the law or rule;

43.10 (2) the specific law or rule that the applicant or certification holder has violated; and

43.11 (3) the time that the applicant or certification holder is allowed to correct each violation.

43.12 (b) If the applicant or certification holder believes that the commissioner's correction
43.13 order is erroneous, the applicant or certification holder may ask the commissioner to
43.14 reconsider the part of the correction order that is allegedly erroneous. An applicant or
43.15 certification holder must make a request for reconsideration in writing. The request must
43.16 be postmarked and sent to the commissioner within 20 calendar days after the applicant or
43.17 certification holder received the correction order; and the request must:

43.18 (1) specify the part of the correction order that is allegedly erroneous;

43.19 (2) explain why the specified part is erroneous; and

43.20 (3) include documentation to support the allegation of error.

43.21 (c) A request for reconsideration does not stay any provision or requirement of the
43.22 correction order. The commissioner's disposition of a request for reconsideration is final
43.23 and not subject to appeal.

43.24 (d) If the commissioner finds that the applicant or certification holder failed to correct
43.25 the violation specified in the correction order, the commissioner may decertify the certified
43.26 mental health clinic according to subdivision 14.

43.27 (e) Nothing in this subdivision prohibits the commissioner from decertifying a mental
43.28 health clinic according to subdivision 14.

43.29 Subd. 14. **Decertification.** (a) The commissioner may decertify a mental health clinic
43.30 if a certification holder:

43.31 (1) failed to comply with an applicable law or rule; or

44.1 (2) knowingly withheld relevant information from or gave false or misleading information
44.2 to the commissioner in connection with an application for certification, during an
44.3 investigation, or regarding compliance with applicable laws or rules.

44.4 (b) When considering decertification of a mental health clinic, the commissioner must
44.5 consider the nature, chronicity, or severity of the violation of law or rule and the effect of
44.6 the violation on the health, safety, or rights of clients.

44.7 (c) If the commissioner decertifies a mental health clinic, the order of decertification
44.8 must inform the certification holder of the right to have a contested case hearing under
44.9 chapter 14 and Minnesota Rules, parts 1400.8505 to 1400.8612. The certification holder
44.10 may appeal the decertification. The certification holder must appeal a decertification in
44.11 writing and send or deliver the appeal to the commissioner by certified mail or personal
44.12 service. If the certification holder mails the appeal, the appeal must be postmarked and sent
44.13 to the commissioner within ten calendar days after the certification holder receives the order
44.14 of decertification. If the certification holder delivers an appeal by personal service, the
44.15 commissioner must receive the appeal within ten calendar days after the certification holder
44.16 received the order. If a certification holder submits a timely appeal of an order of
44.17 decertification, the certification holder may continue to operate the program until the
44.18 commissioner issues a final order on the decertification.

44.19 (d) If the commissioner decertifies a mental health clinic pursuant to paragraph (a),
44.20 clause (1), based on a determination that the mental health clinic was responsible for
44.21 maltreatment, and if the certification holder appeals the decertification according to paragraph
44.22 (c), and appeals the maltreatment determination under section 260E.33, the final
44.23 decertification determination is stayed until the commissioner issues a final decision regarding
44.24 the maltreatment appeal.

44.25 Subd. 15. **Transfer prohibited.** A certification issued under this chapter is only valid
44.26 for the premises and the individual, organization, or government entity identified by the
44.27 commissioner on the certification. A certification is not transferable or assignable.

44.28 Subd. 16. **Notifications required and noncompliance.** (a) A certification holder must
44.29 notify the commissioner, in a manner prescribed by the commissioner, and obtain the
44.30 commissioner's approval before making any change to the name of the certification holder
44.31 or the location of the mental health clinic.

44.32 (b) Changes in mental health clinic organization, staffing, treatment, or quality assurance
44.33 procedures that affect the ability of the certification holder to comply with the minimum
44.34 standards of section 245I.20 must be reported in writing by the certification holder to the

45.1 commissioner within 15 days of the occurrence. Review of the change must be conducted
45.2 by the commissioner. A certification holder with changes resulting in noncompliance in
45.3 minimum standards must receive written notice and may have up to 180 days to correct the
45.4 areas of noncompliance before being decertified. Interim procedures to resolve the
45.5 noncompliance on a temporary basis must be developed and submitted in writing to the
45.6 commissioner for approval within 30 days of the commissioner's determination of the
45.7 noncompliance. Not reporting an occurrence of a change that results in noncompliance
45.8 within 15 days, failure to develop an approved interim procedure within 30 days of the
45.9 determination of the noncompliance, or nonresolution of the noncompliance within 180
45.10 days will result in immediate decertification.

45.11 (c) The mental health clinic may be required to submit written information to the
45.12 department to document that the mental health clinic has maintained compliance with the
45.13 rule and mental health clinic procedures.

45.14 **Sec. 16. [245I.23] INTENSIVE RESIDENTIAL TREATMENT SERVICES AND**
45.15 **RESIDENTIAL CRISIS STABILIZATION.**

45.16 Subdivision 1. **Purpose.** (a) Intensive residential treatment services is a community-based
45.17 medically monitored level of care for an adult client that uses established rehabilitative
45.18 principles to promote a client's recovery and to develop and achieve psychiatric stability,
45.19 personal and emotional adjustment, self-sufficiency, and other skills that help a client
45.20 transition to a more independent setting.

45.21 (b) Residential crisis stabilization provides structure and support to an adult client in a
45.22 community living environment when a client has experienced a mental health crisis and
45.23 needs short-term services to ensure that the client can safely return to the client's home or
45.24 precrisis living environment with additional services and supports identified in the client's
45.25 crisis assessment.

45.26 Subd. 2. **Definitions.** (a) "Program location" means a set of rooms that are each physically
45.27 self-contained and have defining walls extending from floor to ceiling. Program location
45.28 includes bedrooms, living rooms or lounge areas, bathrooms, and connecting areas.

45.29 (b) "Treatment team" means a group of staff persons who provide intensive residential
45.30 treatment services or residential crisis stabilization to clients. The treatment team includes
45.31 mental health professionals, mental health practitioners, clinical trainees, certified
45.32 rehabilitation specialists, mental health rehabilitation workers, and mental health certified
45.33 peer specialists.

46.1 Subd. 3. **Treatment services description.** The license holder must describe in writing
46.2 all treatment services that the license holder provides. The license holder must have the
46.3 description readily available for the commissioner upon the commissioner's request.

46.4 Subd. 4. **Required intensive residential treatment services.** (a) On a daily basis, the
46.5 license holder must follow a client's treatment plan to provide intensive residential treatment
46.6 services to the client to improve the client's functioning.

46.7 (b) The license holder must offer and have the capacity to directly provide the following
46.8 treatment services to each client:

46.9 (1) rehabilitative mental health services;

46.10 (2) crisis prevention planning to assist a client with:

46.11 (i) identifying and addressing patterns in the client's history and experience of the client's
46.12 mental illness; and

46.13 (ii) developing crisis prevention strategies that include de-escalation strategies that have
46.14 been effective for the client in the past;

46.15 (3) health services and administering medication;

46.16 (4) co-occurring substance use disorder treatment;

46.17 (5) engaging the client's family and other natural supports in the client's treatment and
46.18 educating the client's family and other natural supports to strengthen the client's social and
46.19 family relationships; and

46.20 (6) making referrals for the client to other service providers in the community and
46.21 supporting the client's transition from intensive residential treatment services to another
46.22 setting.

46.23 (c) The license holder must include Illness Management and Recovery (IMR), Enhanced
46.24 Illness Management and Recovery (E-IMR), or other similar interventions in the license
46.25 holder's programming as approved by the commissioner.

46.26 Subd. 5. **Required residential crisis stabilization services.** (a) On a daily basis, the
46.27 license holder must follow a client's individual crisis treatment plan to provide services to
46.28 the client in residential crisis stabilization to improve the client's functioning.

46.29 (b) The license holder must offer and have the capacity to directly provide the following
46.30 treatment services to the client:

46.31 (1) crisis stabilization services as described in section 256B.0624, subdivision 7;

47.1 (2) rehabilitative mental health services;

47.2 (3) health services and administering the client's medications; and

47.3 (4) making referrals for the client to other service providers in the community and

47.4 supporting the client's transition from residential crisis stabilization to another setting.

47.5 Subd. 6. **Optional treatment services.** (a) If the license holder offers additional treatment
47.6 services to a client, the treatment service must be:

47.7 (1) approved by the commissioner; and

47.8 (2)(i) a mental health evidence-based practice that the federal Department of Health and
47.9 Human Services Substance Abuse and Mental Health Service Administration has adopted;

47.10 (ii) a nationally recognized mental health service that substantial research has validated
47.11 as effective in helping individuals with serious mental illness achieve treatment goals; or

47.12 (iii) developed under state-sponsored research of publicly funded mental health programs
47.13 and validated to be effective for individuals, families, and communities.

47.14 (b) Before providing an optional treatment service to a client, the license holder must
47.15 provide adequate training to a staff person about providing the optional treatment service
47.16 to a client.

47.17 Subd. 7. **Intensive residential treatment services assessment and treatment**
47.18 **planning.** (a) Within 12 hours of a client's admission, the license holder must evaluate and
47.19 document the client's immediate needs, including the client's:

47.20 (1) health and safety, including the client's need for crisis assistance;

47.21 (2) responsibilities for children, family and other natural supports, and employers; and

47.22 (3) housing and legal issues.

47.23 (b) Within 24 hours of the client's admission, the license holder must complete an initial
47.24 treatment plan for the client. The license holder must:

47.25 (1) base the client's initial treatment plan on the client's referral information and an
47.26 assessment of the client's immediate needs;

47.27 (2) consider crisis assistance strategies that have been effective for the client in the past;

47.28 (3) identify the client's initial treatment goals, measurable treatment objectives, and
47.29 specific interventions that the license holder will use to help the client engage in treatment;

48.1 (4) identify the participants involved in the client's treatment planning. The client must
48.2 be a participant; and

48.3 (5) ensure that a treatment supervisor approves of the client's initial treatment plan if a
48.4 mental health practitioner or clinical trainee completes the client's treatment plan,
48.5 notwithstanding section 245I.08, subdivision 3.

48.6 (c) According to section 245A.65, subdivision 2, paragraph (b), the license holder must
48.7 complete an individual abuse prevention plan as part of a client's initial treatment plan.

48.8 (d) Within five days of the client's admission and again within 60 days after the client's
48.9 admission, the license holder must complete a level of care assessment of the client. If the
48.10 license holder determines that a client does not need a medically monitored level of service,
48.11 a treatment supervisor must document how the client's admission to and continued services
48.12 in intensive residential treatment services are medically necessary for the client.

48.13 (e) Within ten days of a client's admission, the license holder must complete or review
48.14 and update the client's standard diagnostic assessment.

48.15 (f) Within ten days of a client's admission, the license holder must complete the client's
48.16 individual treatment plan, notwithstanding section 245I.10, subdivision 8. Within 40 days
48.17 after the client's admission and again within 70 days after the client's admission, the license
48.18 holder must update the client's individual treatment plan. The license holder must focus the
48.19 client's treatment planning on preparing the client for a successful transition from intensive
48.20 residential treatment services to another setting. In addition to the required elements of an
48.21 individual treatment plan under section 245I.10, subdivision 8, the license holder must
48.22 identify the following information in the client's individual treatment plan: (1) the client's
48.23 referrals and resources for the client's health and safety; and (2) the staff persons who are
48.24 responsible for following up with the client's referrals and resources. If the client does not
48.25 receive a referral or resource that the client needs, the license holder must document the
48.26 reason that the license holder did not make the referral or did not connect the client to a
48.27 particular resource. The license holder is responsible for determining whether additional
48.28 follow-up is required on behalf of the client.

48.29 (g) Within 30 days of the client's admission, the license holder must complete a functional
48.30 assessment of the client. Within 60 days after the client's admission, the license holder must
48.31 update the client's functional assessment to include any changes in the client's functioning
48.32 and symptoms.

48.33 (h) For a client with a current substance use disorder diagnosis and for a client whose
48.34 substance use disorder screening in the client's standard diagnostic assessment indicates the

49.1 possibility that the client has a substance use disorder, the license holder must complete a
49.2 written assessment of the client's substance use within 30 days of the client's admission. In
49.3 the substance use assessment, the license holder must: (1) evaluate the client's history of
49.4 substance use, relapses, and hospitalizations related to substance use; (2) assess the effects
49.5 of the client's substance use on the client's relationships including with family member and
49.6 others; (3) identify financial problems, health issues, housing instability, and unemployment;
49.7 (4) assess the client's legal problems, past and pending incarceration, violence, and
49.8 victimization; and (5) evaluate the client's suicide attempts, noncompliance with taking
49.9 prescribed medications, and noncompliance with psychosocial treatment.

49.10 (i) On a weekly basis, a mental health professional or certified rehabilitation specialist
49.11 must review each client's treatment plan and individual abuse prevention plan. The license
49.12 holder must document in the client's file each weekly review of the client's treatment plan
49.13 and individual abuse prevention plan.

49.14 **Subd. 8. Residential crisis stabilization assessment and treatment planning. (a)**
49.15 Within 12 hours of a client's admission, the license holder must evaluate the client and
49.16 document the client's immediate needs, including the client's:

49.17 (1) health and safety, including the client's need for crisis assistance;

49.18 (2) responsibilities for children, family and other natural supports, and employers; and

49.19 (3) housing and legal issues.

49.20 (b) Within 24 hours of a client's admission, the license holder must complete a crisis
49.21 treatment plan for the client under section 256B.0624, subdivision 11. The license holder
49.22 must base the client's crisis treatment plan on the client's referral information and an
49.23 assessment of the client's immediate needs.

49.24 (c) Section 245A.65, subdivision 2, paragraph (b), requires the license holder to complete
49.25 an individual abuse prevention plan for a client as part of the client's crisis treatment plan.

49.26 **Subd. 9. Key staff positions. (a)** The license holder must have a staff person assigned
49.27 to each of the following key staff positions at all times:

49.28 (1) a program director who qualifies as a mental health practitioner. The license holder
49.29 must designate the program director as responsible for all aspects of the operation of the
49.30 program and the program's compliance with all applicable requirements. The program
49.31 director must know and understand the implications of this chapter; chapters 245A, 245C,
49.32 and 260E; sections 626.557 and 626.5572; Minnesota Rules, chapter 9544; and all other
49.33 applicable requirements. The license holder must document in the program director's

- 50.1 personnel file how the program director demonstrates knowledge of these requirements.
- 50.2 The program director may also serve as the treatment director of the program, if qualified;
- 50.3 (2) a treatment director who qualifies as a mental health professional. The treatment
- 50.4 director must be responsible for overseeing treatment services for clients and the treatment
- 50.5 supervision of all staff persons; and
- 50.6 (3) a registered nurse who qualifies as a mental health practitioner. The registered nurse
- 50.7 must:
- 50.8 (i) work at the program location a minimum of eight hours per week;
- 50.9 (ii) provide monitoring and supervision of staff persons as defined in section 148.171,
- 50.10 subdivisions 8a and 23;
- 50.11 (iii) be responsible for the review and approval of health service and medication policies
- 50.12 and procedures under section 245I.03, subdivision 5; and
- 50.13 (iv) oversee the license holder's provision of health services to clients, medication storage,
- 50.14 and medication administration to clients.
- 50.15 (b) Within five business days of a change in a key staff position, the license holder must
- 50.16 notify the commissioner of the staffing change. The license holder must notify the
- 50.17 commissioner of the staffing change on a form approved by the commissioner and include
- 50.18 the name of the staff person now assigned to the key staff position and the staff person's
- 50.19 qualifications.
- 50.20 Subd. 10. **Minimum treatment team staffing levels and ratios.** (a) The license holder
- 50.21 must maintain a treatment team staffing level sufficient to:
- 50.22 (1) provide continuous daily coverage of all shifts;
- 50.23 (2) follow each client's treatment plan and meet each client's needs as identified in the
- 50.24 client's treatment plan;
- 50.25 (3) implement program requirements; and
- 50.26 (4) safely monitor and guide the activities of each client, taking into account the client's
- 50.27 level of behavioral and psychiatric stability, cultural needs, and vulnerabilities.
- 50.28 (b) The license holder must ensure that treatment team members:
- 50.29 (1) remain awake during all work hours; and
- 50.30 (2) are available to monitor and guide the activities of each client whenever clients are
- 50.31 present in the program.

51.1 (c) On each shift, the license holder must maintain a treatment team staffing ratio of at
51.2 least one treatment team member to nine clients. If the license holder is serving nine or
51.3 fewer clients, at least one treatment team member on the day shift must be a mental health
51.4 professional, clinical trainee, certified rehabilitation specialist, or mental health practitioner.
51.5 If the license holder is serving more than nine clients, at least one of the treatment team
51.6 members working during both the day and evening shifts must be a mental health
51.7 professional, clinical trainee, certified rehabilitation specialist, or mental health practitioner.

51.8 (d) If the license holder provides residential crisis stabilization to clients and is serving
51.9 at least one client in residential crisis stabilization and more than four clients in residential
51.10 crisis stabilization and intensive residential treatment services, the license holder must
51.11 maintain a treatment team staffing ratio on each shift of at least two treatment team members
51.12 during the client's first 48 hours in residential crisis stabilization.

51.13 Subd. 11. **Shift exchange.** A license holder must ensure that treatment team members
51.14 working on different shifts exchange information about a client as necessary to effectively
51.15 care for the client and to follow and update a client's treatment plan and individual abuse
51.16 prevention plan.

51.17 Subd. 12. **Daily documentation.** (a) For each day that a client is present in the program,
51.18 the license holder must provide a daily summary in the client's file that includes observations
51.19 about the client's behavior and symptoms, including any critical incidents in which the client
51.20 was involved.

51.21 (b) For each day that a client is not present in the program, the license holder must
51.22 document the reason for a client's absence in the client's file.

51.23 Subd. 13. **Access to a mental health professional, clinical trainee, certified**
51.24 **rehabilitation specialist, or mental health practitioner.** Treatment team members must
51.25 have access in person or by telephone to a mental health professional, clinical trainee,
51.26 certified rehabilitation specialist, or mental health practitioner within 30 minutes. The license
51.27 holder must maintain a schedule of mental health professionals, clinical trainees, certified
51.28 rehabilitation specialists, or mental health practitioners who will be available and contact
51.29 information to reach them. The license holder must keep the schedule current and make the
51.30 schedule readily available to treatment team members.

51.31 Subd. 14. **Weekly team meetings.** (a) The license holder must hold weekly team meetings
51.32 and ancillary meetings according to this subdivision.

51.33 (b) A mental health professional or certified rehabilitation specialist must hold at least
51.34 one team meeting each calendar week and be physically present at the team meeting. All

52.1 treatment team members, including treatment team members who work on a part-time or
52.2 intermittent basis, must participate in a minimum of one team meeting during each calendar
52.3 week when the treatment team member is working for the license holder. The license holder
52.4 must document all weekly team meetings, including the names of meeting attendees.

52.5 (c) If a treatment team member cannot participate in a weekly team meeting, the treatment
52.6 team member must participate in an ancillary meeting. A mental health professional, certified
52.7 rehabilitation specialist, clinical trainee, or mental health practitioner who participated in
52.8 the most recent weekly team meeting may lead the ancillary meeting. During the ancillary
52.9 meeting, the treatment team member leading the ancillary meeting must review the
52.10 information that was shared at the most recent weekly team meeting, including revisions
52.11 to client treatment plans and other information that the treatment supervisors exchanged
52.12 with treatment team members. The license holder must document all ancillary meetings,
52.13 including the names of meeting attendees.

52.14 Subd. 15. **Intensive residential treatment services admission criteria.** (a) An eligible
52.15 client for intensive residential treatment services is an individual who:

52.16 (1) is age 18 or older;

52.17 (2) is diagnosed with a mental illness;

52.18 (3) because of a mental illness, has a substantial disability and functional impairment
52.19 in three or more areas listed in section 245I.10, subdivision 9, clause (4), that markedly
52.20 reduce the individual's self-sufficiency;

52.21 (4) has one or more of the following: a history of recurring or prolonged inpatient
52.22 hospitalizations during the past year, significant independent living instability, homelessness,
52.23 or very frequent use of mental health and related services with poor outcomes for the
52.24 individual; and

52.25 (5) in the written opinion of a mental health professional, needs mental health services
52.26 that available community-based services cannot provide, or is likely to experience a mental
52.27 health crisis or require a more restrictive setting if the individual does not receive intensive
52.28 rehabilitative mental health services.

52.29 (b) The license holder must not limit or restrict intensive residential treatment services
52.30 to a client based solely on:

52.31 (1) the client's substance use;

52.32 (2) the county in which the client resides; or

53.1 (3) whether the client elects to receive other services for which the client may be eligible,
53.2 including case management services.

53.3 (c) This subdivision does not prohibit the license holder from restricting admissions of
53.4 individuals who present an imminent risk of harm or danger to themselves or others.

53.5 Subd. 16. **Residential crisis stabilization services admission criteria.** An eligible client
53.6 for residential crisis stabilization is an individual who is age 18 or older and meets the
53.7 eligibility criteria in section 256B.0624, subdivision 3.

53.8 Subd. 17. **Admissions referrals and determinations.** (a) The license holder must
53.9 identify the information that the license holder needs to make a determination about a
53.10 person's admission referral.

53.11 (b) The license holder must:

53.12 (1) always be available to receive referral information about a person seeking admission
53.13 to the license holder's program;

53.14 (2) respond to the referral source within eight hours of receiving a referral and, within
53.15 eight hours, communicate with the referral source about what information the license holder
53.16 needs to make a determination concerning the person's admission;

53.17 (3) consider the license holder's staffing ratio and the areas of treatment team members'
53.18 competency when determining whether the license holder is able to meet the needs of a
53.19 person seeking admission; and

53.20 (4) determine whether to admit a person within 72 hours of receiving all necessary
53.21 information from the referral source.

53.22 Subd. 18. **Discharge standards.** (a) When a license holder discharges a client from a
53.23 program, the license holder must categorize the discharge as a successful discharge,
53.24 program-initiated discharge, or non-program-initiated discharge according to the criteria in
53.25 this subdivision. The license holder must meet the standards associated with the type of
53.26 discharge according to this subdivision.

53.27 (b) To successfully discharge a client from a program, the license holder must ensure
53.28 that the following criteria are met:

53.29 (1) the client must substantially meet the client's documented treatment plan goals and
53.30 objectives;

53.31 (2) the client must complete discharge planning with the treatment team; and

54.1 (3) the client and treatment team must arrange for the client to receive continuing care
54.2 at a less intensive level of care after discharge.

54.3 (c) Prior to successfully discharging a client from a program, the license holder must
54.4 complete the client's discharge summary and provide the client with a copy of the client's
54.5 discharge summary in plain language that includes:

54.6 (1) a brief review of the client's problems and strengths during the period that the license
54.7 holder provided services to the client;

54.8 (2) the client's response to the client's treatment plan;

54.9 (3) the goals and objectives that the license holder recommends that the client addresses
54.10 during the first three months following the client's discharge from the program;

54.11 (4) the recommended actions, supports, and services that will assist the client with a
54.12 successful transition from the program to another setting;

54.13 (5) the client's crisis plan; and

54.14 (6) the client's forwarding address and telephone number.

54.15 (d) For a non-program-initiated discharge of a client from a program, the following
54.16 criteria must be met:

54.17 (1)(i) the client has withdrawn the client's consent for treatment; (ii) the license holder
54.18 has determined that the client has the capacity to make an informed decision; and (iii) the
54.19 client does not meet the criteria for an emergency hold under section 253B.051, subdivision
54.20 2;

54.21 (2) the client has left the program against staff person advice;

54.22 (3) an entity with legal authority to remove the client has decided to remove the client
54.23 from the program; or

54.24 (4) a source of payment for the services is no longer available.

54.25 (e) Within ten days of a non-program-initiated discharge of a client from a program, the
54.26 license holder must complete the client's discharge summary in plain language that includes:

54.27 (1) the reasons for the client's discharge;

54.28 (2) a description of attempts by staff persons to enable the client to continue treatment
54.29 or to consent to treatment; and

54.30 (3) recommended actions, supports, and services that will assist the client with a
54.31 successful transition from the program to another setting.

55.1 (f) For a program-initiated discharge of a client from a program, the following criteria
55.2 must be met:

55.3 (1) the client is competent but has not participated in treatment or has not followed the
55.4 program rules and regulations and the client has not participated to such a degree that the
55.5 program's level of care is ineffective or unsafe for the client, despite multiple, documented
55.6 attempts that the license holder has made to address the client's lack of participation in
55.7 treatment;

55.8 (2) the client has not made progress toward the client's treatment goals and objectives
55.9 despite the license holder's persistent efforts to engage the client in treatment, and the license
55.10 holder has no reasonable expectation that the client will make progress at the program's
55.11 level of care nor does the client require the program's level of care to maintain the current
55.12 level of functioning;

55.13 (3) a court order or the client's legal status requires the client to participate in the program
55.14 but the client has left the program against staff person advice; or

55.15 (4) the client meets criteria for a more intensive level of care and a more intensive level
55.16 of care is available to the client.

55.17 (g) Prior to a program-initiated discharge of a client from a program, the license holder
55.18 must consult the client, the client's family and other natural supports, and the client's case
55.19 manager, if applicable, to review the issues involved in the program's decision to discharge
55.20 the client from the program. During the discharge review process, which must not exceed
55.21 five working days, the license holder must determine whether the license holder, treatment
55.22 team, and any interested persons can develop additional strategies to resolve the issues
55.23 leading to the client's discharge and to permit the client to have an opportunity to continue
55.24 receiving services from the license holder. The license holder may temporarily remove a
55.25 client from the program facility during the five-day discharge review period. The license
55.26 holder must document the client's discharge review in the client's file.

55.27 (h) Prior to a program-initiated discharge of a client from the program, the license holder
55.28 must complete the client's discharge summary and provide the client with a copy of the
55.29 discharge summary in plain language that includes:

55.30 (1) the reasons for the client's discharge;

55.31 (2) the alternatives to discharge that the license holder considered or attempted to
55.32 implement;

56.1 (3) the names of each individual who is involved in the decision to discharge the client
56.2 and a description of each individual's involvement; and

56.3 (4) recommended actions, supports, and services that will assist the client with a
56.4 successful transition from the program to another setting.

56.5 Subd. 19. **Program facility.** (a) The license holder must be licensed or certified as a
56.6 board and lodging facility, supervised living facility, or a boarding care home by the
56.7 Department of Health.

56.8 (b) The license holder must have a capacity of five to 16 beds and the program must not
56.9 be declared as an institution for mental disease.

56.10 (c) The license holder must furnish each program location to meet the psychological,
56.11 emotional, and developmental needs of clients.

56.12 (d) The license holder must provide one living room or lounge area per program location.
56.13 There must be space available to provide services according to each client's treatment plan,
56.14 such as an area for learning recreation time skills and areas for learning independent living
56.15 skills, such as laundering clothes and preparing meals.

56.16 (e) The license holder must ensure that each program location allows each client to have
56.17 privacy. Each client must have privacy during assessment interviews and counseling sessions.
56.18 Each client must have a space designated for the client to see outside visitors at the program
56.19 facility.

56.20 Subd. 20. **Physical separation of services.** If the license holder offers services to
56.21 individuals who are not receiving intensive residential treatment services or residential
56.22 stabilization at the program location, the license holder must inform the commissioner and
56.23 submit a plan for approval to the commissioner about how and when the license holder will
56.24 provide services. The license holder must only provide services to clients who are not
56.25 receiving intensive residential treatment services or residential crisis stabilization in an area
56.26 that is physically separated from the area in which the license holder provides clients with
56.27 intensive residential treatment services or residential crisis stabilization.

56.28 Subd. 21. **Dividing staff time between locations.** A license holder must obtain approval
56.29 from the commissioner prior to providing intensive residential treatment services or
56.30 residential crisis stabilization to clients in more than one program location under one license
56.31 and dividing one staff person's time between program locations during the same work period.

57.1 Subd. 22. Additional policy and procedure requirements. (a) In addition to the policies
57.2 and procedures in section 245I.03, the license holder must establish, enforce, and maintain
57.3 the policies and procedures in this subdivision.

57.4 (b) The license holder must have policies and procedures for receiving referrals and
57.5 making admissions determinations about referred persons under subdivisions 14 to 16.

57.6 (c) The license holder must have policies and procedures for discharging clients under
57.7 subdivision 17. In the policies and procedures, the license holder must identify the staff
57.8 persons who are authorized to discharge clients from the program.

57.9 Subd. 23. Quality assurance and improvement plan. (a) A license holder must develop
57.10 a written quality assurance and improvement plan that includes a plan to:

57.11 (1) encourage ongoing consultation between members of the treatment team;

57.12 (2) obtain and evaluate feedback about services from clients, family and other natural
57.13 supports, referral sources, and staff persons;

57.14 (3) measure and evaluate client outcomes in the program;

57.15 (4) review critical incidents in the program;

57.16 (5) examine the quality of clinical services in the program; and

57.17 (6) self-monitor the license holder's compliance with this chapter.

57.18 (b) At least annually, the license holder must review, evaluate, and update the license
57.19 holder's quality assurance and improvement plan. The license holder's review must:

57.20 (1) document the actions that the license holder will take in response to the information
57.21 that the license holder obtains from the monitoring activities in the plan; and

57.22 (2) establish goals for improving the license holder's services to clients during the next
57.23 year.

57.24 Subd. 24. Application. When an applicant requests licensure to provide intensive
57.25 residential treatment services, residential crisis stabilization, or both to clients, the applicant
57.26 must submit, on forms that the commissioner provides, any documents that the commissioner
57.27 requires.

57.28 **Sec. 17. [256B.0671] COVERED MENTAL HEALTH SERVICES.**

57.29 Subdivision 1. Definitions. (a) "Clinical trainee" means a staff person who is qualified
57.30 under section 245I.04, subdivision 6.

58.1 (b) "Mental health practitioner" means a staff person who is qualified under section
58.2 245I.04, subdivision 4.

58.3 (c) "Mental health professional" means a staff person who is qualified under section
58.4 245I.04, subdivision 2.

58.5 Subd. 2. **Generally.** (a) An individual, organization, or government entity providing
58.6 mental health services to a client under this section must obtain a criminal background study
58.7 of each staff person or volunteer who is providing direct contact services to a client.

58.8 (b) An individual, organization, or government entity providing mental health services
58.9 to a client under this section must comply with all responsibilities that chapter 245I assigns
58.10 to a license holder, except section 245I.011, subdivision 1, unless all of the individual's,
58.11 organization's, or government entity's treatment staff are qualified as mental health
58.12 professionals.

58.13 (c) An individual, organization, or government entity providing mental health services
58.14 to a client under this section must comply with the following requirements if all of the
58.15 license holder's treatment staff are qualified as mental health professionals:

58.16 (1) provider qualifications and scopes of practice under section 245I.04;

58.17 (2) maintaining and updating personnel files under section 245I.07;

58.18 (3) documenting under section 245I.08;

58.19 (4) maintaining and updating client files under section 245I.09;

58.20 (5) completing client assessments and treatment planning under section 245I.10;

58.21 (6) providing clients with health services and medications under section 245I.11; and

58.22 (7) respecting and enforcing client rights under section 245I.12.

58.23 Subd. 3. **Adult day treatment services.** (a) Subject to federal approval, medical
58.24 assistance covers adult day treatment (ADT) services that are provided under contract with
58.25 the county board. Adult day treatment payment is subject to the conditions in paragraphs
58.26 (b) to (e). The provider must make reasonable and good faith efforts to report individual
58.27 client outcomes to the commissioner using instruments, protocols, and forms approved by
58.28 the commissioner.

58.29 (b) Adult day treatment is an intensive psychotherapeutic treatment to reduce or relieve
58.30 the effects of mental illness on a client to enable the client to benefit from a lower level of
58.31 care and to live and function more independently in the community. Adult day treatment
58.32 services must be provided to a client to stabilize the client's mental health and to improve

59.1 the client's independent living and socialization skills. Adult day treatment must consist of
59.2 at least one hour of group psychotherapy and must include group time focused on
59.3 rehabilitative interventions or other therapeutic services that a multidisciplinary team provides
59.4 to each client. Adult day treatment services are not a part of inpatient or residential treatment
59.5 services. The following providers may apply to become adult day treatment providers:

59.6 (1) a hospital accredited by the Joint Commission on Accreditation of Health
59.7 Organizations and licensed under sections 144.50 to 144.55;

59.8 (2) a community mental health center under section 256B.0625, subdivision 5; or

59.9 (3) an entity that is under contract with the county board to operate a program that meets
59.10 the requirements of section 245.4712, subdivision 2, and Minnesota Rules, parts 9505.0170
59.11 to 9505.0475.

59.12 (c) An adult day treatment (ADT) services provider must:

59.13 (1) ensure that the commissioner has approved of the organization as an adult day
59.14 treatment provider organization;

59.15 (2) ensure that a multidisciplinary team provides ADT services to a group of clients. A
59.16 mental health professional must supervise each multidisciplinary staff person who provides
59.17 ADT services;

59.18 (3) make ADT services available to the client at least two days a week for at least three
59.19 consecutive hours per day. ADT services may be longer than three hours per day, but medical
59.20 assistance may not reimburse a provider for more than 15 hours per week;

59.21 (4) provide ADT services to each client that includes group psychotherapy by a mental
59.22 health professional or clinical trainee and daily rehabilitative interventions by a mental
59.23 health professional, clinical trainee, or mental health practitioner; and

59.24 (5) include ADT services in the client's individual treatment plan, when appropriate.

59.25 The adult day treatment provider must:

59.26 (i) complete a functional assessment of each client under section 245I.10, subdivision
59.27 9;

59.28 (ii) notwithstanding section 245I.10, subdivision 8, review the client's progress and
59.29 update the individual treatment plan at least every 90 days until the client is discharged
59.30 from the program; and

59.31 (iii) include a discharge plan for the client in the client's individual treatment plan.

59.32 (d) To be eligible for adult day treatment, a client must:

60.1 (1) be 18 years of age or older;

60.2 (2) not reside in a nursing facility, hospital, institute of mental disease, or state-operated
60.3 treatment center unless the client has an active discharge plan that indicates a move to an
60.4 independent living setting within 180 days;

60.5 (3) have the capacity to engage in rehabilitative programming, skills activities, and
60.6 psychotherapy in the structured, therapeutic setting of an adult day treatment program and
60.7 demonstrate measurable improvements in functioning resulting from participation in the
60.8 adult day treatment program;

60.9 (4) have a level of care assessment under section 245I.02, subdivision 19, recommending
60.10 that the client participate in services with the level of intensity and duration of an adult day
60.11 treatment program; and

60.12 (5) have the recommendation of a mental health professional for adult day treatment
60.13 services. The mental health professional must find that adult day treatment services are
60.14 medically necessary for the client.

60.15 (e) Medical assistance does not cover the following services as adult day treatment
60.16 services:

60.17 (1) services that are primarily recreational or that are provided in a setting that is not
60.18 under medical supervision, including sports activities, exercise groups, craft hours, leisure
60.19 time, social hours, meal or snack time, trips to community activities, and tours;

60.20 (2) social or educational services that do not have or cannot reasonably be expected to
60.21 have a therapeutic outcome related to the client's mental illness;

60.22 (3) consultations with other providers or service agency staff persons about the care or
60.23 progress of a client;

60.24 (4) prevention or education programs that are provided to the community;

60.25 (5) day treatment for clients with a primary diagnosis of a substance use disorder;

60.26 (6) day treatment provided in the client's home;

60.27 (7) psychotherapy for more than two hours per day; and

60.28 (8) participation in meal preparation and eating that is not part of a clinical treatment
60.29 plan to address the client's eating disorder.

60.30 Subd. 4. **Explanation of findings.** (a) Subject to federal approval, medical assistance
60.31 covers an explanation of findings that a mental health professional or clinical trainee provides

61.1 when the provider has obtained the authorization from the client or the client's representative
61.2 to release the information.

61.3 (b) A mental health professional or clinical trainee provides an explanation of findings
61.4 to assist the client or related parties in understanding the results of the client's testing or
61.5 diagnostic assessment and the client's mental illness, and provides professional insight that
61.6 the client or related parties need to carry out a client's treatment plan. Related parties may
61.7 include the client's family and other natural supports and other service providers working
61.8 with the client.

61.9 (c) An explanation of findings is not paid for separately when a mental health professional
61.10 or clinical trainee explains the results of psychological testing or a diagnostic assessment
61.11 to the client or the client's representative as part of the client's psychological testing or a
61.12 diagnostic assessment.

61.13 Subd. 5. **Family psychoeducation services.** (a) Subject to federal approval, medical
61.14 assistance covers family psychoeducation services provided to a child up to age 21 with a
61.15 diagnosed mental health condition when identified in the child's individual treatment plan
61.16 and provided by a mental health professional or a clinical trainee who has determined it
61.17 medically necessary to involve family members in the child's care.

61.18 (b) "Family psychoeducation services" means information or demonstration provided
61.19 to an individual or family as part of an individual, family, multifamily group, or peer group
61.20 session to explain, educate, and support the child and family in understanding a child's
61.21 symptoms of mental illness, the impact on the child's development, and needed components
61.22 of treatment and skill development so that the individual, family, or group can help the child
61.23 to prevent relapse, prevent the acquisition of comorbid disorders, and achieve optimal mental
61.24 health and long-term resilience.

61.25 Subd. 6. **Dialectical behavior therapy.** (a) Subject to federal approval, medical assistance
61.26 covers intensive mental health outpatient treatment for dialectical behavior therapy for
61.27 adults. A dialectical behavior therapy provider must make reasonable and good faith efforts
61.28 to report individual client outcomes to the commissioner using instruments and protocols
61.29 that are approved by the commissioner.

61.30 (b) "Dialectical behavior therapy" means an evidence-based treatment approach that a
61.31 mental health professional or clinical trainee provides to a client or a group of clients in an
61.32 intensive outpatient treatment program using a combination of individualized rehabilitative
61.33 and psychotherapeutic interventions. A dialectical behavior therapy program involves:

62.1 individual dialectical behavior therapy, group skills training, telephone coaching, and team
62.2 consultation meetings.

62.3 (c) To be eligible for dialectical behavior therapy, a client must:

62.4 (1) be 18 years of age or older;

62.5 (2) have mental health needs that available community-based services cannot meet or
62.6 that the client must receive concurrently with other community-based services;

62.7 (3) have either:

62.8 (i) a diagnosis of borderline personality disorder; or

62.9 (ii) multiple mental health diagnoses, exhibit behaviors characterized by impulsivity or
62.10 intentional self-harm, and be at significant risk of death, morbidity, disability, or severe
62.11 dysfunction in multiple areas of the client's life;

62.12 (4) be cognitively capable of participating in dialectical behavior therapy as an intensive
62.13 therapy program and be able and willing to follow program policies and rules to ensure the
62.14 safety of the client and others; and

62.15 (5) be at significant risk of one or more of the following if the client does not receive
62.16 dialectical behavior therapy:

62.17 (i) having a mental health crisis;

62.18 (ii) requiring a more restrictive setting such as hospitalization;

62.19 (iii) decompensating; or

62.20 (iv) engaging in intentional self-harm behavior.

62.21 (d) Individual dialectical behavior therapy combines individualized rehabilitative and
62.22 psychotherapeutic interventions to treat a client's suicidal and other dysfunctional behaviors
62.23 and to reinforce a client's use of adaptive skillful behaviors. A mental health professional
62.24 or clinical trainee must provide individual dialectical behavior therapy to a client. A mental
62.25 health professional or clinical trainee providing dialectical behavior therapy to a client must:

62.26 (1) identify, prioritize, and sequence the client's behavioral targets;

62.27 (2) treat the client's behavioral targets;

62.28 (3) assist the client in applying dialectical behavior therapy skills to the client's natural
62.29 environment through telephone coaching outside of treatment sessions;

62.30 (4) measure the client's progress toward dialectical behavior therapy targets;

63.1 (5) help the client manage mental health crises and life-threatening behaviors; and

63.2 (6) help the client learn and apply effective behaviors when working with other treatment
63.3 providers.

63.4 (e) Group skills training combines individualized psychotherapeutic and psychiatric
63.5 rehabilitative interventions conducted in a group setting to reduce the client's suicidal and
63.6 other dysfunctional coping behaviors and restore function. Group skills training must teach
63.7 the client adaptive skills in the following areas: (1) mindfulness; (2) interpersonal
63.8 effectiveness; (3) emotional regulation; and (4) distress tolerance.

63.9 (f) Group skills training must be provided by two mental health professionals or by a
63.10 mental health professional co-facilitating with a clinical trainee or a mental health practitioner.
63.11 Individual skills training must be provided by a mental health professional, a clinical trainee,
63.12 or a mental health practitioner.

63.13 (g) Before a program provides dialectical behavior therapy to a client, the commissioner
63.14 must certify the program as a dialectical behavior therapy provider. To qualify for
63.15 certification as a dialectical behavior therapy provider, a provider must:

63.16 (1) allow the commissioner to inspect the provider's program;

63.17 (2) provide evidence to the commissioner that the program's policies, procedures, and
63.18 practices meet the requirements of this subdivision and chapter 245I;

63.19 (3) be enrolled as a MHCP provider; and

63.20 (4) have a manual that outlines the program's policies, procedures, and practices that
63.21 meet the requirements of this subdivision.

63.22 **Subd. 7. Mental health clinical care consultation.** (a) Subject to federal approval,
63.23 medical assistance covers clinical care consultation for a person up to age 21 who is
63.24 diagnosed with a complex mental health condition or a mental health condition that co-occurs
63.25 with other complex and chronic conditions, when described in the person's individual
63.26 treatment plan and provided by a mental health professional or a clinical trainee.

63.27 (b) "Clinical care consultation" means communication from a treating mental health
63.28 professional to other providers or educators not under the treatment supervision of the
63.29 treating mental health professional who are working with the same client to inform, inquire,
63.30 and instruct regarding the client's symptoms; strategies for effective engagement, care, and
63.31 intervention needs; and treatment expectations across service settings and to direct and
63.32 coordinate clinical service components provided to the client and family.

64.1 Subd. 8. Neuropsychological assessment. (a) Subject to federal approval, medical
64.2 assistance covers a client's neuropsychological assessment.

64.3 (b) Neuropsychological assessment" means a specialized clinical assessment of the
64.4 client's underlying cognitive abilities related to thinking, reasoning, and judgment that is
64.5 conducted by a qualified neuropsychologist. A neuropsychological assessment must include
64.6 a face-to-face interview with the client, interpretation of the test results, and preparation
64.7 and completion of a report.

64.8 (c) A client is eligible for a neuropsychological assessment if the client meets at least
64.9 one of the following criteria:

64.10 (1) the client has a known or strongly suspected brain disorder based on the client's
64.11 medical history or the client's prior neurological evaluation, including a history of significant
64.12 head trauma, brain tumor, stroke, seizure disorder, multiple sclerosis, neurodegenerative
64.13 disorder, significant exposure to neurotoxins, central nervous system infection, metabolic
64.14 or toxic encephalopathy, fetal alcohol syndrome, or congenital malformation of the brain;
64.15 or

64.16 (2) the client has cognitive or behavioral symptoms that suggest that the client has an
64.17 organic condition that cannot be readily attributed to functional psychopathology or suspected
64.18 neuropsychological impairment in addition to functional psychopathology. The client's
64.19 symptoms may include:

64.20 (i) having a poor memory or impaired problem solving;

64.21 (ii) experiencing change in mental status evidenced by lethargy, confusion, or
64.22 disorientation;

64.23 (iii) experiencing a deteriorating level of functioning;

64.24 (iv) displaying a marked change in behavior or personality;

64.25 (v) in a child or an adolescent, having significant delays in acquiring academic skill or
64.26 poor attention relative to peers;

64.27 (vi) in a child or an adolescent, having reached a significant plateau in expected
64.28 development of cognitive, social, emotional, or physical functioning relative to peers; and

64.29 (vii) in a child or an adolescent, significant inability to develop expected knowledge,
64.30 skills, or abilities to adapt to new or changing cognitive, social, emotional, or physical
64.31 demands.

64.32 (d) The neuropsychological assessment must be completed by a neuropsychologist who:

65.1 (1) was awarded a diploma by the American Board of Clinical Neuropsychology, the
65.2 American Board of Professional Neuropsychology, or the American Board of Pediatric
65.3 Neuropsychology;

65.4 (2) earned a doctoral degree in psychology from an accredited university training program
65.5 and:

65.6 (i) completed an internship or its equivalent in a clinically relevant area of professional
65.7 psychology;

65.8 (ii) completed the equivalent of two full-time years of experience and specialized training,
65.9 at least one of which is at the postdoctoral level, supervised by a clinical neuropsychologist
65.10 in the study and practice of clinical neuropsychology and related neurosciences; and

65.11 (iii) holds a current license to practice psychology independently according to sections
65.12 144.88 to 144.98;

65.13 (3) is licensed or credentialed by another state's board of psychology examiners in the
65.14 specialty of neuropsychology using requirements equivalent to requirements specified by
65.15 one of the boards named in clause (1); or

65.16 (4) was approved by the commissioner as an eligible provider of neuropsychological
65.17 assessments prior to December 31, 2010.

65.18 Subd. 9. **Neuropsychological testing.** (a) Subject to federal approval, medical assistance
65.19 covers neuropsychological testing for clients.

65.20 (b) "Neuropsychological testing" means administering standardized tests and measures
65.21 designed to evaluate the client's ability to attend to, process, interpret, comprehend,
65.22 communicate, learn, and recall information and use problem solving and judgment.

65.23 (c) Medical assistance covers neuropsychological testing of a client when the client:

65.24 (1) has a significant mental status change that is not a result of a metabolic disorder and
65.25 that has failed to respond to treatment;

65.26 (2) is a child or adolescent with a significant plateau in expected development of
65.27 cognitive, social, emotional, or physical function relative to peers;

65.28 (3) is a child or adolescent with a significant inability to develop expected knowledge,
65.29 skills, or abilities to adapt to new or changing cognitive, social, physical, or emotional
65.30 demands; or

66.1 (4) has a significant behavioral change, memory loss, or suspected neuropsychological
66.2 impairment in addition to functional psychopathology, or other organic brain injury or one
66.3 of the following:

66.4 (i) traumatic brain injury;

66.5 (ii) stroke;

66.6 (iii) brain tumor;

66.7 (iv) substance use disorder;

66.8 (v) cerebral anoxic or hypoxic episode;

66.9 (vi) central nervous system infection or other infectious disease;

66.10 (vii) neoplasms or vascular injury of the central nervous system;

66.11 (viii) neurodegenerative disorders;

66.12 (ix) demyelinating disease;

66.13 (x) extrapyramidal disease;

66.14 (xi) exposure to systemic or intrathecal agents or cranial radiation known to be associated
66.15 with cerebral dysfunction;

66.16 (xii) systemic medical conditions known to be associated with cerebral dysfunction,
66.17 including renal disease, hepatic encephalopathy, cardiac anomaly, sickle cell disease, and
66.18 related hematologic anomalies, and autoimmune disorders, including lupus, erythematosus,
66.19 or celiac disease;

66.20 (xiii) congenital genetic or metabolic disorders known to be associated with cerebral
66.21 dysfunction, including phenylketonuria, craniofacial syndromes, or congenital hydrocephalus;

66.22 (xiv) severe or prolonged nutrition or malabsorption syndromes; or

66.23 (xv) a condition presenting in a manner difficult for a clinician to distinguish between
66.24 the neurocognitive effects of a neurogenic syndrome, including dementia or encephalopathy;
66.25 and a major depressive disorder when adequate treatment for major depressive disorder has
66.26 not improved the client's neurocognitive functioning; or another disorder, including autism,
66.27 selective mutism, anxiety disorder, or reactive attachment disorder.

66.28 (d) Neuropsychological testing must be administered or clinically supervised by a
66.29 qualified neuropsychologist under subdivision 8, paragraph (c).

67.1 (e) Medical assistance does not cover neuropsychological testing of a client when the
67.2 testing is:

67.3 (1) primarily for educational purposes;

67.4 (2) primarily for vocational counseling or training;

67.5 (3) for personnel or employment testing;

67.6 (4) a routine battery of psychological tests given to the client at the client's inpatient
67.7 admission or during a client's continued inpatient stay; or

67.8 (5) for legal or forensic purposes.

67.9 Subd. 10. **Psychological testing.** (a) Subject to federal approval, medical assistance
67.10 covers psychological testing of a client.

67.11 (b) "Psychological testing" means the use of tests or other psychometric instruments to
67.12 determine the status of a client's mental, intellectual, and emotional functioning.

67.13 (c) The psychological testing must:

67.14 (1) be administered or supervised by a licensed psychologist qualified under section
67.15 245I.04, subdivision 2, clause (3), who is competent in the area of psychological testing;
67.16 and

67.17 (2) be validated in a face-to-face interview between the client and a licensed psychologist
67.18 or a clinical trainee in psychology under the treatment supervision of a licensed psychologist
67.19 under section 245I.06.

67.20 (d) A licensed psychologist must supervise the administration, scoring, and interpretation
67.21 of a client's psychological tests when a clinical psychology trainee, technician, psychometrist,
67.22 or psychological assistant or a computer-assisted psychological testing program completes
67.23 the psychological testing of the client. The report resulting from the psychological testing
67.24 must be signed by the licensed psychologist who conducts the face-to-face interview with
67.25 the client. The licensed psychologist or a staff person who is under treatment supervision
67.26 must place the client's psychological testing report in the client's record and release one
67.27 copy of the report to the client and additional copies to individuals authorized by the client
67.28 to receive the report.

67.29 Subd. 11. **Psychotherapy.** (a) Subject to federal approval, medical assistance covers
67.30 psychotherapy for a client.

67.31 (b) "Psychotherapy" means treatment of a client with mental illness that applies to the
67.32 most appropriate psychological, psychiatric, psychosocial, or interpersonal method that

68.1 conforms to prevailing community standards of professional practice to meet the mental
68.2 health needs of the client. Medical assistance covers psychotherapy if a mental health
68.3 professional or a clinical trainee provides psychotherapy to a client.

68.4 (c) "Individual psychotherapy" means psychotherapy that a mental health professional
68.5 or clinical trainee designs for a client.

68.6 (d) "Family psychotherapy" means psychotherapy that a mental health professional or
68.7 clinical trainee designs for a client and one or more and the client's family members or
68.8 primary caregiver whose participation is necessary to accomplish the client's treatment
68.9 goals. Family members or primary caregivers participating in a therapy session do not need
68.10 to be eligible for medical assistance for medical assistance to cover family psychotherapy.
68.11 For purposes of this paragraph, "primary caregiver whose participation is necessary to
68.12 accomplish the client's treatment goals" excludes shift or facility staff persons who work at
68.13 the client's residence. Medical assistance payments for family psychotherapy are limited to
68.14 face-to-face sessions during which the client is present throughout the session, unless the
68.15 mental health professional or clinical trainee believes that the client's exclusion from the
68.16 family psychotherapy session is necessary to meet the goals of the client's individual
68.17 treatment plan. If the client is excluded from a family psychotherapy session, a mental health
68.18 professional or clinical trainee must document the reason for the client's exclusion and the
68.19 length of time that the client is excluded. The mental health professional must also document
68.20 any reason that a member of the client's family is excluded from a psychotherapy session.

68.21 (e) Group psychotherapy is appropriate for a client who, because of the nature of the
68.22 client's emotional, behavioral, or social dysfunctions, can benefit from treatment in a group
68.23 setting. For a group of three to eight clients, at least one mental health professional or clinical
68.24 trainee must provide psychotherapy to the group. For a group of nine to 12 clients, a team
68.25 of at least two mental health professionals or two clinical trainees or one mental health
68.26 professional and one clinical trainee must provide psychotherapy to the group. Medical
68.27 assistance will cover group psychotherapy for a group of no more than 12 persons.

68.28 (f) A multiple-family group psychotherapy session is eligible for medical assistance if
68.29 a mental health professional or clinical trainee designs the psychotherapy session for at least
68.30 two but not more than five families. A mental health professional or clinical trainee must
68.31 design multiple-family group psychotherapy sessions to meet the treatment needs of each
68.32 client. If the client is excluded from a psychotherapy session, the mental health professional
68.33 or clinical trainee must document the reason for the client's exclusion and the length of time
68.34 that the client was excluded. The mental health professional or clinical trainee must document
68.35 any reason that a member of the client's family was excluded from a psychotherapy session.

69.1 Subd. 12. **Partial hospitalization.** (a) Subject to federal approval, medical assistance
69.2 covers a client's partial hospitalization.

69.3 (b) "Partial hospitalization" means a provider's time-limited, structured program of
69.4 psychotherapy and other therapeutic services, as defined in United States Code, title 42,
69.5 chapter 7, subchapter XVIII, part E, section 1395x(ff), that a multidisciplinary staff person
69.6 provides in an outpatient hospital facility or community mental health center that meets
69.7 Medicare requirements to provide partial hospitalization services to a client.

69.8 (c) Partial hospitalization is an appropriate alternative to inpatient hospitalization for a
69.9 client who is experiencing an acute episode of mental illness who meets the criteria for an
69.10 inpatient hospital admission under Minnesota Rules, part 9505.0520, subpart 1, and who
69.11 has family and community resources that support the client's residence in the community.
69.12 Partial hospitalization consists of multiple intensive short-term therapeutic services for a
69.13 client that a multidisciplinary staff person provides to a client to treat the client's mental
69.14 illness.

69.15 Subd. 13. **Diagnostic assessments.** Subject to federal approval, medical assistance covers
69.16 a client's diagnostic assessments that a mental health professional or clinical trainee completes
69.17 under section 245I.10.

69.18 Sec. 18. **DIRECTION TO COMMISSIONER; SINGLE COMPREHENSIVE**
69.19 **LICENSE STRUCTURE.**

69.20 The commissioner of human services, in consultation with stakeholders including
69.21 counties, tribes, managed care organizations, provider organizations, advocacy groups, and
69.22 clients and clients' families, shall develop recommendations to develop a single
69.23 comprehensive licensing structure for mental health service programs, including outpatient
69.24 and residential services for adults and children. The recommendations must prioritize
69.25 program integrity, the welfare of clients and clients' families, improved integration of mental
69.26 health and substance use disorder services, and the reduction of administrative burden on
69.27 providers.

69.28 **ARTICLE 2**

69.29 **CRISIS RESPONSE SERVICES**

69.30 Section 1. Minnesota Statutes 2020, section 245.469, subdivision 1, is amended to read:

69.31 Subdivision 1. **Availability of emergency services.** ~~By July 1, 1988,~~ (a) County boards
69.32 must provide or contract for enough emergency services within the county to meet the needs

70.1 of adults, children, and families in the county who are experiencing an emotional crisis or
70.2 mental illness. Clients may be required to pay a fee according to section 245.481. Emergency
70.3 service providers must not delay the timely provision of emergency services to a client
70.4 because of delays in determining the fee under section 245.481 or because of the
70.5 unwillingness or inability of the client to pay the fee. Emergency services must include
70.6 assessment, crisis intervention, and appropriate case disposition. Emergency services must:

70.7 (1) promote the safety and emotional stability of ~~adults with mental illness or emotional~~
70.8 ~~crises~~ each client;

70.9 (2) minimize further deterioration of ~~adults with mental illness or emotional crises~~ each
70.10 client;

70.11 (3) help ~~adults with mental illness or emotional crises~~ each client to obtain ongoing care
70.12 and treatment; ~~and~~

70.13 (4) prevent placement in settings that are more intensive, costly, or restrictive than
70.14 necessary and appropriate to meet client needs; and

70.15 (5) provide support, psychoeducation, and referrals to each client's family members,
70.16 service providers, and other third parties on behalf of the client in need of emergency
70.17 services.

70.18 (b) If a county provides engagement services under section 253B.041, the county's
70.19 emergency service providers must refer clients to engagement services when the client
70.20 meets the criteria for engagement services.

70.21 Sec. 2. Minnesota Statutes 2020, section 245.469, subdivision 2, is amended to read:

70.22 Subd. 2. **Specific requirements.** (a) The county board shall require that all service
70.23 providers of emergency services to adults with mental illness provide immediate direct
70.24 access to a mental health professional during regular business hours. For evenings, weekends,
70.25 and holidays, the service may be by direct toll-free telephone access to a mental health
70.26 professional, a clinical trainee, or mental health practitioner, ~~or until January 1, 1991, a~~
70.27 ~~designated person with training in human services who receives clinical supervision from~~
70.28 ~~a mental health professional.~~

70.29 (b) The commissioner may waive the requirement in paragraph (a) that the evening,
70.30 weekend, and holiday service be provided by a mental health professional, clinical trainee,
70.31 or mental health practitioner ~~after January 1, 1991,~~ if the county documents that:

71.1 (1) mental health professionals, clinical trainees, or mental health practitioners are
71.2 unavailable to provide this service;

71.3 (2) services are provided by a designated person with training in human services who
71.4 receives ~~clinical~~ clinical treatment supervision from a mental health professional; and

71.5 (3) the service provider is not also the provider of fire and public safety emergency
71.6 services.

71.7 (c) The commissioner may waive the requirement in paragraph (b), clause (3), that the
71.8 evening, weekend, and holiday service not be provided by the provider of fire and public
71.9 safety emergency services if:

71.10 (1) every person who will be providing the first telephone contact has received at least
71.11 eight hours of training on emergency mental health services ~~reviewed by the state advisory~~
71.12 ~~council on mental health and then~~ approved by the commissioner;

71.13 (2) every person who will be providing the first telephone contact will annually receive
71.14 at least four hours of continued training on emergency mental health services ~~reviewed by~~
71.15 ~~the state advisory council on mental health and then~~ approved by the commissioner;

71.16 (3) the local social service agency has provided public education about available
71.17 emergency mental health services and can assure potential users of emergency services that
71.18 their calls will be handled appropriately;

71.19 (4) the local social service agency agrees to provide the commissioner with accurate
71.20 data on the number of emergency mental health service calls received;

71.21 (5) the local social service agency agrees to monitor the frequency and quality of
71.22 emergency services; and

71.23 (6) the local social service agency describes how it will comply with paragraph (d).

71.24 (d) Whenever emergency service during nonbusiness hours is provided by anyone other
71.25 than a mental health professional, a mental health professional must be available on call for
71.26 an emergency assessment and crisis intervention services, and must be available for at least
71.27 telephone consultation within 30 minutes.

71.28 Sec. 3. Minnesota Statutes 2020, section 245.4879, subdivision 1, is amended to read:

71.29 Subdivision 1. **Availability of emergency services.** County boards must provide or
71.30 contract for ~~enough~~ mental health emergency services ~~within the county to meet the needs~~
71.31 ~~of children, and children's families when clinically appropriate, in the county who are~~
71.32 ~~experiencing an emotional crisis or emotional disturbance. The county board shall ensure~~

72.1 ~~that parents, providers, and county residents are informed about when and how to access~~
72.2 ~~emergency mental health services for children. A child or the child's parent may be required~~
72.3 ~~to pay a fee according to section 245.481. Emergency service providers shall not delay the~~
72.4 ~~timely provision of emergency service because of delays in determining this fee or because~~
72.5 ~~of the unwillingness or inability of the parent to pay the fee. Emergency services must~~
72.6 ~~include assessment, crisis intervention, and appropriate case disposition. Emergency services~~
72.7 ~~must: according to section 245.469.~~

72.8 ~~(1) promote the safety and emotional stability of children with emotional disturbances~~
72.9 ~~or emotional crises;~~

72.10 ~~(2) minimize further deterioration of the child with emotional disturbance or emotional~~
72.11 ~~crisis;~~

72.12 ~~(3) help each child with an emotional disturbance or emotional crisis to obtain ongoing~~
72.13 ~~care and treatment; and~~

72.14 ~~(4) prevent placement in settings that are more intensive, costly, or restrictive than~~
72.15 ~~necessary and appropriate to meet the child's needs.~~

72.16 Sec. 4. Minnesota Statutes 2020, section 256B.0624, is amended to read:

72.17 **256B.0624 ADULT CRISIS RESPONSE SERVICES COVERED.**

72.18 Subdivision 1. **Scope.** ~~Medical assistance covers adult mental health crisis response~~
72.19 ~~services as defined in subdivision 2, paragraphs (c) to (e); (a) Subject to federal approval,~~
72.20 ~~if provided to a recipient as defined in subdivision 3 and provided by a qualified provider~~
72.21 ~~entity as defined in this section and by a qualified individual provider working within the~~
72.22 ~~provider's scope of practice and as defined in this subdivision and identified in the recipient's~~
72.23 ~~individual crisis treatment plan as defined in subdivision 11 and if determined to be medically~~
72.24 ~~necessary medical assistance covers medically necessary crisis response services when the~~
72.25 ~~services are provided according to the standards in this section.~~

72.26 ~~(b) Subject to federal approval, medical assistance covers medically necessary residential~~
72.27 ~~crisis stabilization for adults when the services are provided by an entity licensed under and~~
72.28 ~~meeting the standards in section 245I.23.~~

72.29 ~~(c) The provider entity must make reasonable and good faith efforts to report individual~~
72.30 ~~client outcomes to the commissioner using instruments and protocols approved by the~~
72.31 ~~commissioner.~~

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

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

73.8 ~~(b) "Mental health emergency" is an adult behavioral, emotional, or psychiatric situation~~
73.9 ~~which causes an immediate need for mental health services and is consistent with section~~
73.10 ~~62Q.55.~~

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

73.14 (a) "Certified rehabilitation specialist" means a staff person who is qualified under section
73.15 245I.04, subdivision 8.

73.16 (b) "Clinical trainee" means a staff person who is qualified under section 245I.04,
73.17 subdivision 6.

73.18 ~~(c) "Mental health Crisis assessment" means an immediate face-to-face assessment by~~
73.19 ~~a physician, a mental health professional, or mental health practitioner under the clinical~~
73.20 ~~supervision of a mental health professional, following a screening that suggests that the~~
73.21 ~~adult may be experiencing a mental health crisis or mental health emergency situation. It~~
73.22 ~~includes, when feasible, assessing whether the person might be willing to voluntarily accept~~
73.23 ~~treatment, determining whether the person has an advance directive, and obtaining~~
73.24 ~~information and history from involved family members or caretakers a qualified member~~
73.25 ~~of a crisis team, as described in subdivision 6a.~~

73.26 ~~(d) "Mental health mobile Crisis intervention services" means face-to-face, short-term~~
73.27 ~~intensive mental health services initiated during a mental health crisis or mental health~~
73.28 ~~emergency to help the recipient cope with immediate stressors, identify and utilize available~~
73.29 ~~resources and strengths, engage in voluntary treatment, and begin to return to the recipient's~~
73.30 ~~baseline level of functioning. The services, including screening and treatment plan~~
73.31 ~~recommendations, must be culturally and linguistically appropriate.~~

74.1 ~~(1) This service is provided on site by a mobile crisis intervention team outside of an~~
74.2 ~~inpatient hospital setting. Mental health mobile crisis intervention services must be available~~
74.3 ~~24 hours a day, seven days a week.~~

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

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

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

74.11 ~~(5) The team must be available to individuals who are experiencing a co-occurring~~
74.12 ~~substance use disorder, who do not need the level of care provided in a detoxification facility.~~

74.13 ~~(6) The treatment plan must include recommendations for any needed crisis stabilization~~
74.14 ~~services for the recipient, including engagement in treatment planning and family~~
74.15 ~~psychoeducation.~~

74.16 (e) "Crisis screening" means a screening of a client's potential mental health crisis
74.17 situation under subdivision 6.

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

74.25 (g) "Crisis team" means the staff of a provider entity who are supervised and prepared
74.26 to provide mobile crisis services to a client in a potential mental health crisis situation.

74.27 (h) "Mental health certified family peer specialist" means a staff person who is qualified
74.28 under section 245I.04, subdivision 12.

74.29 (i) "Mental health certified peer specialist" means a staff person who is qualified under
74.30 section 245I.04, subdivision 10.

74.31 (j) "Mental health crisis" is a behavioral, emotional, or psychiatric situation that, without
74.32 the provision of crisis response services, would likely result in significantly reducing the

75.1 recipient's levels of functioning in primary activities of daily living, in an emergency situation
75.2 under section 62Q.55, or in the placement of the recipient in a more restrictive setting,
75.3 including but not limited to inpatient hospitalization.

75.4 (k) "Mental health practitioner" means a staff person who is qualified under section
75.5 245I.04, subdivision 4.

75.6 (l) "Mental health professional" means a staff person who is qualified under section
75.7 245I.04, subdivision 2.

75.8 (m) "Mental health rehabilitation worker" means a staff person who is qualified under
75.9 section 245I.04, subdivision 14.

75.10 (n) "Mobile crisis services" means screening, assessment, intervention, and community
75.11 based stabilization, excluding residential crisis stabilization, that is provided to a recipient.

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

75.13 ~~(1) is age 18 or older;~~

75.14 ~~(2) is screened as possibly experiencing a mental health crisis or emergency where a~~
75.15 ~~mental health crisis assessment is needed; and~~

75.16 ~~(3) is assessed as experiencing a mental health crisis or emergency, and mental health~~
75.17 ~~crisis intervention or crisis intervention and stabilization services are determined to be~~
75.18 ~~medically necessary.~~

75.19 (a) A recipient is eligible for crisis assessment services when the recipient has screened
75.20 positive for a potential mental health crisis during a crisis screening.

75.21 (b) A recipient is eligible for crisis intervention services and crisis stabilization services
75.22 when the recipient has been assessed during a crisis assessment to be experiencing a mental
75.23 health crisis.

75.24 Subd. 4. **Provider entity standards.** ~~(a) A provider entity is an entity that meets the~~
75.25 ~~standards listed in paragraph (c) and~~ mobile crisis provider must be:

75.26 ~~(1) is a county board operated entity; or~~

75.27 (2) an Indian health services facility or facility owned and operated by a tribe or tribal
75.28 organization operating under United States Code, title 325, section 450f; or

75.29 ~~(2) is~~ (3) a provider entity that is under contract with the county board in the county
75.30 where the potential crisis or emergency is occurring. To provide services under this section,

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

76.3 (b) A mobile crisis provider must meet the following standards:

76.4 (1) must ensure that crisis screenings, crisis assessments, and crisis intervention services
 76.5 are available to a recipient 24 hours a day, seven days a week;

76.6 (2) must be able to respond to a call for services in a designated service area or according
 76.7 to a written agreement with the local mental health authority for an adjacent area;

76.8 (3) must have at least one mental health professional on staff at all times and at least
 76.9 one additional staff member capable of leading a crisis response in the community; and

76.10 (4) must provide the commissioner with information about the number of requests for
 76.11 service, the number of people that the provider serves face-to-face, outcomes, and the
 76.12 protocols that the provider uses when deciding when to respond in the community.

76.13 ~~(b)~~ (c) A provider entity that provides crisis stabilization services in a residential setting
 76.14 under subdivision 7 is not required to meet the requirements of ~~paragraph~~ paragraphs (a);
 76.15 ~~clauses (1) and (2) to (b),~~ but must meet all other requirements of this subdivision.

76.16 ~~(e) The adult mental health~~ (d) A crisis response services provider entity must have the
 76.17 capacity to meet and carry out the standards in section 245I.011, subdivision 5, and the
 76.18 following standards:

76.19 ~~(1) has the capacity to recruit, hire, and manage and train mental health professionals,~~
 76.20 ~~practitioners, and rehabilitation workers~~ ensures that staff persons provide support for a
 76.21 recipient's family and natural supports, by enabling the recipient's family and natural supports
 76.22 to observe and participate in the recipient's treatment, assessments, and planning services;

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

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

76.25 ~~(4)~~ (3) is able to ensure that staff providing these services are skilled in the delivery of
 76.26 mental health crisis response services to recipients;

76.27 ~~(5)~~ (4) is able to ensure that staff are ~~capable of~~ implementing culturally specific treatment
 76.28 identified in the individual crisis treatment plan that is meaningful and appropriate as
 76.29 determined by the recipient's culture, beliefs, values, and language;

76.30 ~~(6)~~ (5) is able to ensure enough flexibility to respond to the changing intervention and
 76.31 care needs of a recipient as identified by the recipient or family member during the service
 76.32 partnership between the recipient and providers;

77.1 ~~(7)~~ (6) is able to ensure that ~~mental health professionals and mental health practitioners~~
77.2 staff have the communication tools and procedures to communicate and consult promptly
77.3 about crisis assessment and interventions as services occur;

77.4 ~~(8)~~ (7) is able to coordinate these services with county emergency services, community
77.5 hospitals, ambulance, transportation services, social services, law enforcement, engagement
77.6 services, and mental health crisis services through regularly scheduled interagency meetings;

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

77.9 ~~(10)~~ (8) is able to ensure that services are coordinated with other ~~mental~~ behavioral
77.10 health service providers, county mental health authorities, or federally recognized American
77.11 Indian authorities and others as necessary, with the consent of the ~~adult~~ recipient or parent
77.12 or guardian. Services must also be coordinated with the recipient's case manager if the ~~adult~~
77.13 recipient is receiving case management services;

77.14 ~~(11)~~ (9) is able to ensure that crisis intervention services are provided in a manner
77.15 consistent with sections 245.461 to 245.486 and 245.487 to 245.4879;

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

77.17 ~~(13) maintains staff training and personnel files;~~

77.18 (10) is able to coordinate detoxification services for the recipient according to Minnesota
77.19 Rules, parts 9530.6605 to 9530.6655, or withdrawal management according to chapter 245F;

77.20 ~~(14)~~ (11) is able to establish and maintain a quality assurance and evaluation plan to
77.21 evaluate the outcomes of services and recipient satisfaction; and

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

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

77.24 ~~(17)~~ (12) is an enrolled medical assistance provider; ~~and~~ .

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

77.28 Subd. 4a. **Alternative provider standards.** If a county or tribe demonstrates that, due
77.29 to geographic or other barriers, it is not feasible to provide mobile crisis intervention services
77.30 according to the standards in subdivision 4, paragraph ~~(e)~~, clause (9) (b), the commissioner
77.31 may approve a ~~crisis response provider based on~~ an alternative plan proposed by a county
77.32 or group of counties tribe. The alternative plan must:

78.1 (1) result in increased access and a reduction in disparities in the availability of mobile
78.2 crisis services;

78.3 (2) provide mobile crisis services outside of the usual nine-to-five office hours and on
78.4 weekends and holidays; and

78.5 (3) comply with standards for emergency mental health services in section 245.469.

78.6 Subd. 5. **Mobile Crisis assessment and intervention staff qualifications.** ~~For provision~~
78.7 ~~of adult mental health mobile crisis intervention services, a mobile crisis intervention team~~
78.8 ~~is comprised of at least two mental health professionals as defined in section 245.462,~~
78.9 ~~subdivision 18, clauses (1) to (6), or a combination of at least one mental health professional~~
78.10 ~~and one mental health practitioner as defined in section 245.462, subdivision 17, with the~~
78.11 ~~required mental health crisis training and under the clinical supervision of a mental health~~
78.12 ~~professional on the team. The team must have at least two people with at least one member~~
78.13 ~~providing on-site crisis intervention services when needed. (a) Qualified individual staff of~~
78.14 a qualified provider entity must provide crisis assessment and intervention services to a
78.15 recipient. A staff member providing crisis assessment and intervention services to a recipient
78.16 must be qualified as a:

78.17 (1) mental health professional;

78.18 (2) clinical trainee;

78.19 (3) mental health practitioner;

78.20 (4) mental health certified family peer specialist; or

78.21 (5) mental health certified peer specialist.

78.22 (b) When crisis assessment and intervention services are provided to a recipient in the
78.23 community, a mental health professional, clinical trainee, or mental health practitioner must
78.24 lead the response.

78.25 (c) The 30 hours of ongoing training required by section 245I.05, subdivision 4, paragraph
78.26 (b), must be specific to providing crisis services to children and adults and include training
78.27 about evidence-based practices identified by the commissioner of health to reduce the
78.28 recipient's risk of suicide and self-injurious behavior.

78.29 (d) Team members must be experienced in ~~mental health~~ crisis assessment, crisis
78.30 intervention techniques, treatment engagement strategies, working with families, and clinical
78.31 decision-making under emergency conditions and have knowledge of local services and
78.32 resources. ~~The team must recommend and coordinate the team's services with appropriate~~

79.1 ~~local resources such as the county social services agency, mental health services, and local~~
79.2 ~~law enforcement when necessary.~~

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

79.10 (b) When conducting the crisis screening of a recipient, a provider must:

79.11 (1) employ evidence-based practices to reduce the recipient's risk of suicide and
79.12 self-injurious behavior;

79.13 (2) work with the recipient to establish a plan and time frame for responding to the
79.14 recipient's mental health crisis, including responding to the recipient's immediate need for
79.15 support by telephone or text message until the provider can respond to the recipient
79.16 face-to-face;

79.17 (3) document significant factors in determining whether the recipient is experiencing a
79.18 mental health crisis, including prior requests for crisis services, a recipient's recent
79.19 presentation at an emergency department, known calls to 911 or law enforcement, or
79.20 information from third parties with knowledge of a recipient's history or current needs;

79.21 (4) accept calls from interested third parties and consider the additional needs or potential
79.22 mental health crises that the third parties may be experiencing;

79.23 (5) provide psychoeducation, including means reduction, to relevant third parties
79.24 including family members or other persons living with the recipient; and

79.25 (6) consider other available services to determine which service intervention would best
79.26 address the recipient's needs and circumstances.

79.27 (c) For the purposes of this section, the following situations indicate a positive screen
79.28 for a potential mental health crisis and the provider must prioritize providing a face-to-face
79.29 crisis assessment of the recipient, unless a provider documents specific evidence to show
79.30 why this was not possible, including insufficient staffing resources, concerns for staff or
79.31 recipient safety, or other clinical factors:

79.32 (1) the recipient presents at an emergency department or urgent care setting and the
79.33 health care team at that location requested crisis services; or

80.1 (2) a peace officer requested crisis services for a recipient who is potentially subject to
80.2 transportation under section 253B.051.

80.3 (d) A provider is not required to have direct contact with the recipient to determine that
80.4 the recipient is experiencing a potential mental health crisis. A mobile crisis provider may
80.5 gather relevant information about the recipient from a third party at the scene to establish
80.6 the recipient's need for services and potential safety factors.

80.7 Subd. 6a. **Crisis assessment.** ~~(b)~~ (a) If a ~~crisis exists~~ recipient screens positive for
80.8 potential mental health crisis, a crisis assessment must be completed. A crisis assessment
80.9 evaluates any immediate needs for which emergency services are needed and, as time
80.10 permits, the recipient's current life situation, health information, including current
80.11 medications, sources of stress, mental health problems and symptoms, strengths, cultural
80.12 considerations, support network, vulnerabilities, current functioning, and the recipient's
80.13 preferences as communicated directly by the recipient, or as communicated in a health care
80.14 directive as described in chapters 145C and 253B, the crisis treatment plan described under
80.15 ~~paragraph (d)~~ subdivision 11, a crisis prevention plan, or a wellness recovery action plan.

80.16 (b) A provider must conduct a crisis assessment at the recipient's location whenever
80.17 possible.

80.18 (c) Whenever possible, the assessor must attempt to include input from the recipient and
80.19 the recipient's family and other natural supports to assess whether a crisis exists.

80.20 (d) A crisis assessment includes determining: (1) whether the recipient is willing to
80.21 voluntarily engage in treatment or (2) has an advance directive and (3) gathering the
80.22 recipient's information and history from involved family or other natural supports.

80.23 (e) A crisis assessment must include coordinated response with other health care providers
80.24 if the assessment indicates that a recipient needs detoxification, withdrawal management,
80.25 or medical stabilization in addition to crisis response services. If the recipient does not need
80.26 an acute level of care, a team must serve an otherwise eligible recipient who has a
80.27 co-occurring substance use disorder.

80.28 (f) If, after completing a crisis assessment of a recipient, a provider refers a recipient to
80.29 an intensive setting, including an emergency department, inpatient hospitalization, or
80.30 residential crisis stabilization, one of the crisis team members who completed or conferred
80.31 about the recipient's crisis assessment must immediately contact the referral entity and
80.32 consult with the triage nurse or other staff responsible for intake at the referral entity. During
80.33 the consultation, the crisis team member must convey key findings or concerns that led to
80.34 the recipient's referral. Following the immediate consultation, the provider must also send

81.1 written documentation upon completion. The provider must document if these releases
81.2 occurred with authorization by the recipient, the recipient's legal guardian, or as allowed
81.3 by section 144.293, subdivision 5.

81.4 Subd. 6b. Crisis intervention services. ~~(e)~~ (a) If the crisis assessment determines mobile
81.5 crisis intervention services are needed, the crisis intervention services must be provided
81.6 promptly. As opportunity presents during the intervention, at least two members of the
81.7 mobile crisis intervention team must confer directly or by telephone about the crisis
81.8 assessment, crisis treatment plan, and actions taken and needed. At least one of the team
81.9 members must be ~~on-site~~ providing face-to-face crisis intervention services. If providing
81.10 ~~on-site~~ crisis intervention services, a clinical trainee or mental health practitioner must seek
81.11 ~~clinical~~ treatment supervision as required in subdivision 9.

81.12 (b) If a provider delivers crisis intervention services while the recipient is absent, the
81.13 provider must document the reason for delivering services while the recipient is absent.

81.14 ~~(d)~~ (c) The mobile crisis intervention team must develop ~~an initial, brief~~ a crisis treatment
81.15 ~~plan as soon as appropriate but no later than 24 hours after the initial face-to-face intervention~~
81.16 according to subdivision 11. The plan must address the needs and problems noted in the
81.17 ~~crisis assessment and include measurable short-term goals, cultural considerations, and~~
81.18 ~~frequency and type of services to be provided to achieve the goals and reduce or eliminate~~
81.19 ~~the crisis. The treatment plan must be updated as needed to reflect current goals and services.~~

81.20 ~~(e)~~ (d) The mobile crisis intervention team must document which ~~short-term goals~~ crisis
81.21 treatment plan goals and objectives have been met and when no further crisis intervention
81.22 services are required.

81.23 ~~(f)~~ (e) If the recipient's mental health crisis is stabilized, but the recipient needs a referral
81.24 to other services, the team must provide referrals to these services. If the recipient has a
81.25 case manager, planning for other services must be coordinated with the case manager. If
81.26 the recipient is unable to follow up on the referral, the team must link the recipient to the
81.27 service and follow up to ensure the recipient is receiving the service.

81.28 ~~(g)~~ (f) If the recipient's mental health crisis is stabilized and the recipient does not have
81.29 an advance directive, the case manager or crisis team shall offer to work with the recipient
81.30 to develop one.

81.31 Subd. 7. Crisis stabilization services. (a) Crisis stabilization services must be provided
81.32 by qualified staff of a crisis stabilization services provider entity and must meet the following
81.33 standards:

82.1 (1) a crisis ~~stabilization~~ treatment plan must be developed ~~which~~ that meets the criteria
82.2 in subdivision 11;

82.3 (2) staff must be qualified as defined in subdivision 8; ~~and~~

82.4 (3) crisis stabilization services must be delivered according to the crisis treatment plan
82.5 and include face-to-face contact with the recipient by qualified staff for further assessment,
82.6 help with referrals, updating of the crisis ~~stabilization~~ treatment plan, ~~supportive counseling,~~
82.7 skills training, and collaboration with other service providers in the community; and

82.8 (4) if a provider delivers crisis stabilization services while the recipient is absent, the
82.9 provider must document the reason for delivering services while the recipient is absent.

82.10 ~~(b) If crisis stabilization services are provided in a supervised, licensed residential setting,~~
82.11 ~~the recipient must be contacted face-to-face daily by a qualified mental health practitioner~~
82.12 ~~or mental health professional. The program must have 24-hour-a-day residential staffing~~
82.13 ~~which may include staff who do not meet the qualifications in subdivision 8. The residential~~
82.14 ~~staff must have 24-hour-a-day immediate direct or telephone access to a qualified mental~~
82.15 ~~health professional or practitioner.~~

82.16 ~~(e)~~ (b) If crisis stabilization services are provided in a supervised, licensed residential
82.17 setting that serves no more than four adult residents, and one or more individuals are present
82.18 at the setting to receive residential crisis stabilization ~~services~~, the residential staff must
82.19 include, for at least eight hours per day, at least one ~~individual who meets the qualifications~~
82.20 ~~in subdivision 8, paragraph (a), clause (1) or (2)~~ mental health professional, clinical trainee,
82.21 certified rehabilitation specialist, or mental health practitioner.

82.22 ~~(d) If crisis stabilization services are provided in a supervised, licensed residential setting~~
82.23 ~~that serves more than four adult residents, and one or more are recipients of crisis stabilization~~
82.24 ~~services, the residential staff must include, for 24 hours a day, at least one individual who~~
82.25 ~~meets the qualifications in subdivision 8. During the first 48 hours that a recipient is in the~~
82.26 ~~residential program, the residential program must have at least two staff working 24 hours~~
82.27 ~~a day. Staffing levels may be adjusted thereafter according to the needs of the recipient as~~
82.28 ~~specified in the crisis stabilization treatment plan.~~

82.29 Subd. 8. **Adult Crisis stabilization staff qualifications.** (a) ~~Adult~~ Mental health crisis
82.30 stabilization services must be provided by qualified individual staff of a qualified provider
82.31 entity. ~~Individual provider staff must have the following qualifications~~ A staff member
82.32 providing crisis stabilization services to a recipient must be qualified as a:

83.1 (1) ~~be a mental health professional as defined in section 245.462, subdivision 18, clauses~~
83.2 ~~(1) to (6);~~

83.3 (2) ~~be a~~ certified rehabilitation specialist;

83.4 (3) clinical trainee;

83.5 (4) mental health practitioner as defined in section 245.462, subdivision 17. The mental
83.6 health practitioner must work under the clinical supervision of a mental health professional;

83.7 (5) mental health certified family peer specialist;

83.8 (3) ~~be a~~ (6) mental health certified peer specialist under section 256B.0615. The certified
83.9 peer specialist must work under the clinical supervision of a mental health professional; or

83.10 (4) ~~be a~~ (7) mental health rehabilitation worker who meets the criteria in section
83.11 256B.0623, subdivision 5, paragraph (a), clause (4); works under the direction of a mental
83.12 health practitioner as defined in section 245.462, subdivision 17, or under direction of a
83.13 mental health professional; and works under the clinical supervision of a mental health
83.14 professional.

83.15 (b) ~~Mental health practitioners and mental health rehabilitation workers must have~~
83.16 ~~completed at least 30 hours of training in crisis intervention and stabilization during the~~
83.17 ~~past two years. The 30 hours of ongoing training required in section 245I.05, subdivision~~
83.18 ~~4, paragraph (b), must be specific to providing crisis services to children and adults and~~
83.19 ~~include training about evidence-based practices identified by the commissioner of health~~
83.20 ~~to reduce a recipient's risk of suicide and self-injurious behavior.~~

83.21 Subd. 9. **Supervision.** Clinical trainees and mental health practitioners may provide
83.22 crisis assessment and mobile crisis intervention services if the following clinical treatment
83.23 supervision requirements are met:

83.24 (1) the mental health provider entity must accept full responsibility for the services
83.25 provided;

83.26 (2) the mental health professional of the provider entity, ~~who is an employee or under~~
83.27 ~~contract with the provider entity,~~ must be immediately available by phone or in person for
83.28 clinical treatment supervision;

83.29 (3) the mental health professional is consulted, in person or by phone, during the first
83.30 three hours when a clinical trainee or mental health practitioner provides on-site service
83.31 crisis assessment or crisis intervention services; and

83.32 (4) the mental health professional must:

84.1 (i) review and approve, as defined in section 245I.02, subdivision 2, of the tentative
84.2 crisis assessment and crisis treatment plan within 24 hours of first providing services to the
84.3 recipient, notwithstanding section 245I.08, subdivision 3; and

84.4 (ii) document the consultation required in clause (3).; and

84.5 ~~(iii) sign the crisis assessment and treatment plan within the next business day;~~

84.6 ~~(5) if the mobile crisis intervention services continue into a second calendar day, a mental~~
84.7 ~~health professional must contact the recipient face-to-face on the second day to provide~~
84.8 ~~services and update the crisis treatment plan; and~~

84.9 ~~(6) the on-site observation must be documented in the recipient's record and signed by~~
84.10 ~~the mental health professional.~~

84.11 ~~Subd. 10. **Recipient file.** Providers of mobile crisis intervention or crisis stabilization~~
84.12 ~~services must maintain a file for each recipient containing the following information:~~

84.13 ~~(1) individual crisis treatment plans signed by the recipient, mental health professional,~~
84.14 ~~and mental health practitioner who developed the crisis treatment plan, or if the recipient~~
84.15 ~~refused to sign the plan, the date and reason stated by the recipient as to why the recipient~~
84.16 ~~would not sign the plan;~~

84.17 ~~(2) signed release forms;~~

84.18 ~~(3) recipient health information and current medications;~~

84.19 ~~(4) emergency contacts for the recipient;~~

84.20 ~~(5) case records which document the date of service, place of service delivery, signature~~
84.21 ~~of the person providing the service, and the nature, extent, and units of service. Direct or~~
84.22 ~~telephone contact with the recipient's family or others should be documented;~~

84.23 ~~(6) required clinical supervision by mental health professionals;~~

84.24 ~~(7) summary of the recipient's case reviews by staff;~~

84.25 ~~(8) any written information by the recipient that the recipient wants in the file; and~~

84.26 ~~(9) an advance directive, if there is one available.~~

84.27 ~~Documentation in the file must comply with all requirements of the commissioner.~~

84.28 Subd. 11. **Crisis treatment plan.** The individual crisis stabilization treatment plan must
84.29 include, at a minimum:

84.30 (1) a list of problems identified in the assessment;

- 85.1 ~~(2) a list of the recipient's strengths and resources;~~
- 85.2 ~~(3) concrete, measurable short-term goals and tasks to be achieved, including time frames~~
- 85.3 ~~for achievement;~~
- 85.4 ~~(4) specific objectives directed toward the achievement of each one of the goals;~~
- 85.5 ~~(5) documentation of the participants involved in the service planning. The recipient, if~~
- 85.6 ~~possible, must be a participant. The recipient or the recipient's legal guardian must sign the~~
- 85.7 ~~service plan or documentation must be provided why this was not possible. A copy of the~~
- 85.8 ~~plan must be given to the recipient and the recipient's legal guardian. The plan should include~~
- 85.9 ~~services arranged, including specific providers where applicable;~~
- 85.10 ~~(6) planned frequency and type of services initiated;~~
- 85.11 ~~(7) a crisis response action plan if a crisis should occur;~~
- 85.12 ~~(8) clear progress notes on outcome of goals;~~
- 85.13 ~~(9) a written plan must be completed within 24 hours of beginning services with the~~
- 85.14 ~~recipient; and~~
- 85.15 ~~(10) a treatment plan must be developed by a mental health professional or mental health~~
- 85.16 ~~practitioner under the clinical supervision of a mental health professional. The mental health~~
- 85.17 ~~professional must approve and sign all treatment plans.~~
- 85.18 (a) Within 24 hours of the recipient's admission, the provider entity must complete the
- 85.19 recipient's crisis treatment plan. The provider entity must:
- 85.20 (1) base the recipient's crisis treatment plan on the recipient's crisis assessment;
- 85.21 (2) consider crisis assistance strategies that have been effective for the recipient in the
- 85.22 past;
- 85.23 (3) for a child recipient, use a child-centered, family-driven, and culturally appropriate
- 85.24 planning process that allows the recipient's parents and guardians to observe or participate
- 85.25 in the recipient's individual and family treatment services, assessment, and treatment
- 85.26 planning;
- 85.27 (4) for an adult recipient, use a person-centered, culturally appropriate planning process
- 85.28 that allows the recipient's family and other natural supports to observe or participate in
- 85.29 treatment services, assessment, and treatment planning;
- 85.30 (5) identify the participants involved in the recipient's treatment planning. The recipient,
- 85.31 if possible, must be a participant;

86.1 (6) identify the recipient's initial treatment goals, measurable treatment objectives, and
86.2 specific interventions that the license holder will use to help the recipient engage in treatment;

86.3 (7) include documentation of referral to and scheduling of services, including specific
86.4 providers where applicable;

86.5 (8) ensure that the recipient or the recipient's legal guardian approves under section
86.6 245I.02, subdivision 2, of the recipient's crisis treatment plan unless a court orders the
86.7 recipient's treatment plan under chapter 253B. If the recipient or the recipient's legal guardian
86.8 disagrees with the crisis treatment plan, the license holder must document in the client file
86.9 the reasons why the recipient disagrees with the crisis treatment plan; and

86.10 (9) ensure that a treatment supervisor approves under section 245I.02, subdivision 2, of
86.11 the recipient's treatment plan within 24 hours of the recipient's admission if a mental health
86.12 practitioner or clinical trainee completes the crisis treatment plan, notwithstanding section
86.13 245I.08, subdivision 3.

86.14 (b) The provider entity must provide the recipient and the recipient's legal guardian with
86.15 a copy of the recipient's crisis treatment plan.

86.16 Subd. 12. **Excluded services.** The following services are excluded from reimbursement
86.17 under this section:

86.18 (1) room and board services;

86.19 (2) services delivered to a recipient while admitted to an inpatient hospital;

86.20 (3) recipient transportation costs may be covered under other medical assistance
86.21 provisions, but transportation services are not an adult mental health crisis response service;

86.22 (4) services provided and billed by a provider who is not enrolled under medical
86.23 assistance to provide adult mental health crisis response services;

86.24 (5) services performed by volunteers;

86.25 (6) direct billing of time spent "on call" when not delivering services to a recipient;

86.26 (7) provider service time included in case management reimbursement. When a provider
86.27 is eligible to provide more than one type of medical assistance service, the recipient must
86.28 have a choice of provider for each service, unless otherwise provided for by law;

86.29 (8) outreach services to potential recipients; and

86.30 (9) a mental health service that is not medically necessary;

87.1 (10) services that a residential treatment center licensed under Minnesota Rules, chapter
87.2 2960, provides to a client;

87.3 (11) partial hospitalization or day treatment; and

87.4 (12) a crisis assessment that a residential provider completes when a daily rate is paid
87.5 for the recipient's crisis stabilization.

87.6 ARTICLE 3

87.7 UNIFORM SERVICE STANDARDS; CONFORMING CHANGES

87.8 Section 1. Minnesota Statutes 2020, section 62A.152, subdivision 3, is amended to read:

87.9 Subd. 3. **Provider discrimination prohibited.** All group policies and group subscriber
87.10 contracts that provide benefits for mental or nervous disorder treatments in a hospital must
87.11 provide direct reimbursement for those services if performed by a mental health professional;
87.12 ~~as defined in sections 245.462, subdivision 18, clauses (1) to (5); and 245.4871, subdivision~~
87.13 ~~27, clauses (1) to (5)~~ qualified according to section 245I.04, subdivision 2, to the extent that
87.14 the services and treatment are within the scope of mental health professional licensure.

87.15 This subdivision is intended to provide payment of benefits for mental or nervous disorder
87.16 treatments performed by a licensed mental health professional in a hospital and is not
87.17 intended to change or add benefits for those services provided in policies or contracts to
87.18 which this subdivision applies.

87.19 Sec. 2. Minnesota Statutes 2020, section 62A.3094, subdivision 1, is amended to read:

87.20 Subdivision 1. **Definitions.** (a) For purposes of this section, the terms defined in
87.21 paragraphs (b) to (d) have the meanings given.

87.22 (b) "Autism spectrum disorders" means the conditions as determined by criteria set forth
87.23 in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of
87.24 the American Psychiatric Association.

87.25 (c) "Medically necessary care" means health care services appropriate, in terms of type,
87.26 frequency, level, setting, and duration, to the enrollee's condition, and diagnostic testing
87.27 and preventative services. Medically necessary care must be consistent with generally
87.28 accepted practice parameters as determined by physicians and licensed psychologists who
87.29 typically manage patients who have autism spectrum disorders.

87.30 (d) "Mental health professional" means a mental health professional ~~as defined in section~~
87.31 ~~245.4871, subdivision 27~~ qualified according to section 245I.04, subdivision 2, clause (1),

88.1 (2), (3), (4), or (6), who has training and expertise in autism spectrum disorder and child
88.2 development.

88.3 Sec. 3. Minnesota Statutes 2020, section 62Q.096, is amended to read:

88.4 **62Q.096 CREDENTIALING OF PROVIDERS.**

88.5 If a health plan company has initially credentialed, as providers in its provider network,
88.6 individual providers employed by or under contract with an entity that:

88.7 (1) is authorized to bill under section 256B.0625, subdivision 5;

88.8 (2) ~~meets the requirements of Minnesota Rules, parts 9520.0750 to 9520.0870~~ is a mental
88.9 health clinic certified under section 245I.20;

88.10 (3) is designated an essential community provider under section 62Q.19; and

88.11 (4) is under contract with the health plan company to provide mental health services,
88.12 the health plan company must continue to credential at least the same number of providers
88.13 from that entity, as long as those providers meet the health plan company's credentialing
88.14 standards.

88.15 A health plan company shall not refuse to credential these providers on the grounds that
88.16 their provider network has a sufficient number of providers of that type.

88.17 Sec. 4. Minnesota Statutes 2020, section 144.651, subdivision 2, is amended to read:

88.18 Subd. 2. **Definitions.** For the purposes of this section, "patient" means a person who is
88.19 admitted to an acute care inpatient facility for a continuous period longer than 24 hours, for
88.20 the purpose of diagnosis or treatment bearing on the physical or mental health of that person.
88.21 For purposes of subdivisions 4 to 9, 12, 13, 15, 16, and 18 to 20, "patient" also means a
88.22 person who receives health care services at an outpatient surgical center or at a birth center
88.23 licensed under section 144.615. "Patient" also means a minor who is admitted to a residential
88.24 program as defined in section 253C.01. For purposes of subdivisions 1, 3 to 16, 18, 20 and
88.25 30, "patient" also means any person who is receiving mental health treatment on an outpatient
88.26 basis or in a community support program or other community-based program. "Resident"
88.27 means a person who is admitted to a nonacute care facility including extended care facilities,
88.28 nursing homes, and boarding care homes for care required because of prolonged mental or
88.29 physical illness or disability, recovery from injury or disease, or advancing age. For purposes
88.30 of all subdivisions except subdivisions 28 and 29, "resident" also means a person who is
88.31 admitted to a facility licensed as a board and lodging facility under Minnesota Rules, parts
88.32 4625.0100 to 4625.2355, a boarding care home under sections 144.50 to 144.56, or a

89.1 supervised living facility under Minnesota Rules, parts 4665.0100 to 4665.9900, and which
89.2 operates a rehabilitation program licensed under chapter 245G or 245I, or Minnesota Rules,
89.3 parts 9530.6510 to 9530.6590.

89.4 Sec. 5. Minnesota Statutes 2020, section 144D.01, subdivision 4, is amended to read:

89.5 Subd. 4. **Housing with services establishment or establishment.** (a) "Housing with
89.6 services establishment" or "establishment" means:

89.7 (1) an establishment providing sleeping accommodations to one or more adult residents,
89.8 at least 80 percent of which are 55 years of age or older, and offering or providing, for a
89.9 fee, one or more regularly scheduled health-related services or two or more regularly
89.10 scheduled supportive services, whether offered or provided directly by the establishment
89.11 or by another entity arranged for by the establishment; or

89.12 (2) an establishment that registers under section 144D.025.

89.13 (b) Housing with services establishment does not include:

89.14 (1) a nursing home licensed under chapter 144A;

89.15 (2) a hospital, certified boarding care home, or supervised living facility licensed under
89.16 sections 144.50 to 144.56;

89.17 (3) a board and lodging establishment licensed under chapter 157 and Minnesota Rules,
89.18 parts 9520.0500 to 9520.0670, or under chapter 245D ~~or~~, 245G, or 245I;

89.19 (4) a board and lodging establishment which serves as a shelter for battered women or
89.20 other similar purpose;

89.21 (5) a family adult foster care home licensed by the Department of Human Services;

89.22 (6) private homes in which the residents are related by kinship, law, or affinity with the
89.23 providers of services;

89.24 (7) residential settings for persons with developmental disabilities in which the services
89.25 are licensed under chapter 245D;

89.26 (8) a home-sharing arrangement such as when an elderly or disabled person or
89.27 single-parent family makes lodging in a private residence available to another person in
89.28 exchange for services or rent, or both;

89.29 (9) a duly organized condominium, cooperative, common interest community, or owners'
89.30 association of the foregoing where at least 80 percent of the units that comprise the

90.1 condominium, cooperative, or common interest community are occupied by individuals
90.2 who are the owners, members, or shareholders of the units;

90.3 (10) services for persons with developmental disabilities that are provided under a license
90.4 under chapter 245D; or

90.5 (11) a temporary family health care dwelling as defined in sections 394.307 and 462.3593.

90.6 Sec. 6. Minnesota Statutes 2020, section 144G.08, subdivision 7, as amended by Laws
90.7 2020, Seventh Special Session chapter 1, article 6, section 5, is amended to read:

90.8 Subd. 7. **Assisted living facility.** "Assisted living facility" means a facility that provides
90.9 sleeping accommodations and assisted living services to one or more adults. Assisted living
90.10 facility includes assisted living facility with dementia care, and does not include:

90.11 (1) emergency shelter, transitional housing, or any other residential units serving
90.12 exclusively or primarily homeless individuals, as defined under section 116L.361;

90.13 (2) a nursing home licensed under chapter 144A;

90.14 (3) a hospital, certified boarding care, or supervised living facility licensed under sections
90.15 144.50 to 144.56;

90.16 (4) a lodging establishment licensed under chapter 157 and Minnesota Rules, parts
90.17 9520.0500 to 9520.0670, or under chapter 245D ~~or~~, 245G, or 245I;

90.18 (5) services and residential settings licensed under chapter 245A, including adult foster
90.19 care and services and settings governed under the standards in chapter 245D;

90.20 (6) a private home in which the residents are related by kinship, law, or affinity with the
90.21 provider of services;

90.22 (7) a duly organized condominium, cooperative, and common interest community, or
90.23 owners' association of the condominium, cooperative, and common interest community
90.24 where at least 80 percent of the units that comprise the condominium, cooperative, or
90.25 common interest community are occupied by individuals who are the owners, members, or
90.26 shareholders of the units;

90.27 (8) a temporary family health care dwelling as defined in sections 394.307 and 462.3593;

90.28 (9) a setting offering services conducted by and for the adherents of any recognized
90.29 church or religious denomination for its members exclusively through spiritual means or
90.30 by prayer for healing;

91.1 (10) housing financed pursuant to sections 462A.37 and 462A.375, units financed with
91.2 low-income housing tax credits pursuant to United States Code, title 26, section 42, and
91.3 units financed by the Minnesota Housing Finance Agency that are intended to serve
91.4 individuals with disabilities or individuals who are homeless, except for those developments
91.5 that market or hold themselves out as assisted living facilities and provide assisted living
91.6 services;

91.7 (11) rental housing developed under United States Code, title 42, section 1437, or United
91.8 States Code, title 12, section 1701q;

91.9 (12) rental housing designated for occupancy by only elderly or elderly and disabled
91.10 residents under United States Code, title 42, section 1437e, or rental housing for qualifying
91.11 families under Code of Federal Regulations, title 24, section 983.56;

91.12 (13) rental housing funded under United States Code, title 42, chapter 89, or United
91.13 States Code, title 42, section 8011;

91.14 (14) a covered setting as defined in section 325F.721, subdivision 1, paragraph (b); or

91.15 (15) any establishment that exclusively or primarily serves as a shelter or temporary
91.16 shelter for victims of domestic or any other form of violence.

91.17 Sec. 7. Minnesota Statutes 2020, section 148B.5301, subdivision 2, is amended to read:

91.18 Subd. 2. **Supervision.** (a) To qualify as a LPCC, an applicant must have completed
91.19 4,000 hours of post-master's degree supervised professional practice in the delivery of
91.20 clinical services in the diagnosis and treatment of mental illnesses and disorders in both
91.21 children and adults. The supervised practice shall be conducted according to the requirements
91.22 in paragraphs (b) to (e).

91.23 (b) The supervision must have been received under a contract that defines clinical practice
91.24 and supervision from a mental health professional ~~as defined in section 245.462, subdivision~~
91.25 ~~18, clauses (1) to (6), or 245.4871, subdivision 27, clauses (1) to (6)~~ qualified according to
91.26 section 245I.04, subdivision 2, or by a board-approved supervisor, who has at least two
91.27 years of postlicensure experience in the delivery of clinical services in the diagnosis and
91.28 treatment of mental illnesses and disorders. All supervisors must meet the supervisor
91.29 requirements in Minnesota Rules, part 2150.5010.

91.30 (c) The supervision must be obtained at the rate of two hours of supervision per 40 hours
91.31 of professional practice. The supervision must be evenly distributed over the course of the
91.32 supervised professional practice. At least 75 percent of the required supervision hours must
91.33 be received in person. The remaining 25 percent of the required hours may be received by

92.1 telephone or by audio or audiovisual electronic device. At least 50 percent of the required
92.2 hours of supervision must be received on an individual basis. The remaining 50 percent
92.3 may be received in a group setting.

92.4 (d) The supervised practice must include at least 1,800 hours of clinical client contact.

92.5 (e) The supervised practice must be clinical practice. Supervision includes the observation
92.6 by the supervisor of the successful application of professional counseling knowledge, skills,
92.7 and values in the differential diagnosis and treatment of psychosocial function, disability,
92.8 or impairment, including addictions and emotional, mental, and behavioral disorders.

92.9 Sec. 8. Minnesota Statutes 2020, section 148E.120, subdivision 2, is amended to read:

92.10 Subd. 2. **Alternate supervisors.** (a) The board may approve an alternate supervisor as
92.11 determined in this subdivision. The board shall approve up to 25 percent of the required
92.12 supervision hours by a ~~licensed~~ mental health professional who is competent and qualified
92.13 to provide supervision according to the mental health professional's respective licensing
92.14 board, as established by section ~~245.462, subdivision 18, clauses (1) to (6), or 245.4871,~~
92.15 ~~subdivision 27, clauses (1) to (6)~~ 245I.04, subdivision 2.

92.16 (b) The board shall approve up to 100 percent of the required supervision hours by an
92.17 alternate supervisor if the board determines that:

92.18 (1) there are five or fewer supervisors in the county where the licensee practices social
92.19 work who meet the applicable licensure requirements in subdivision 1;

92.20 (2) the supervisor is an unlicensed social worker who is employed in, and provides the
92.21 supervision in, a setting exempt from licensure by section 148E.065, and who has
92.22 qualifications equivalent to the applicable requirements specified in sections 148E.100 to
92.23 148E.115;

92.24 (3) the supervisor is a social worker engaged in authorized social work practice in Iowa,
92.25 Manitoba, North Dakota, Ontario, South Dakota, or Wisconsin, and has the qualifications
92.26 equivalent to the applicable requirements in sections 148E.100 to 148E.115; or

92.27 (4) the applicant or licensee is engaged in nonclinical authorized social work practice
92.28 outside of Minnesota and the supervisor meets the qualifications equivalent to the applicable
92.29 requirements in sections 148E.100 to 148E.115, or the supervisor is an equivalent mental
92.30 health professional, as determined by the board, who is credentialed by a state, territorial,
92.31 provincial, or foreign licensing agency; or

93.1 (5) the applicant or licensee is engaged in clinical authorized social work practice outside
93.2 of Minnesota and the supervisor meets qualifications equivalent to the applicable
93.3 requirements in section 148E.115, or the supervisor is an equivalent mental health
93.4 professional as determined by the board, who is credentialed by a state, territorial, provincial,
93.5 or foreign licensing agency.

93.6 (c) In order for the board to consider an alternate supervisor under this section, the
93.7 licensee must:

93.8 (1) request in the supervision plan and verification submitted according to section
93.9 148E.125 that an alternate supervisor conduct the supervision; and

93.10 (2) describe the proposed supervision and the name and qualifications of the proposed
93.11 alternate supervisor. The board may audit the information provided to determine compliance
93.12 with the requirements of this section.

93.13 Sec. 9. Minnesota Statutes 2020, section 148F.11, subdivision 1, is amended to read:

93.14 Subdivision 1. **Other professionals.** (a) Nothing in this chapter prevents members of
93.15 other professions or occupations from performing functions for which they are qualified or
93.16 licensed. This exception includes, but is not limited to: licensed physicians; registered nurses;
93.17 licensed practical nurses; licensed psychologists and licensed psychological practitioners;
93.18 members of the clergy provided such services are provided within the scope of regular
93.19 ministries; American Indian medicine men and women; licensed attorneys; probation officers;
93.20 licensed marriage and family therapists; licensed social workers; social workers employed
93.21 by city, county, or state agencies; licensed professional counselors; licensed professional
93.22 clinical counselors; licensed school counselors; registered occupational therapists or
93.23 occupational therapy assistants; Upper Midwest Indian Council on Addictive Disorders
93.24 (UMICAD) certified counselors when providing services to Native American people; city,
93.25 county, or state employees when providing assessments or case management under Minnesota
93.26 Rules, chapter 9530; and individuals defined in section 256B.0623, subdivision 5, paragraph
93.27 (a), clauses (1) ~~and (2)~~ to (6), providing integrated dual diagnosis co-occurring substance
93.28 use disorder treatment in adult mental health rehabilitative programs certified or licensed
93.29 by the Department of Human Services under section 245I.23, 256B.0622, or 256B.0623.

93.30 (b) Nothing in this chapter prohibits technicians and resident managers in programs
93.31 licensed by the Department of Human Services from discharging their duties as provided
93.32 in Minnesota Rules, chapter 9530.

94.1 (c) Any person who is exempt from licensure under this section must not use a title
94.2 incorporating the words "alcohol and drug counselor" or "licensed alcohol and drug
94.3 counselor" or otherwise hold himself or herself out to the public by any title or description
94.4 stating or implying that he or she is engaged in the practice of alcohol and drug counseling,
94.5 or that he or she is licensed to engage in the practice of alcohol and drug counseling, unless
94.6 that person is also licensed as an alcohol and drug counselor. Persons engaged in the practice
94.7 of alcohol and drug counseling are not exempt from the board's jurisdiction solely by the
94.8 use of one of the titles in paragraph (a).

94.9 Sec. 10. Minnesota Statutes 2020, section 245.462, subdivision 1, is amended to read:

94.10 Subdivision 1. **Definitions.** The definitions in this section apply to sections 245.461 to
94.11 ~~245.486~~ 245.4863.

94.12 Sec. 11. Minnesota Statutes 2020, section 245.462, subdivision 6, is amended to read:

94.13 Subd. 6. **Community support services program.** "Community support services program"
94.14 means services, other than inpatient or residential treatment services, provided or coordinated
94.15 by an identified program and staff under the ~~clinical~~ treatment supervision of a mental health
94.16 professional designed to help adults with serious and persistent mental illness to function
94.17 and remain in the community. A community support services program includes:

94.18 (1) client outreach,

94.19 (2) medication monitoring,

94.20 (3) assistance in independent living skills,

94.21 (4) development of employability and work-related opportunities,

94.22 (5) crisis assistance,

94.23 (6) psychosocial rehabilitation,

94.24 (7) help in applying for government benefits, and

94.25 (8) housing support services.

94.26 The community support services program must be coordinated with the case management
94.27 services specified in section 245.4711.

94.28 Sec. 12. Minnesota Statutes 2020, section 245.462, subdivision 8, is amended to read:

94.29 Subd. 8. **Day treatment services.** "Day treatment," "day treatment services," or "day
94.30 treatment program" means ~~a structured program of treatment and care provided to an adult~~

95.1 ~~in or by: (1) a hospital accredited by the joint commission on accreditation of health~~
95.2 ~~organizations and licensed under sections 144.50 to 144.55; (2) a community mental health~~
95.3 ~~center under section 245.62; or (3) an entity that is under contract with the county board to~~
95.4 ~~operate a program that meets the requirements of section 245.4712, subdivision 2, and~~
95.5 ~~Minnesota Rules, parts 9505.0170 to 9505.0475. Day treatment consists of group~~
95.6 ~~psychotherapy and other intensive therapeutic services that are provided at least two days~~
95.7 ~~a week by a multidisciplinary staff under the clinical supervision of a mental health~~
95.8 ~~professional. Day treatment may include education and consultation provided to families~~
95.9 ~~and other individuals as part of the treatment process. The services are aimed at stabilizing~~
95.10 ~~the adult's mental health status, providing mental health services, and developing and~~
95.11 ~~improving the adult's independent living and socialization skills. The goal of day treatment~~
95.12 ~~is to reduce or relieve mental illness and to enable the adult to live in the community. Day~~
95.13 ~~treatment services are not a part of inpatient or residential treatment services. Day treatment~~
95.14 ~~services are distinguished from day care by their structured therapeutic program of~~
95.15 ~~psychotherapy services. The commissioner may limit medical assistance reimbursement~~
95.16 ~~for day treatment to 15 hours per week per person the treatment services described under~~
95.17 ~~section 256B.0671, subdivision 3.~~

95.18 Sec. 13. Minnesota Statutes 2020, section 245.462, subdivision 9, is amended to read:

95.19 Subd. 9. **Diagnostic assessment.** ~~(a) "Diagnostic assessment" has the meaning given in~~
95.20 ~~Minnesota Rules, part 9505.0370, subpart 11, and is delivered as provided in Minnesota~~
95.21 ~~Rules, part 9505.0372, subpart 1, items A, B, C, and E. Diagnostic assessment includes a~~
95.22 ~~standard, extended, or brief diagnostic assessment, or an adult update section 245I.10,~~
95.23 ~~subdivisions 4 to 6.~~

95.24 ~~(b) A brief diagnostic assessment must include a face-to-face interview with the client~~
95.25 ~~and a written evaluation of the client by a mental health professional or a clinical trainee,~~
95.26 ~~as provided in Minnesota Rules, part 9505.0371, subpart 5, item C. The professional or~~
95.27 ~~clinical trainee must gather initial components of a standard diagnostic assessment, including~~
95.28 ~~the client's:~~

95.29 (1) age;

95.30 (2) description of symptoms, including reason for referral;

95.31 (3) history of mental health treatment;

95.32 (4) cultural influences and their impact on the client; and

95.33 (5) mental status examination.

96.1 ~~(e) On the basis of the initial components, the professional or clinical trainee must draw~~
96.2 ~~a provisional clinical hypothesis. The clinical hypothesis may be used to address the client's~~
96.3 ~~immediate needs or presenting problem.~~

96.4 ~~(d) Treatment sessions conducted under authorization of a brief assessment may be used~~
96.5 ~~to gather additional information necessary to complete a standard diagnostic assessment or~~
96.6 ~~an extended diagnostic assessment.~~

96.7 ~~(e) Notwithstanding Minnesota Rules, part 9505.0371, subpart 2, item A, subitem (1),~~
96.8 ~~unit (b), prior to completion of a client's initial diagnostic assessment, a client is eligible~~
96.9 ~~for psychological testing as part of the diagnostic process.~~

96.10 ~~(f) Notwithstanding Minnesota Rules, part 9505.0371, subpart 2, item A, subitem (1),~~
96.11 ~~unit (c), prior to completion of a client's initial diagnostic assessment, but in conjunction~~
96.12 ~~with the diagnostic assessment process, a client is eligible for up to three individual or family~~
96.13 ~~psychotherapy sessions or family psychoeducation sessions or a combination of the above~~
96.14 ~~sessions not to exceed three sessions.~~

96.15 ~~(g) Notwithstanding Minnesota Rules, part 9505.0371, subpart 2, item B, subitem (3),~~
96.16 ~~unit (a), a brief diagnostic assessment may be used for a client's family who requires a~~
96.17 ~~language interpreter to participate in the assessment.~~

96.18 Sec. 14. Minnesota Statutes 2020, section 245.462, subdivision 14, is amended to read:

96.19 Subd. 14. **Individual treatment plan.** "Individual treatment plan" means ~~a written plan~~
96.20 ~~of intervention, treatment, and services for an adult with mental illness that is developed~~
96.21 ~~by a service provider under the clinical supervision of a mental health professional on the~~
96.22 ~~basis of a diagnostic assessment. The plan identifies goals and objectives of treatment,~~
96.23 ~~treatment strategy, a schedule for accomplishing treatment goals and objectives, and the~~
96.24 ~~individual responsible for providing treatment to the adult with mental illness~~ the formulation
96.25 of planned services that are responsive to the needs and goals of a client. An individual
96.26 treatment plan must be completed according to section 245I.10, subdivisions 7 and 8.

96.27 Sec. 15. Minnesota Statutes 2020, section 245.462, subdivision 16, is amended to read:

96.28 Subd. 16. **Mental health funds.** "Mental health funds" are funds expended under sections
96.29 245.73 and 256E.12, federal mental health block grant funds, and funds expended under
96.30 section 256D.06 to facilities licensed under section 245I.23 or Minnesota Rules, parts
96.31 9520.0500 to 9520.0670.

97.1 Sec. 16. Minnesota Statutes 2020, section 245.462, subdivision 17, is amended to read:

97.2 Subd. 17. **Mental health practitioner.** ~~(a) "Mental health practitioner" means a staff~~
97.3 ~~person providing services to adults with mental illness or children with emotional disturbance~~
97.4 ~~who is qualified in at least one of the ways described in paragraphs (b) to (g). A mental~~
97.5 ~~health practitioner for a child client must have training working with children. A mental~~
97.6 ~~health practitioner for an adult client must have training working with adults qualified~~
97.7 ~~according to section 245I.04, subdivision 4.~~

97.8 ~~(b) For purposes of this subdivision, a practitioner is qualified through relevant~~
97.9 ~~coursework if the practitioner completes at least 30 semester hours or 45 quarter hours in~~
97.10 ~~behavioral sciences or related fields and:~~

97.11 ~~(1) has at least 2,000 hours of supervised experience in the delivery of services to adults~~
97.12 ~~or children with:~~

97.13 ~~(i) mental illness, substance use disorder, or emotional disturbance; or~~

97.14 ~~(ii) traumatic brain injury or developmental disabilities and completes training on mental~~
97.15 ~~illness, recovery from mental illness, mental health de-escalation techniques, co-occurring~~
97.16 ~~mental illness and substance abuse, and psychotropic medications and side effects;~~

97.17 ~~(2) is fluent in the non-English language of the ethnic group to which at least 50 percent~~
97.18 ~~of the practitioner's clients belong, completes 40 hours of training in the delivery of services~~
97.19 ~~to adults with mental illness or children with emotional disturbance, and receives clinical~~
97.20 ~~supervision from a mental health professional at least once a week until the requirement of~~
97.21 ~~2,000 hours of supervised experience is met;~~

97.22 ~~(3) is working in a day treatment program under section 245.4712, subdivision 2; or~~

97.23 ~~(4) has completed a practicum or internship that (i) requires direct interaction with adults~~
97.24 ~~or children served, and (ii) is focused on behavioral sciences or related fields.~~

97.25 ~~(c) For purposes of this subdivision, a practitioner is qualified through work experience~~
97.26 ~~if the person:~~

97.27 ~~(1) has at least 4,000 hours of supervised experience in the delivery of services to adults~~
97.28 ~~or children with:~~

97.29 ~~(i) mental illness, substance use disorder, or emotional disturbance; or~~

97.30 ~~(ii) traumatic brain injury or developmental disabilities and completes training on mental~~
97.31 ~~illness, recovery from mental illness, mental health de-escalation techniques, co-occurring~~
97.32 ~~mental illness and substance abuse, and psychotropic medications and side effects; or~~

98.1 ~~(2) has at least 2,000 hours of supervised experience in the delivery of services to adults~~
98.2 ~~or children with:~~

98.3 ~~(i) mental illness, emotional disturbance, or substance use disorder, and receives clinical~~
98.4 ~~supervision as required by applicable statutes and rules from a mental health professional~~
98.5 ~~at least once a week until the requirement of 4,000 hours of supervised experience is met;~~
98.6 ~~or~~

98.7 ~~(ii) traumatic brain injury or developmental disabilities; completes training on mental~~
98.8 ~~illness, recovery from mental illness, mental health de-escalation techniques, co-occurring~~
98.9 ~~mental illness and substance abuse, and psychotropic medications and side effects; and~~
98.10 ~~receives clinical supervision as required by applicable statutes and rules at least once a week~~
98.11 ~~from a mental health professional until the requirement of 4,000 hours of supervised~~
98.12 ~~experience is met.~~

98.13 ~~(d) For purposes of this subdivision, a practitioner is qualified through a graduate student~~
98.14 ~~internship if the practitioner is a graduate student in behavioral sciences or related fields~~
98.15 ~~and is formally assigned by an accredited college or university to an agency or facility for~~
98.16 ~~clinical training.~~

98.17 ~~(e) For purposes of this subdivision, a practitioner is qualified by a bachelor's or master's~~
98.18 ~~degree if the practitioner:~~

98.19 ~~(1) holds a master's or other graduate degree in behavioral sciences or related fields; or~~

98.20 ~~(2) holds a bachelor's degree in behavioral sciences or related fields and completes a~~
98.21 ~~practicum or internship that (i) requires direct interaction with adults or children served,~~
98.22 ~~and (ii) is focused on behavioral sciences or related fields.~~

98.23 ~~(f) For purposes of this subdivision, a practitioner is qualified as a vendor of medical~~
98.24 ~~care if the practitioner meets the definition of vendor of medical care in section 256B.02,~~
98.25 ~~subdivision 7, paragraphs (b) and (c), and is serving a federally recognized tribe.~~

98.26 ~~(g) For purposes of medical assistance coverage of diagnostic assessments, explanations~~
98.27 ~~of findings, and psychotherapy under section 256B.0625, subdivision 65, a mental health~~
98.28 ~~practitioner working as a clinical trainee means that the practitioner's clinical supervision~~
98.29 ~~experience is helping the practitioner gain knowledge and skills necessary to practice~~
98.30 ~~effectively and independently. This may include supervision of direct practice, treatment~~
98.31 ~~team collaboration, continued professional learning, and job management. The practitioner~~
98.32 ~~must also:~~

99.1 ~~(1) comply with requirements for licensure or board certification as a mental health~~
99.2 ~~professional, according to the qualifications under Minnesota Rules, part 9505.0371, subpart~~
99.3 ~~5, item A, including supervised practice in the delivery of mental health services for the~~
99.4 ~~treatment of mental illness; or~~

99.5 ~~(2) be a student in a bona fide field placement or internship under a program leading to~~
99.6 ~~completion of the requirements for licensure as a mental health professional according to~~
99.7 ~~the qualifications under Minnesota Rules, part 9505.0371, subpart 5, item A.~~

99.8 ~~(h) For purposes of this subdivision, "behavioral sciences or related fields" has the~~
99.9 ~~meaning given in section 256B.0623, subdivision 5, paragraph (d).~~

99.10 ~~(i) Notwithstanding the licensing requirements established by a health-related licensing~~
99.11 ~~board, as defined in section 214.01, subdivision 2, this subdivision supersedes any other~~
99.12 ~~statute or rule.~~

99.13 Sec. 17. Minnesota Statutes 2020, section 245.462, subdivision 18, is amended to read:

99.14 Subd. 18. **Mental health professional.** "Mental health professional" means a staff person
99.15 ~~providing clinical services in the treatment of mental illness who is qualified in at least one~~
99.16 ~~of the following ways: qualified according to section 245I.04, subdivision 2.~~

99.17 ~~(1) in psychiatric nursing: a registered nurse who is licensed under sections 148.171 to~~
99.18 ~~148.285; and:~~

99.19 ~~(i) who is certified as a clinical specialist or as a nurse practitioner in adult or family~~
99.20 ~~psychiatric and mental health nursing by a national nurse certification organization; or~~

99.21 ~~(ii) who has a master's degree in nursing or one of the behavioral sciences or related~~
99.22 ~~fields from an accredited college or university or its equivalent, with at least 4,000 hours~~
99.23 ~~of post-master's supervised experience in the delivery of clinical services in the treatment~~
99.24 ~~of mental illness;~~

99.25 ~~(2) in clinical social work: a person licensed as an independent clinical social worker~~
99.26 ~~under chapter 148D, or a person with a master's degree in social work from an accredited~~
99.27 ~~college or university, with at least 4,000 hours of post-master's supervised experience in~~
99.28 ~~the delivery of clinical services in the treatment of mental illness;~~

99.29 ~~(3) in psychology: an individual licensed by the Board of Psychology under sections~~
99.30 ~~148.88 to 148.98 who has stated to the Board of Psychology competencies in the diagnosis~~
99.31 ~~and treatment of mental illness;~~

100.1 ~~(4) in psychiatry: a physician licensed under chapter 147 and certified by the American~~
100.2 ~~Board of Psychiatry and Neurology or eligible for board certification in psychiatry, or an~~
100.3 ~~osteopathic physician licensed under chapter 147 and certified by the American Osteopathic~~
100.4 ~~Board of Neurology and Psychiatry or eligible for board certification in psychiatry;~~

100.5 ~~(5) in marriage and family therapy: the mental health professional must be a marriage~~
100.6 ~~and family therapist licensed under sections 148B.29 to 148B.39 with at least two years of~~
100.7 ~~post-master's supervised experience in the delivery of clinical services in the treatment of~~
100.8 ~~mental illness;~~

100.9 ~~(6) in licensed professional clinical counseling, the mental health professional shall be~~
100.10 ~~a licensed professional clinical counselor under section 148B.5301 with at least 4,000 hours~~
100.11 ~~of post-master's supervised experience in the delivery of clinical services in the treatment~~
100.12 ~~of mental illness; or~~

100.13 ~~(7) in allied fields: a person with a master's degree from an accredited college or university~~
100.14 ~~in one of the behavioral sciences or related fields, with at least 4,000 hours of post-master's~~
100.15 ~~supervised experience in the delivery of clinical services in the treatment of mental illness.~~

100.16 Sec. 18. Minnesota Statutes 2020, section 245.462, subdivision 21, is amended to read:

100.17 Subd. 21. **Outpatient services.** "Outpatient services" means mental health services,
100.18 excluding day treatment and community support services programs, provided by or under
100.19 the ~~clinical~~ clinical treatment supervision of a mental health professional to adults with mental
100.20 illness who live outside a hospital. Outpatient services include clinical activities such as
100.21 individual, group, and family therapy; individual treatment planning; diagnostic assessments;
100.22 medication management; and psychological testing.

100.23 Sec. 19. Minnesota Statutes 2020, section 245.462, subdivision 23, is amended to read:

100.24 Subd. 23. **Residential treatment.** "Residential treatment" means a 24-hour-a-day program
100.25 under the ~~clinical~~ clinical treatment supervision of a mental health professional, in a community
100.26 residential setting other than an acute care hospital or regional treatment center inpatient
100.27 unit, that must be licensed as a residential treatment program for adults with mental illness
100.28 under chapter 245I, Minnesota Rules, parts 9520.0500 to 9520.0670, or other rules adopted
100.29 by the commissioner.

101.1 Sec. 20. Minnesota Statutes 2020, section 245.462, is amended by adding a subdivision
101.2 to read:

101.3 Subd. 27. **Treatment supervision.** "Treatment supervision" means the treatment
101.4 supervision described under section 245I.06.

101.5 Sec. 21. Minnesota Statutes 2020, section 245.4661, subdivision 5, is amended to read:

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

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

101.17 (c) For purposes of this section, "Minnesota specialty treatment facility" is defined as
101.18 an intensive residential treatment service licensed under section 256B.0622, subdivision 2,
101.19 paragraph (b) chapter 245I.

101.20 Sec. 22. Minnesota Statutes 2020, section 245.4662, subdivision 1, is amended to read:

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

101.23 (b) "Community partnership" means a project involving the collaboration of two or more
101.24 eligible applicants.

101.25 (c) "Eligible applicant" means an eligible county, Indian tribe, mental health service
101.26 provider, hospital, or community partnership. Eligible applicant does not include a
101.27 state-operated direct care and treatment facility or program under chapter 246.

101.28 (d) "Intensive residential treatment services" has the meaning given in section 256B.0622,
101.29 ~~subdivision 2.~~

101.30 (e) "Metropolitan area" means the seven-county metropolitan area, as defined in section
101.31 473.121, subdivision 2.

102.1 Sec. 23. Minnesota Statutes 2020, section 245.467, subdivision 2, is amended to read:

102.2 Subd. 2. **Diagnostic assessment.** ~~All providers of residential, acute care hospital inpatient,~~
102.3 ~~and regional treatment centers must complete a diagnostic assessment for each of their~~
102.4 ~~clients within five days of admission. Providers of day treatment services must complete a~~
102.5 ~~diagnostic assessment within five days after the adult's second visit or within 30 days after~~
102.6 ~~intake, whichever occurs first. In cases where a diagnostic assessment is available and has~~
102.7 ~~been completed within three years preceding admission, only an adult diagnostic assessment~~
102.8 ~~update is necessary. An "adult diagnostic assessment update" means a written summary by~~
102.9 ~~a mental health professional of the adult's current mental health status and service needs~~
102.10 ~~and includes a face-to-face interview with the adult. If the adult's mental health status has~~
102.11 ~~changed markedly since the adult's most recent diagnostic assessment, a new diagnostic~~
102.12 ~~assessment is required. Compliance with the provisions of this subdivision does not ensure~~
102.13 ~~eligibility for medical assistance reimbursement under chapter 256B. Providers of services~~
102.14 governed by this section must complete a diagnostic assessment according to the standards
102.15 of section 245I.10, subdivisions 4 to 6.

102.16 Sec. 24. Minnesota Statutes 2020, section 245.467, subdivision 3, is amended to read:

102.17 Subd. 3. **Individual treatment plans.** ~~All providers of outpatient services, day treatment~~
102.18 ~~services, residential treatment, acute care hospital inpatient treatment, and all regional~~
102.19 ~~treatment centers must develop an individual treatment plan for each of their adult clients.~~
102.20 ~~The individual treatment plan must be based on a diagnostic assessment. To the extent~~
102.21 ~~possible, the adult client shall be involved in all phases of developing and implementing~~
102.22 ~~the individual treatment plan. Providers of residential treatment and acute care hospital~~
102.23 ~~inpatient treatment, and all regional treatment centers must develop the individual treatment~~
102.24 ~~plan within ten days of client intake and must review the individual treatment plan every~~
102.25 ~~90 days after intake. Providers of day treatment services must develop the individual~~
102.26 ~~treatment plan before the completion of five working days in which service is provided or~~
102.27 ~~within 30 days after the diagnostic assessment is completed or obtained, whichever occurs~~
102.28 ~~first. Providers of outpatient services must develop the individual treatment plan within 30~~
102.29 ~~days after the diagnostic assessment is completed or obtained or by the end of the second~~
102.30 ~~session of an outpatient service, not including the session in which the diagnostic assessment~~
102.31 ~~was provided, whichever occurs first. Outpatient and day treatment services providers must~~
102.32 ~~review the individual treatment plan every 90 days after intake. Providers of services~~
102.33 governed by this section must complete an individual treatment plan according to the
102.34 standards of section 245I.10, subdivisions 7 and 8.

103.1 Sec. 25. Minnesota Statutes 2020, section 245.470, subdivision 1, is amended to read:

103.2 Subdivision 1. **Availability of outpatient services.** (a) County boards must provide or
103.3 contract for enough outpatient services within the county to meet the needs of adults with
103.4 mental illness residing in the county. Services may be provided directly by the county
103.5 through county-operated ~~mental health centers or mental health clinics approved by the~~
103.6 ~~commissioner under section 245.69, subdivision 2 meeting the standards of chapter 245I;~~
103.7 by contract with privately operated ~~mental health centers or mental health clinics approved~~
103.8 ~~by the commissioner under section 245.69, subdivision 2 meeting the standards of chapter~~
103.9 245I; by contract with hospital mental health outpatient programs certified by the Joint
103.10 Commission on Accreditation of Hospital Organizations; or by contract with a licensed
103.11 mental health professional ~~as defined in section 245.462, subdivision 18, clauses (1) to (6).~~
103.12 Clients may be required to pay a fee according to section 245.481. Outpatient services
103.13 include:

103.14 (1) conducting diagnostic assessments;

103.15 (2) conducting psychological testing;

103.16 (3) developing or modifying individual treatment plans;

103.17 (4) making referrals and recommending placements as appropriate;

103.18 (5) treating an adult's mental health needs through therapy;

103.19 (6) prescribing and managing medication and evaluating the effectiveness of prescribed
103.20 medication; and

103.21 (7) preventing placement in settings that are more intensive, costly, or restrictive than
103.22 necessary and appropriate to meet client needs.

103.23 (b) County boards may request a waiver allowing outpatient services to be provided in
103.24 a nearby trade area if it is determined that the client can best be served outside the county.

103.25 Sec. 26. Minnesota Statutes 2020, section 245.4712, subdivision 2, is amended to read:

103.26 Subd. 2. **Day treatment services provided.** (a) Day treatment services must be developed
103.27 as a part of the community support services available to adults with serious and persistent
103.28 mental illness residing in the county. Adults may be required to pay a fee according to
103.29 section 245.481. Day treatment services must be designed to:

103.30 (1) provide a structured environment for treatment;

103.31 (2) provide support for residing in the community;

104.1 (3) prevent placement in settings that are more intensive, costly, or restrictive than
104.2 necessary and appropriate to meet client need;

104.3 (4) coordinate with or be offered in conjunction with a local education agency's special
104.4 education program; and

104.5 (5) operate on a continuous basis throughout the year.

104.6 (b) ~~For purposes of complying with medical assistance requirements, an adult day~~
104.7 ~~treatment program must comply with the method of clinical supervision specified in~~
104.8 ~~Minnesota Rules, part 9505.0371, subpart 4. The clinical supervision must be performed~~
104.9 ~~by a qualified supervisor who satisfies the requirements of Minnesota Rules, part 9505.0371,~~
104.10 ~~subpart 5. An adult day treatment program must comply with medical assistance requirements~~
104.11 ~~in section 256B.0671, subdivision 3.~~

104.12 ~~A day treatment program must demonstrate compliance with this clinical supervision~~
104.13 ~~requirement by the commissioner's review and approval of the program according to~~
104.14 ~~Minnesota Rules, part 9505.0372, subpart 8.~~

104.15 (c) County boards may request a waiver from including day treatment services if they
104.16 can document that:

104.17 (1) an alternative plan of care exists through the county's community support services
104.18 for clients who would otherwise need day treatment services;

104.19 (2) day treatment, if included, would be duplicative of other components of the
104.20 community support services; and

104.21 (3) county demographics and geography make the provision of day treatment services
104.22 cost ineffective and infeasible.

104.23 Sec. 27. Minnesota Statutes 2020, section 245.472, subdivision 2, is amended to read:

104.24 Subd. 2. **Specific requirements.** Providers of residential services must be licensed under
104.25 chapter 245I or applicable rules adopted by the commissioner and must be clinically
104.26 supervised by a mental health professional. Persons employed in facilities licensed under
104.27 Minnesota Rules, parts 9520.0500 to 9520.0670, in the capacity of program director as of
104.28 July 1, 1987, in accordance with Minnesota Rules, parts 9520.0500 to 9520.0670, may be
104.29 allowed to continue providing clinical supervision within a facility, provided they continue
104.30 to be employed as a program director in a facility licensed under Minnesota Rules, parts
104.31 9520.0500 to 9520.0670. Residential services must be provided under treatment supervision.

105.1 Sec. 28. Minnesota Statutes 2020, section 245.4863, is amended to read:

105.2 **245.4863 INTEGRATED CO-OCCURRING DISORDER TREATMENT.**

105.3 (a) The commissioner shall require individuals who perform chemical dependency
105.4 assessments to screen clients for co-occurring mental health disorders, and staff who perform
105.5 mental health diagnostic assessments to screen for co-occurring substance use disorders.
105.6 Screening tools must be approved by the commissioner. If a client screens positive for a
105.7 co-occurring mental health or substance use disorder, the individual performing the screening
105.8 must document what actions will be taken in response to the results and whether further
105.9 assessments must be performed.

105.10 (b) Notwithstanding paragraph (a), screening is not required when:

105.11 (1) the presence of co-occurring disorders was documented for the client in the past 12
105.12 months;

105.13 (2) the client is currently receiving co-occurring disorders treatment;

105.14 (3) the client is being referred for co-occurring disorders treatment; or

105.15 (4) a mental health professional, ~~as defined in Minnesota Rules, part 9505.0370, subpart~~
105.16 ~~18,~~ who is competent to perform diagnostic assessments of co-occurring disorders is
105.17 performing a diagnostic assessment ~~that meets the requirements in Minnesota Rules, part~~
105.18 ~~9533.0090, subpart 5,~~ to identify whether the client may have co-occurring mental health
105.19 and chemical dependency disorders. If an individual is identified to have co-occurring
105.20 mental health and substance use disorders, the assessing mental health professional must
105.21 document what actions will be taken to address the client's co-occurring disorders.

105.22 (c) The commissioner shall adopt rules as necessary to implement this section. The
105.23 commissioner shall ensure that the rules are effective on July 1, 2013, thereby establishing
105.24 a certification process for integrated dual disorder treatment providers and a system through
105.25 which individuals receive integrated dual diagnosis treatment if assessed as having both a
105.26 substance use disorder and either a serious mental illness or emotional disturbance.

105.27 (d) The commissioner shall apply for any federal waivers necessary to secure, to the
105.28 extent allowed by law, federal financial participation for the provision of integrated dual
105.29 diagnosis treatment to persons with co-occurring disorders.

105.30 Sec. 29. Minnesota Statutes 2020, section 245.4871, subdivision 9a, is amended to read:

105.31 Subd. 9a. **Crisis assistance planning.** "Crisis assistance planning" means ~~assistance to~~
105.32 ~~the child, the child's family, and all providers of services to the child to: recognize factors~~

106.1 ~~precipitating a mental health crisis, identify behaviors related to the crisis, and be informed~~
106.2 ~~of available resources to resolve the crisis. Crisis assistance requires the development of a~~
106.3 ~~plan which addresses prevention and intervention strategies to be used in a potential crisis.~~
106.4 ~~Other interventions include: (1) arranging for admission to acute care hospital inpatient~~
106.5 ~~treatment~~ the development of a written plan to assist a child and the child's family in
106.6 preventing and addressing a potential crisis and is distinct from mobile crisis services as
106.7 defined in section 256B.0624. The plan must address prevention, deescalation, and
106.8 intervention strategies to be used in a crisis. The plan identifies factors that might precipitate
106.9 a crisis, behaviors or symptoms related to the emergence of a crisis, and the resources
106.10 available to resolve a crisis. The plan must address the following potential needs: (1) acute
106.11 care; (2) crisis placement; (3) community resources for follow-up; and (4) emotional support
106.12 to the family during crisis. Crisis assistance planning does not include services designed to
106.13 secure the safety of a child who is at risk of abuse or neglect or necessary emergency services.

106.14 Sec. 30. Minnesota Statutes 2020, section 245.4871, subdivision 10, is amended to read:

106.15 Subd. 10. **Day treatment services.** "Day treatment," "day treatment services," or "day
106.16 treatment program" means a structured program of treatment and care provided to a child
106.17 in:

106.18 (1) an outpatient hospital accredited by the Joint Commission on Accreditation of Health
106.19 Organizations and licensed under sections 144.50 to 144.55;

106.20 (2) a community mental health center under section 245.62;

106.21 (3) an entity that is under contract with the county board to operate a program that meets
106.22 the requirements of section 245.4884, subdivision 2, and Minnesota Rules, parts 9505.0170
106.23 to 9505.0475; ~~or~~

106.24 (4) an entity that operates a program that meets the requirements of section 245.4884,
106.25 subdivision 2, and Minnesota Rules, parts 9505.0170 to 9505.0475, that is under contract
106.26 with an entity that is under contract with a county board; or

106.27 (5) a program certified under section 256B.0943.

106.28 Day treatment consists of group psychotherapy and other intensive therapeutic services
106.29 that are provided for a minimum two-hour time block by a multidisciplinary staff under the
106.30 ~~clinical~~ treatment supervision of a mental health professional. Day treatment may include
106.31 education and consultation provided to families and other individuals as an extension of the
106.32 treatment process. The services are aimed at stabilizing the child's mental health status, and
106.33 developing and improving the child's daily independent living and socialization skills. Day

107.1 treatment services are distinguished from day care by their structured therapeutic program
107.2 of psychotherapy services. Day treatment services are not a part of inpatient hospital or
107.3 residential treatment services.

107.4 A day treatment service must be available to a child up to 15 hours a week throughout
107.5 the year and must be coordinated with, integrated with, or part of an education program
107.6 offered by the child's school.

107.7 Sec. 31. Minnesota Statutes 2020, section 245.4871, subdivision 11a, is amended to read:

107.8 Subd. 11a. **Diagnostic assessment.** (a) "Diagnostic assessment" has the meaning given
107.9 in ~~Minnesota Rules, part 9505.0370, subpart 11, and is delivered as provided in Minnesota~~
107.10 ~~Rules, part 9505.0372, subpart 1, items A, B, C, and E. Diagnostic assessment includes a~~
107.11 ~~standard, extended, or brief diagnostic assessment, or an adult update section 245I.10,~~
107.12 ~~subdivisions 4 to 6.~~

107.13 ~~(b) A brief diagnostic assessment must include a face-to-face interview with the client~~
107.14 ~~and a written evaluation of the client by a mental health professional or a clinical trainee,~~
107.15 ~~as provided in Minnesota Rules, part 9505.0371, subpart 5, item C. The professional or~~
107.16 ~~clinical trainee must gather initial components of a standard diagnostic assessment, including~~
107.17 ~~the client's:~~

107.18 ~~(1) age;~~

107.19 ~~(2) description of symptoms, including reason for referral;~~

107.20 ~~(3) history of mental health treatment;~~

107.21 ~~(4) cultural influences and their impact on the client; and~~

107.22 ~~(5) mental status examination.~~

107.23 ~~(c) On the basis of the brief components, the professional or clinical trainee must draw~~
107.24 ~~a provisional clinical hypothesis. The clinical hypothesis may be used to address the client's~~
107.25 ~~immediate needs or presenting problem.~~

107.26 ~~(d) Treatment sessions conducted under authorization of a brief assessment may be used~~
107.27 ~~to gather additional information necessary to complete a standard diagnostic assessment or~~
107.28 ~~an extended diagnostic assessment.~~

107.29 ~~(e) Notwithstanding Minnesota Rules, part 9505.0371, subpart 2, item A, subitem (1),~~
107.30 ~~unit (b), prior to completion of a client's initial diagnostic assessment, a client is eligible~~
107.31 ~~for psychological testing as part of the diagnostic process.~~

108.1 ~~(f) Notwithstanding Minnesota Rules, part 9505.0371, subpart 2, item A, subitem (1),~~
108.2 ~~unit (e), prior to completion of a client's initial diagnostic assessment, but in conjunction~~
108.3 ~~with the diagnostic assessment process, a client is eligible for up to three individual or family~~
108.4 ~~psychotherapy sessions or family psychoeducation sessions or a combination of the above~~
108.5 ~~sessions not to exceed three sessions.~~

108.6 Sec. 32. Minnesota Statutes 2020, section 245.4871, subdivision 17, is amended to read:

108.7 Subd. 17. **Family community support services.** "Family community support services"
108.8 means services provided under the ~~clinical~~ treatment supervision of a mental health
108.9 professional and designed to help each child with severe emotional disturbance to function
108.10 and remain with the child's family in the community. Family community support services
108.11 do not include acute care hospital inpatient treatment, residential treatment services, or
108.12 regional treatment center services. Family community support services include:

108.13 (1) client outreach to each child with severe emotional disturbance and the child's family;

108.14 (2) medication monitoring where necessary;

108.15 (3) assistance in developing independent living skills;

108.16 (4) assistance in developing parenting skills necessary to address the needs of the child
108.17 with severe emotional disturbance;

108.18 (5) assistance with leisure and recreational activities;

108.19 (6) crisis ~~assistance~~ planning, including crisis placement and respite care;

108.20 (7) professional home-based family treatment;

108.21 (8) foster care with therapeutic supports;

108.22 (9) day treatment;

108.23 (10) assistance in locating respite care and special needs day care; and

108.24 (11) assistance in obtaining potential financial resources, including those benefits listed
108.25 in section 245.4884, subdivision 5.

108.26 Sec. 33. Minnesota Statutes 2020, section 245.4871, subdivision 21, is amended to read:

108.27 Subd. 21. **Individual treatment plan.** "Individual treatment plan" means ~~a written plan~~
108.28 ~~of intervention, treatment, and services for a child with an emotional disturbance that is~~
108.29 ~~developed by a service provider under the clinical supervision of a mental health professional~~
108.30 ~~on the basis of a diagnostic assessment. An individual treatment plan for a child must be~~

109.1 ~~developed in conjunction with the family unless clinically inappropriate. The plan identifies~~
109.2 ~~goals and objectives of treatment, treatment strategy, a schedule for accomplishing treatment~~
109.3 ~~goals and objectives, and the individuals responsible for providing treatment to the child~~
109.4 ~~with an emotional disturbance~~ the formulation of planned services that are responsive to
109.5 the needs and goals of a client. An individual treatment plan must be completed according
109.6 to section 245I.10, subdivisions 7 and 8.

109.7 Sec. 34. Minnesota Statutes 2020, section 245.4871, subdivision 26, is amended to read:

109.8 Subd. 26. **Mental health practitioner.** "Mental health practitioner" ~~has the meaning~~
109.9 ~~given in section 245.462, subdivision 17~~ means a staff person who is qualified according
109.10 to section 245I.04, subdivision 4.

109.11 Sec. 35. Minnesota Statutes 2020, section 245.4871, subdivision 27, is amended to read:

109.12 Subd. 27. **Mental health professional.** "Mental health professional" means a staff person
109.13 ~~providing clinical services in the diagnosis and treatment of children's emotional disorders.~~
109.14 ~~A mental health professional must have training and experience in working with children~~
109.15 ~~consistent with the age group to which the mental health professional is assigned. A mental~~
109.16 ~~health professional must be qualified in at least one of the following ways:~~ qualified according
109.17 to section 245I.04, subdivision 2.

109.18 ~~(1) in psychiatric nursing, the mental health professional must be a registered nurse who~~
109.19 ~~is licensed under sections 148.171 to 148.285 and who is certified as a clinical specialist in~~
109.20 ~~child and adolescent psychiatric or mental health nursing by a national nurse certification~~
109.21 ~~organization or who has a master's degree in nursing or one of the behavioral sciences or~~
109.22 ~~related fields from an accredited college or university or its equivalent, with at least 4,000~~
109.23 ~~hours of post-master's supervised experience in the delivery of clinical services in the~~
109.24 ~~treatment of mental illness;~~

109.25 ~~(2) in clinical social work, the mental health professional must be a person licensed as~~
109.26 ~~an independent clinical social worker under chapter 148D, or a person with a master's degree~~
109.27 ~~in social work from an accredited college or university, with at least 4,000 hours of~~
109.28 ~~post-master's supervised experience in the delivery of clinical services in the treatment of~~
109.29 ~~mental disorders;~~

109.30 ~~(3) in psychology, the mental health professional must be an individual licensed by the~~
109.31 ~~board of psychology under sections 148.88 to 148.98 who has stated to the board of~~
109.32 ~~psychology competencies in the diagnosis and treatment of mental disorders;~~

110.1 ~~(4) in psychiatry, the mental health professional must be a physician licensed under~~
110.2 ~~chapter 147 and certified by the American Board of Psychiatry and Neurology or eligible~~
110.3 ~~for board certification in psychiatry or an osteopathic physician licensed under chapter 147~~
110.4 ~~and certified by the American Osteopathic Board of Neurology and Psychiatry or eligible~~
110.5 ~~for board certification in psychiatry;~~

110.6 ~~(5) in marriage and family therapy, the mental health professional must be a marriage~~
110.7 ~~and family therapist licensed under sections 148B.29 to 148B.39 with at least two years of~~
110.8 ~~post-master's supervised experience in the delivery of clinical services in the treatment of~~
110.9 ~~mental disorders or emotional disturbances;~~

110.10 ~~(6) in licensed professional clinical counseling, the mental health professional shall be~~
110.11 ~~a licensed professional clinical counselor under section 148B.5301 with at least 4,000 hours~~
110.12 ~~of post-master's supervised experience in the delivery of clinical services in the treatment~~
110.13 ~~of mental disorders or emotional disturbances; or~~

110.14 ~~(7) in allied fields, the mental health professional must be a person with a master's degree~~
110.15 ~~from an accredited college or university in one of the behavioral sciences or related fields,~~
110.16 ~~with at least 4,000 hours of post-master's supervised experience in the delivery of clinical~~
110.17 ~~services in the treatment of emotional disturbances.~~

110.18 Sec. 36. Minnesota Statutes 2020, section 245.4871, subdivision 29, is amended to read:

110.19 Subd. 29. **Outpatient services.** "Outpatient services" means mental health services,
110.20 excluding day treatment and community support services programs, provided by or under
110.21 the ~~clinical~~ clinical treatment supervision of a mental health professional to children with emotional
110.22 disturbances who live outside a hospital. Outpatient services include clinical activities such
110.23 as individual, group, and family therapy; individual treatment planning; diagnostic
110.24 assessments; medication management; and psychological testing.

110.25 Sec. 37. Minnesota Statutes 2020, section 245.4871, subdivision 31, is amended to read:

110.26 Subd. 31. **Professional home-based family treatment.** "Professional home-based family
110.27 treatment" means intensive mental health services provided to children because of an
110.28 emotional disturbance (1) who are at risk of out-of-home placement; (2) who are in
110.29 out-of-home placement; or (3) who are returning from out-of-home placement. Services
110.30 are provided to the child and the child's family primarily in the child's home environment.
110.31 Services may also be provided in the child's school, child care setting, or other community
110.32 setting appropriate to the child. Services must be provided on an individual family basis,
110.33 must be child-oriented and family-oriented, and must be designed using information from

111.1 diagnostic and functional assessments to meet the specific mental health needs of the child
111.2 and the child's family. Examples of services are: (1) individual therapy; (2) family therapy;
111.3 (3) client outreach; (4) assistance in developing individual living skills; (5) assistance in
111.4 developing parenting skills necessary to address the needs of the child; (6) assistance with
111.5 leisure and recreational services; (7) ~~assistance~~ planning, including crisis respite care
111.6 and arranging for crisis placement; and (8) assistance in locating respite and child care.
111.7 Services must be coordinated with other services provided to the child and family.

111.8 Sec. 38. Minnesota Statutes 2020, section 245.4871, subdivision 32, is amended to read:

111.9 Subd. 32. **Residential treatment.** "Residential treatment" means a 24-hour-a-day program
111.10 under the ~~clinical~~ treatment supervision of a mental health professional, in a community
111.11 residential setting other than an acute care hospital or regional treatment center inpatient
111.12 unit, that must be licensed as a residential treatment program for children with emotional
111.13 disturbances under Minnesota Rules, parts 2960.0580 to 2960.0700, or other rules adopted
111.14 by the commissioner.

111.15 Sec. 39. Minnesota Statutes 2020, section 245.4871, subdivision 34, is amended to read:

111.16 Subd. 34. **Therapeutic support of foster care.** "Therapeutic support of foster care"
111.17 means the mental health training and mental health support services and ~~clinical~~ treatment
111.18 supervision provided by a mental health professional to foster families caring for children
111.19 with severe emotional disturbance to provide a therapeutic family environment and support
111.20 for the child's improved functioning. Therapeutic support of foster care includes services
111.21 provided under section 256B.0946.

111.22 Sec. 40. Minnesota Statutes 2020, section 245.4871, is amended by adding a subdivision
111.23 to read:

111.24 Subd. 36. **Treatment supervision.** "Treatment supervision" means the treatment
111.25 supervision described under section 245I.06.

111.26 Sec. 41. Minnesota Statutes 2020, section 245.4876, subdivision 2, is amended to read:

111.27 Subd. 2. **Diagnostic assessment.** ~~All residential treatment facilities and acute care~~
111.28 ~~hospital inpatient treatment facilities that provide mental health services for children must~~
111.29 ~~complete a diagnostic assessment for each of their child clients within five working days~~
111.30 ~~of admission. Providers of day treatment services for children must complete a diagnostic~~
111.31 ~~assessment within five days after the child's second visit or 30 days after intake, whichever~~

112.1 ~~occurs first. In cases where a diagnostic assessment is available and has been completed~~
112.2 ~~within 180 days preceding admission, only updating is necessary. "Updating" means a~~
112.3 ~~written summary by a mental health professional of the child's current mental health status~~
112.4 ~~and service needs. If the child's mental health status has changed markedly since the child's~~
112.5 ~~most recent diagnostic assessment, a new diagnostic assessment is required. Compliance~~
112.6 ~~with the provisions of this subdivision does not ensure eligibility for medical assistance~~
112.7 ~~reimbursement under chapter 256B. Providers of services governed by this section shall~~
112.8 ~~complete a diagnostic assessment according to the standards of section 245I.10, subdivisions~~
112.9 ~~4 to 6.~~

112.10 Sec. 42. Minnesota Statutes 2020, section 245.4876, subdivision 3, is amended to read:

112.11 Subd. 3. **Individual treatment plans.** ~~All providers of outpatient services, day treatment~~
112.12 ~~services, professional home-based family treatment, residential treatment, and acute care~~
112.13 ~~hospital inpatient treatment, and all regional treatment centers that provide mental health~~
112.14 ~~services for children must develop an individual treatment plan for each child client. The~~
112.15 ~~individual treatment plan must be based on a diagnostic assessment. To the extent appropriate,~~
112.16 ~~the child and the child's family shall be involved in all phases of developing and~~
112.17 ~~implementing the individual treatment plan. Providers of residential treatment, professional~~
112.18 ~~home-based family treatment, and acute care hospital inpatient treatment, and regional~~
112.19 ~~treatment centers must develop the individual treatment plan within ten working days of~~
112.20 ~~client intake or admission and must review the individual treatment plan every 90 days after~~
112.21 ~~intake, except that the administrative review of the treatment plan of a child placed in a~~
112.22 ~~residential facility shall be as specified in sections 260C.203 and 260C.212, subdivision 9.~~
112.23 ~~Providers of day treatment services must develop the individual treatment plan before the~~
112.24 ~~completion of five working days in which service is provided or within 30 days after the~~
112.25 ~~diagnostic assessment is completed or obtained, whichever occurs first. Providers of~~
112.26 ~~outpatient services must develop the individual treatment plan within 30 days after the~~
112.27 ~~diagnostic assessment is completed or obtained or by the end of the second session of an~~
112.28 ~~outpatient service, not including the session in which the diagnostic assessment was provided,~~
112.29 ~~whichever occurs first. Providers of outpatient and day treatment services must review the~~
112.30 ~~individual treatment plan every 90 days after intake. Providers of services governed by this~~
112.31 ~~section shall complete an individual treatment plan according to the standards of section~~
112.32 ~~245I.10, subdivisions 7 and 8.~~

113.1 Sec. 43. Minnesota Statutes 2020, section 245.488, subdivision 1, is amended to read:

113.2 Subdivision 1. **Availability of outpatient services.** (a) County boards must provide or
113.3 contract for enough outpatient services within the county to meet the needs of each child
113.4 with emotional disturbance residing in the county and the child's family. Services may be
113.5 provided directly by the county through county-operated ~~mental health centers or mental~~
113.6 ~~health clinics approved by the commissioner under section 245.69, subdivision 2~~ meeting
113.7 the standards of chapter 245I; by contract with privately operated ~~mental health centers or~~
113.8 ~~mental health clinics approved by the commissioner under section 245.69, subdivision 2~~
113.9 meeting the standards of chapter 245I; by contract with hospital mental health outpatient
113.10 programs certified by the Joint Commission on Accreditation of Hospital Organizations;
113.11 or by contract with a ~~licensed~~ mental health professional ~~as defined in section 245.4871,~~
113.12 ~~subdivision 27, clauses (1) to (6)~~. A child or a child's parent may be required to pay a fee
113.13 based in accordance with section 245.481. Outpatient services include:

113.14 (1) conducting diagnostic assessments;

113.15 (2) conducting psychological testing;

113.16 (3) developing or modifying individual treatment plans;

113.17 (4) making referrals and recommending placements as appropriate;

113.18 (5) treating the child's mental health needs through therapy; and

113.19 (6) prescribing and managing medication and evaluating the effectiveness of prescribed
113.20 medication.

113.21 (b) County boards may request a waiver allowing outpatient services to be provided in
113.22 a nearby trade area if it is determined that the child requires necessary and appropriate
113.23 services that are only available outside the county.

113.24 (c) Outpatient services offered by the county board to prevent placement must be at the
113.25 level of treatment appropriate to the child's diagnostic assessment.

113.26 Sec. 44. Minnesota Statutes 2020, section 245.4901, subdivision 2, is amended to read:

113.27 Subd. 2. **Eligible applicants.** An eligible applicant for school-linked mental health grants
113.28 is an entity that is:

113.29 (1) a mental health clinic certified under ~~Minnesota Rules, parts 9520.0750 to 9520.0870~~
113.30 section 245I.20;

113.31 (2) a community mental health center under section 256B.0625, subdivision 5;

114.1 (3) an Indian health service facility or a facility owned and operated by a tribe or tribal
114.2 organization operating under United States Code, title 25, section 5321;

114.3 (4) a provider of children's therapeutic services and supports as defined in section
114.4 256B.0943; or

114.5 (5) enrolled in medical assistance as a mental health or substance use disorder provider
114.6 agency and employs at least two full-time equivalent mental health professionals qualified
114.7 according to section ~~245I.16~~ 245I.04, subdivision 2, or two alcohol and drug counselors
114.8 licensed or exempt from licensure under chapter 148F who are qualified to provide clinical
114.9 services to children and families.

114.10 Sec. 45. Minnesota Statutes 2020, section 245.62, subdivision 2, is amended to read:

114.11 Subd. 2. **Definition.** A community mental health center is a private nonprofit corporation
114.12 or public agency approved under the ~~rules promulgated by the commissioner pursuant to~~
114.13 ~~subdivision 4~~ standards of section 256B.0625, subdivision 5.

114.14 Sec. 46. Minnesota Statutes 2020, section 245.735, subdivision 3, is amended to read:

114.15 Subd. 3. **Certified community behavioral health clinics.** (a) The commissioner shall
114.16 establish a state certification process for certified community behavioral health clinics
114.17 (CCBHCs). Entities that choose to be CCBHCs must:

114.18 (1) comply with the CCBHC criteria published by the United States Department of
114.19 Health and Human Services;

114.20 (2) employ or contract for clinic staff who have backgrounds in diverse disciplines,
114.21 including licensed mental health professionals and licensed alcohol and drug counselors,
114.22 and staff who are culturally and linguistically trained to meet the needs of the population
114.23 the clinic serves;

114.24 (3) ensure that clinic services are available and accessible to individuals and families of
114.25 all ages and genders and that crisis management services are available 24 hours per day;

114.26 (4) establish fees for clinic services for individuals who are not enrolled in medical
114.27 assistance using a sliding fee scale that ensures that services to patients are not denied or
114.28 limited due to an individual's inability to pay for services;

114.29 (5) comply with quality assurance reporting requirements and other reporting
114.30 requirements, including any required reporting of encounter data, clinical outcomes data,
114.31 and quality data;

115.1 (6) provide crisis mental health and substance use services, withdrawal management
115.2 services, emergency crisis intervention services, and stabilization services; screening,
115.3 assessment, and diagnosis services, including risk assessments and level of care
115.4 determinations; person- and family-centered treatment planning; outpatient mental health
115.5 and substance use services; targeted case management; psychiatric rehabilitation services;
115.6 peer support and counselor services and family support services; and intensive
115.7 community-based mental health services, including mental health services for members of
115.8 the armed forces and veterans;

115.9 (7) provide coordination of care across settings and providers to ensure seamless
115.10 transitions for individuals being served across the full spectrum of health services, including
115.11 acute, chronic, and behavioral needs. Care coordination may be accomplished through
115.12 partnerships or formal contracts with:

115.13 (i) counties, health plans, pharmacists, pharmacies, rural health clinics, federally qualified
115.14 health centers, inpatient psychiatric facilities, substance use and detoxification facilities, or
115.15 community-based mental health providers; and

115.16 (ii) other community services, supports, and providers, including schools, child welfare
115.17 agencies, juvenile and criminal justice agencies, Indian health services clinics, tribally
115.18 licensed health care and mental health facilities, urban Indian health clinics, Department of
115.19 Veterans Affairs medical centers, outpatient clinics, drop-in centers, acute care hospitals,
115.20 and hospital outpatient clinics;

115.21 (8) be ~~certified as mental health clinics under section 245.69, subdivision 2~~ meeting the
115.22 standards of chapter 245I;

115.23 (9) ~~comply with standards relating to mental health services in Minnesota Rules, parts~~
115.24 ~~9505.0370 to 9505.0372~~ be a co-occurring disorder specialist;

115.25 (10) be licensed to provide substance use disorder treatment under chapter 245G;

115.26 (11) be certified to provide children's therapeutic services and supports under section
115.27 256B.0943;

115.28 (12) be certified to provide adult rehabilitative mental health services under section
115.29 256B.0623;

115.30 (13) be enrolled to provide mental health crisis response services under ~~sections~~ section
115.31 ~~256B.0624 and 256B.0944;~~

115.32 (14) be enrolled to provide mental health targeted case management under section
115.33 256B.0625, subdivision 20;

116.1 (15) comply with standards relating to mental health case management in Minnesota
116.2 Rules, parts 9520.0900 to 9520.0926;

116.3 (16) provide services that comply with the evidence-based practices described in
116.4 paragraph (e); and

116.5 (17) comply with standards relating to peer services under sections 256B.0615,
116.6 256B.0616, and 245G.07, subdivision 1, paragraph (a), clause (5), as applicable when peer
116.7 services are provided.

116.8 (b) If an entity is unable to provide one or more of the services listed in paragraph (a),
116.9 clauses (6) to (17), the commissioner may certify the entity as a CCBHC, if the entity has
116.10 a current contract with another entity that has the required authority to provide that service
116.11 and that meets federal CCBHC criteria as a designated collaborating organization, or, to
116.12 the extent allowed by the federal CCBHC criteria, the commissioner may approve a referral
116.13 arrangement. The CCBHC must meet federal requirements regarding the type and scope of
116.14 services to be provided directly by the CCBHC.

116.15 (c) Notwithstanding any other law that requires a county contract or other form of county
116.16 approval for certain services listed in paragraph (a), clause (6), a clinic that otherwise meets
116.17 CCBHC requirements may receive the prospective payment under section 256B.0625,
116.18 subdivision 5m, for those services without a county contract or county approval. As part of
116.19 the certification process in paragraph (a), the commissioner shall require a letter of support
116.20 from the CCBHC's host county confirming that the CCBHC and the county or counties it
116.21 serves have an ongoing relationship to facilitate access and continuity of care, especially
116.22 for individuals who are uninsured or who may go on and off medical assistance.

116.23 (d) When the standards listed in paragraph (a) or other applicable standards conflict or
116.24 address similar issues in duplicative or incompatible ways, the commissioner may grant
116.25 variances to state requirements if the variances do not conflict with federal requirements.
116.26 If standards overlap, the commissioner may substitute all or a part of a licensure or
116.27 certification that is substantially the same as another licensure or certification. The
116.28 commissioner shall consult with stakeholders, as described in subdivision 4, before granting
116.29 variances under this provision. For the CCBHC that is certified but not approved for
116.30 prospective payment under section 256B.0625, subdivision 5m, the commissioner may
116.31 grant a variance under this paragraph if the variance does not increase the state share of
116.32 costs.

116.33 (e) The commissioner shall issue a list of required evidence-based practices to be
116.34 delivered by CCBHCs, and may also provide a list of recommended evidence-based practices.

117.1 The commissioner may update the list to reflect advances in outcomes research and medical
117.2 services for persons living with mental illnesses or substance use disorders. The commissioner
117.3 shall take into consideration the adequacy of evidence to support the efficacy of the practice,
117.4 the quality of workforce available, and the current availability of the practice in the state.
117.5 At least 30 days before issuing the initial list and any revisions, the commissioner shall
117.6 provide stakeholders with an opportunity to comment.

117.7 (f) The commissioner shall recertify CCBHCs at least every three years. The
117.8 commissioner shall establish a process for decertification and shall require corrective action,
117.9 medical assistance repayment, or decertification of a CCBHC that no longer meets the
117.10 requirements in this section or that fails to meet the standards provided by the commissioner
117.11 in the application and certification process.

117.12 Sec. 47. Minnesota Statutes 2020, section 245A.04, subdivision 5, is amended to read:

117.13 Subd. 5. **Commissioner's right of access.** (a) When the commissioner is exercising the
117.14 powers conferred by this chapter, ~~sections 245.69 and~~ section 626.557, and chapter 260E,
117.15 the commissioner must be given access to:

117.16 (1) the physical plant and grounds where the program is provided;

117.17 (2) documents and records, including records maintained in electronic format;

117.18 (3) persons served by the program; and

117.19 (4) staff and personnel records of current and former staff whenever the program is in
117.20 operation and the information is relevant to inspections or investigations conducted by the
117.21 commissioner. Upon request, the license holder must provide the commissioner verification
117.22 of documentation of staff work experience, training, or educational requirements.

117.23 The commissioner must be given access without prior notice and as often as the
117.24 commissioner considers necessary if the commissioner is investigating alleged maltreatment,
117.25 conducting a licensing inspection, or investigating an alleged violation of applicable laws
117.26 or rules. In conducting inspections, the commissioner may request and shall receive assistance
117.27 from other state, county, and municipal governmental agencies and departments. The
117.28 applicant or license holder shall allow the commissioner to photocopy, photograph, and
117.29 make audio and video tape recordings during the inspection of the program at the
117.30 commissioner's expense. The commissioner shall obtain a court order or the consent of the
117.31 subject of the records or the parents or legal guardian of the subject before photocopying
117.32 hospital medical records.

118.1 (b) Persons served by the program have the right to refuse to consent to be interviewed,
 118.2 photographed, or audio or videotaped. Failure or refusal of an applicant or license holder
 118.3 to fully comply with this subdivision is reasonable cause for the commissioner to deny the
 118.4 application or immediately suspend or revoke the license.

118.5 Sec. 48. Minnesota Statutes 2020, section 245A.10, subdivision 4, is amended to read:

118.6 Subd. 4. **License or certification fee for certain programs.** (a) Child care centers shall
 118.7 pay an annual nonrefundable license fee based on the following schedule:

118.8 Licensed Capacity	118.9 Child Care Center License Fee
118.10 1 to 24 persons	\$200
118.11 25 to 49 persons	\$300
118.12 50 to 74 persons	\$400
118.13 75 to 99 persons	\$500
118.14 100 to 124 persons	\$600
118.15 125 to 149 persons	\$700
118.16 150 to 174 persons	\$800
118.17 175 to 199 persons	\$900
118.18 200 to 224 persons	\$1,000
118.19 225 or more persons	\$1,100

118.20 (b)(1) A program licensed to provide one or more of the home and community-based
 118.21 services and supports identified under chapter 245D to persons with disabilities or age 65
 118.22 and older, shall pay an annual nonrefundable license fee based on revenues derived from
 118.23 the provision of services that would require licensure under chapter 245D during the calendar
 118.24 year immediately preceding the year in which the license fee is paid, according to the
 118.25 following schedule:

118.26 License Holder Annual Revenue	118.27 License Fee
118.28 less than or equal to \$10,000	\$200
118.29 greater than \$10,000 but less than or equal to \$25,000	\$300
118.30 greater than \$25,000 but less than or equal to \$50,000	\$400
118.31 greater than \$50,000 but less than or equal to \$100,000	\$500
118.32 greater than \$100,000 but less than or equal to \$150,000	\$600
118.33 greater than \$150,000 but less than or equal to \$200,000	\$800

119.1	greater than \$200,000 but less than or	
119.2	equal to \$250,000	\$1,000
119.3	greater than \$250,000 but less than or	
119.4	equal to \$300,000	\$1,200
119.5	greater than \$300,000 but less than or	
119.6	equal to \$350,000	\$1,400
119.7	greater than \$350,000 but less than or	
119.8	equal to \$400,000	\$1,600
119.9	greater than \$400,000 but less than or	
119.10	equal to \$450,000	\$1,800
119.11	greater than \$450,000 but less than or	
119.12	equal to \$500,000	\$2,000
119.13	greater than \$500,000 but less than or	
119.14	equal to \$600,000	\$2,250
119.15	greater than \$600,000 but less than or	
119.16	equal to \$700,000	\$2,500
119.17	greater than \$700,000 but less than or	
119.18	equal to \$800,000	\$2,750
119.19	greater than \$800,000 but less than or	
119.20	equal to \$900,000	\$3,000
119.21	greater than \$900,000 but less than or	
119.22	equal to \$1,000,000	\$3,250
119.23	greater than \$1,000,000 but less than or	
119.24	equal to \$1,250,000	\$3,500
119.25	greater than \$1,250,000 but less than or	
119.26	equal to \$1,500,000	\$3,750
119.27	greater than \$1,500,000 but less than or	
119.28	equal to \$1,750,000	\$4,000
119.29	greater than \$1,750,000 but less than or	
119.30	equal to \$2,000,000	\$4,250
119.31	greater than \$2,000,000 but less than or	
119.32	equal to \$2,500,000	\$4,500
119.33	greater than \$2,500,000 but less than or	
119.34	equal to \$3,000,000	\$4,750
119.35	greater than \$3,000,000 but less than or	
119.36	equal to \$3,500,000	\$5,000
119.37	greater than \$3,500,000 but less than or	
119.38	equal to \$4,000,000	\$5,500
119.39	greater than \$4,000,000 but less than or	
119.40	equal to \$4,500,000	\$6,000
119.41	greater than \$4,500,000 but less than or	
119.42	equal to \$5,000,000	\$6,500
119.43	greater than \$5,000,000 but less than or	
119.44	equal to \$7,500,000	\$7,000
119.45	greater than \$7,500,000 but less than or	
119.46	equal to \$10,000,000	\$8,500

120.1	greater than \$10,000,000 but less than or	
120.2	equal to \$12,500,000	\$10,000
120.3	greater than \$12,500,000 but less than or	
120.4	equal to \$15,000,000	\$14,000
120.5	greater than \$15,000,000	\$18,000

120.6 (2) If requested, the license holder shall provide the commissioner information to verify
 120.7 the license holder's annual revenues or other information as needed, including copies of
 120.8 documents submitted to the Department of Revenue.

120.9 (3) At each annual renewal, a license holder may elect to pay the highest renewal fee,
 120.10 and not provide annual revenue information to the commissioner.

120.11 (4) A license holder that knowingly provides the commissioner incorrect revenue amounts
 120.12 for the purpose of paying a lower license fee shall be subject to a civil penalty in the amount
 120.13 of double the fee the provider should have paid.

120.14 (5) Notwithstanding clause (1), a license holder providing services under one or more
 120.15 licenses under chapter 245B that are in effect on May 15, 2013, shall pay an annual license
 120.16 fee for calendar years 2014, 2015, and 2016, equal to the total license fees paid by the license
 120.17 holder for all licenses held under chapter 245B for calendar year 2013. For calendar year
 120.18 2017 and thereafter, the license holder shall pay an annual license fee according to clause
 120.19 (1).

120.20 (c) A chemical dependency treatment program licensed under chapter 245G, to provide
 120.21 chemical dependency treatment shall pay an annual nonrefundable license fee based on the
 120.22 following schedule:

120.23	Licensed Capacity	License Fee
120.24	1 to 24 persons	\$600
120.25	25 to 49 persons	\$800
120.26	50 to 74 persons	\$1,000
120.27	75 to 99 persons	\$1,200
120.28	100 or more persons	\$1,400

120.29 (d) A chemical dependency program licensed under Minnesota Rules, parts 9530.6510
 120.30 to 9530.6590, to provide detoxification services shall pay an annual nonrefundable license
 120.31 fee based on the following schedule:

120.32	Licensed Capacity	License Fee
120.33	1 to 24 persons	\$760
120.34	25 to 49 persons	\$960
120.35	50 or more persons	\$1,160

121.1 (e) Except for child foster care, a residential facility licensed under Minnesota Rules,
 121.2 chapter 2960, to serve children shall pay an annual nonrefundable license fee based on the
 121.3 following schedule:

121.4	Licensed Capacity	License Fee
121.5	1 to 24 persons	\$1,000
121.6	25 to 49 persons	\$1,100
121.7	50 to 74 persons	\$1,200
121.8	75 to 99 persons	\$1,300
121.9	100 or more persons	\$1,400

121.10 (f) A residential facility licensed under section 245I.23 or Minnesota Rules, parts
 121.11 9520.0500 to 9520.0670, to serve persons with mental illness shall pay an annual
 121.12 nonrefundable license fee based on the following schedule:

121.13	Licensed Capacity	License Fee
121.14	1 to 24 persons	\$2,525
121.15	25 or more persons	\$2,725

121.16 (g) A residential facility licensed under Minnesota Rules, parts 9570.2000 to 9570.3400,
 121.17 to serve persons with physical disabilities shall pay an annual nonrefundable license fee
 121.18 based on the following schedule:

121.19	Licensed Capacity	License Fee
121.20	1 to 24 persons	\$450
121.21	25 to 49 persons	\$650
121.22	50 to 74 persons	\$850
121.23	75 to 99 persons	\$1,050
121.24	100 or more persons	\$1,250

121.25 (h) A program licensed to provide independent living assistance for youth under section
 121.26 245A.22 shall pay an annual nonrefundable license fee of \$1,500.

121.27 (i) A private agency licensed to provide foster care and adoption services under Minnesota
 121.28 Rules, parts 9545.0755 to 9545.0845, shall pay an annual nonrefundable license fee of \$875.

121.29 (j) A program licensed as an adult day care center licensed under Minnesota Rules, parts
 121.30 9555.9600 to 9555.9730, shall pay an annual nonrefundable license fee based on the
 121.31 following schedule:

121.32	Licensed Capacity	License Fee
121.33	1 to 24 persons	\$500
121.34	25 to 49 persons	\$700

122.1	50 to 74 persons	\$900
122.2	75 to 99 persons	\$1,100
122.3	100 or more persons	\$1,300

122.4 (k) A program licensed to provide treatment services to persons with sexual psychopathic
 122.5 personalities or sexually dangerous persons under Minnesota Rules, parts 9515.3000 to
 122.6 9515.3110, shall pay an annual nonrefundable license fee of \$20,000.

122.7 (l) ~~A mental health center or mental health clinic requesting certification for purposes~~
 122.8 ~~of insurance and subscriber contract reimbursement under Minnesota Rules, parts 9520.0750~~
 122.9 ~~to 9520.0870~~ certified under section 245I.20, shall pay a an annual nonrefundable certification
 122.10 fee of \$1,550 ~~per year~~. If the ~~mental health center or~~ mental health clinic provides services
 122.11 at a primary location with satellite facilities, the satellite facilities shall be certified with the
 122.12 primary location without an additional charge.

122.13 Sec. 49. Minnesota Statutes 2020, section 245A.65, subdivision 2, is amended to read:

122.14 Subd. 2. **Abuse prevention plans.** All license holders shall establish and enforce ongoing
 122.15 written program abuse prevention plans and individual abuse prevention plans as required
 122.16 under section 626.557, subdivision 14.

122.17 (a) The scope of the program abuse prevention plan is limited to the population, physical
 122.18 plant, and environment within the control of the license holder and the location where
 122.19 licensed services are provided. In addition to the requirements in section 626.557, subdivision
 122.20 14, the program abuse prevention plan shall meet the requirements in clauses (1) to (5).

122.21 (1) The assessment of the population shall include an evaluation of the following factors:
 122.22 age, gender, mental functioning, physical and emotional health or behavior of the client;
 122.23 the need for specialized programs of care for clients; the need for training of staff to meet
 122.24 identified individual needs; and the knowledge a license holder may have regarding previous
 122.25 abuse that is relevant to minimizing risk of abuse for clients.

122.26 (2) The assessment of the physical plant where the licensed services are provided shall
 122.27 include an evaluation of the following factors: the condition and design of the building as
 122.28 it relates to the safety of the clients; and the existence of areas in the building which are
 122.29 difficult to supervise.

122.30 (3) The assessment of the environment (3) for each facility and for each site when living
 122.31 arrangements are provided by the agency shall include an evaluation of the following factors:
 122.32 the location of the program in a particular neighborhood or community; the type of grounds

123.1 and terrain surrounding the building; the type of internal programming; and the program's
123.2 staffing patterns.

123.3 (4) The license holder shall provide an orientation to the program abuse prevention plan
123.4 for clients receiving services. If applicable, the client's legal representative must be notified
123.5 of the orientation. The license holder shall provide this orientation for each new person
123.6 within 24 hours of admission, or for persons who would benefit more from a later orientation,
123.7 the orientation may take place within 72 hours.

123.8 (5) The license holder's governing body or the governing body's delegated representative
123.9 shall review the plan at least annually using the assessment factors in the plan and any
123.10 substantiated maltreatment findings that occurred since the last review. The governing body
123.11 or the governing body's delegated representative shall revise the plan, if necessary, to reflect
123.12 the review results.

123.13 (6) A copy of the program abuse prevention plan shall be posted in a prominent location
123.14 in the program and be available upon request to mandated reporters, persons receiving
123.15 services, and legal representatives.

123.16 (b) In addition to the requirements in section 626.557, subdivision 14, the individual
123.17 abuse prevention plan shall meet the requirements in clauses (1) and (2).

123.18 (1) The plan shall include a statement of measures that will be taken to minimize the
123.19 risk of abuse to the vulnerable adult when the individual assessment required in section
123.20 626.557, subdivision 14, paragraph (b), indicates the need for measures in addition to the
123.21 specific measures identified in the program abuse prevention plan. The measures shall
123.22 include the specific actions the program will take to minimize the risk of abuse within the
123.23 scope of the licensed services, and will identify referrals made when the vulnerable adult
123.24 is susceptible to abuse outside the scope or control of the licensed services. When the
123.25 assessment indicates that the vulnerable adult does not need specific risk reduction measures
123.26 in addition to those identified in the program abuse prevention plan, the individual abuse
123.27 prevention plan shall document this determination.

123.28 (2) An individual abuse prevention plan shall be developed for each new person as part
123.29 of the initial individual program plan or service plan required under the applicable licensing
123.30 rule or statute. The review and evaluation of the individual abuse prevention plan shall be
123.31 done as part of the review of the program plan ~~or~~ service plan, or treatment plan. The person
123.32 receiving services shall participate in the development of the individual abuse prevention
123.33 plan to the full extent of the person's abilities. If applicable, the person's legal representative
123.34 shall be given the opportunity to participate with or for the person in the development of

124.1 the plan. The interdisciplinary team shall document the review of all abuse prevention plans
124.2 at least annually, using the individual assessment and any reports of abuse relating to the
124.3 person. The plan shall be revised to reflect the results of this review.

124.4 Sec. 50. Minnesota Statutes 2020, section 245D.02, subdivision 20, is amended to read:

124.5 Subd. 20. **Mental health crisis intervention team.** "Mental health crisis intervention
124.6 team" means a mental health crisis response provider as identified in section 256B.0624,
124.7 ~~subdivision 2, paragraph (d), for adults, and in section 256B.0944, subdivision 1, paragraph~~
124.8 ~~(d), for children.~~

124.9 Sec. 51. Minnesota Statutes 2020, section 254B.05, subdivision 5, is amended to read:

124.10 Subd. 5. **Rate requirements.** (a) The commissioner shall establish rates for substance
124.11 use disorder services and service enhancements funded under this chapter.

124.12 (b) Eligible substance use disorder treatment services include:

124.13 (1) outpatient treatment services that are licensed according to sections 245G.01 to
124.14 245G.17, or applicable tribal license;

124.15 (2) comprehensive assessments provided according to sections 245.4863, paragraph (a),
124.16 and 245G.05;

124.17 (3) care coordination services provided according to section 245G.07, subdivision 1,
124.18 paragraph (a), clause (5);

124.19 (4) peer recovery support services provided according to section 245G.07, subdivision
124.20 2, clause (8);

124.21 (5) on July 1, 2019, or upon federal approval, whichever is later, withdrawal management
124.22 services provided according to chapter 245F;

124.23 (6) medication-assisted therapy services that are licensed according to sections 245G.01
124.24 to 245G.17 and 245G.22, or applicable tribal license;

124.25 (7) medication-assisted therapy plus enhanced treatment services that meet the
124.26 requirements of clause (6) and provide nine hours of clinical services each week;

124.27 (8) high, medium, and low intensity residential treatment services that are licensed
124.28 according to sections 245G.01 to 245G.17 and 245G.21 or applicable tribal license which
124.29 provide, respectively, 30, 15, and five hours of clinical services each week;

125.1 (9) hospital-based treatment services that are licensed according to sections 245G.01 to
125.2 245G.17 or applicable tribal license and licensed as a hospital under sections 144.50 to
125.3 144.56;

125.4 (10) adolescent treatment programs that are licensed as outpatient treatment programs
125.5 according to sections 245G.01 to 245G.18 or as residential treatment programs according
125.6 to Minnesota Rules, parts 2960.0010 to 2960.0220, and 2960.0430 to 2960.0490, or
125.7 applicable tribal license;

125.8 (11) high-intensity residential treatment services that are licensed according to sections
125.9 245G.01 to 245G.17 and 245G.21 or applicable tribal license, which provide 30 hours of
125.10 clinical services each week provided by a state-operated vendor or to clients who have been
125.11 civilly committed to the commissioner, present the most complex and difficult care needs,
125.12 and are a potential threat to the community; and

125.13 (12) room and board facilities that meet the requirements of subdivision 1a.

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

125.16 (1) programs that serve parents with their children if the program:

125.17 (i) provides on-site child care during the hours of treatment activity that:

125.18 (A) is licensed under chapter 245A as a child care center under Minnesota Rules, chapter
125.19 9503; or

125.20 (B) meets the licensure exclusion criteria of section 245A.03, subdivision 2, paragraph
125.21 (a), clause (6), and meets the requirements under section 245G.19, subdivision 4; or

125.22 (ii) arranges for off-site child care during hours of treatment activity at a facility that is
125.23 licensed under chapter 245A as:

125.24 (A) a child care center under Minnesota Rules, chapter 9503; or

125.25 (B) a family child care home under Minnesota Rules, chapter 9502;

125.26 (2) culturally specific programs as defined in section 254B.01, subdivision 4a, or
125.27 programs or subprograms serving special populations, if the program or subprogram meets
125.28 the following requirements:

125.29 (i) is designed to address the unique needs of individuals who share a common language,
125.30 racial, ethnic, or social background;

125.31 (ii) is governed with significant input from individuals of that specific background; and

126.1 (iii) employs individuals to provide individual or group therapy, at least 50 percent of
126.2 whom are of that specific background, except when the common social background of the
126.3 individuals served is a traumatic brain injury or cognitive disability and the program employs
126.4 treatment staff who have the necessary professional training, as approved by the
126.5 commissioner, to serve clients with the specific disabilities that the program is designed to
126.6 serve;

126.7 (3) programs that offer medical services delivered by appropriately credentialed health
126.8 care staff in an amount equal to two hours per client per week if the medical needs of the
126.9 client and the nature and provision of any medical services provided are documented in the
126.10 client file; and

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

126.13 (i) the program meets the co-occurring requirements in section 245G.20;

126.14 (ii) 25 percent of the counseling staff are ~~licensed~~ mental health professionals, ~~as defined~~
126.15 ~~in section 245.462, subdivision 18, clauses (1) to (6)~~ qualified according to section 245I.04,
126.16 subdivision 2, or are students or licensing candidates under the supervision of a licensed
126.17 alcohol and drug counselor supervisor and ~~licensed~~ mental health professional, except that
126.18 no more than 50 percent of the mental health staff may be students or licensing candidates
126.19 with time documented to be directly related to provisions of co-occurring services;

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

126.22 (iv) the program has standards for multidisciplinary case review that include a monthly
126.23 review for each client that, at a minimum, includes a ~~licensed~~ mental health professional
126.24 and licensed alcohol and drug counselor, and their involvement in the review is documented;

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

126.27 (vi) co-occurring counseling staff shall receive eight hours of co-occurring disorder
126.28 training annually.

126.29 (d) In order to be eligible for a higher rate under paragraph (c), clause (1), a program
126.30 that provides arrangements for off-site child care must maintain current documentation at
126.31 the chemical dependency facility of the child care provider's current licensure to provide
126.32 child care services. Programs that provide child care according to paragraph (c), clause (1),
126.33 must be deemed in compliance with the licensing requirements in section 245G.19.

127.1 (e) Adolescent residential programs that meet the requirements of Minnesota Rules,
127.2 parts 2960.0430 to 2960.0490 and 2960.0580 to 2960.0690, are exempt from the requirements
127.3 in paragraph (c), clause (4), items (i) to (iv).

127.4 (f) Subject to federal approval, chemical dependency services that are otherwise covered
127.5 as direct face-to-face services may be provided via two-way interactive video. The use of
127.6 two-way interactive video must be medically appropriate to the condition and needs of the
127.7 person being served. Reimbursement shall be at the same rates and under the same conditions
127.8 that would otherwise apply to direct face-to-face services. The interactive video equipment
127.9 and connection must comply with Medicare standards in effect at the time the service is
127.10 provided.

127.11 (g) For the purpose of reimbursement under this section, substance use disorder treatment
127.12 services provided in a group setting without a group participant maximum or maximum
127.13 client to staff ratio under chapter 245G shall not exceed a client to staff ratio of 48 to one.
127.14 At least one of the attending staff must meet the qualifications as established under this
127.15 chapter for the type of treatment service provided. A recovery peer may not be included as
127.16 part of the staff ratio.

127.17 Sec. 52. Minnesota Statutes 2020, section 256B.0615, subdivision 1, is amended to read:

127.18 Subdivision 1. **Scope.** Medical assistance covers mental health certified peer specialist
127.19 services, as established in subdivision 2, subject to federal approval, if provided to recipients
127.20 who are eligible for services under sections 256B.0622, 256B.0623, and 256B.0624 and
127.21 are provided by a mental health certified peer specialist who has completed the training
127.22 under subdivision 5 and is qualified according to section 245I.04, subdivision 10.

127.23 Sec. 53. Minnesota Statutes 2020, section 256B.0615, subdivision 5, is amended to read:

127.24 Subd. 5. **Certified peer specialist training and certification.** The commissioner of
127.25 human services shall develop a training and certification process for certified peer specialists,
127.26 ~~who must be at least 21 years of age.~~ The candidates must have had a primary diagnosis of
127.27 mental illness, be a current or former consumer of mental health services, and must
127.28 demonstrate leadership and advocacy skills and a strong dedication to recovery. The training
127.29 curriculum must teach participating consumers specific skills relevant to providing peer
127.30 support to other consumers. In addition to initial training and certification, the commissioner
127.31 shall develop ongoing continuing educational workshops on pertinent issues related to peer
127.32 support counseling.

128.1 Sec. 54. Minnesota Statutes 2020, section 256B.0616, subdivision 1, is amended to read:

128.2 Subdivision 1. **Scope.** Medical assistance covers mental health certified family peer
128.3 specialists services, as established in subdivision 2, subject to federal approval, if provided
128.4 to recipients who have an emotional disturbance or severe emotional disturbance under
128.5 chapter 245, and are provided by a mental health certified family peer specialist who has
128.6 completed the training under subdivision 5 and is qualified according to section 245I.04,
128.7 subdivision 12. A family peer specialist cannot provide services to the peer specialist's
128.8 family.

128.9 Sec. 55. Minnesota Statutes 2020, section 256B.0616, subdivision 3, is amended to read:

128.10 Subd. 3. **Eligibility.** Family peer support services may be ~~located in~~ provided to recipients
128.11 of inpatient hospitalization, partial hospitalization, residential treatment, intensive treatment
128.12 in foster care, day treatment, children's therapeutic services and supports, or crisis services.

128.13 Sec. 56. Minnesota Statutes 2020, section 256B.0616, subdivision 5, is amended to read:

128.14 Subd. 5. **Certified family peer specialist training and certification.** The commissioner
128.15 shall develop a training and certification process for certified family peer specialists ~~who~~
128.16 ~~must be at least 21 years of age.~~ The candidates must have raised or be currently raising a
128.17 child with a mental illness, have had experience navigating the children's mental health
128.18 system, and must demonstrate leadership and advocacy skills and a strong dedication to
128.19 family-driven and family-focused services. The training curriculum must teach participating
128.20 family peer specialists specific skills relevant to providing peer support to other parents. In
128.21 addition to initial training and certification, the commissioner shall develop ongoing
128.22 continuing educational workshops on pertinent issues related to family peer support
128.23 counseling.

128.24 Sec. 57. Minnesota Statutes 2020, section 256B.0622, subdivision 1, is amended to read:

128.25 Subdivision 1. **Scope.** (a) Subject to federal approval, medical assistance covers medically
128.26 necessary, assertive community treatment for clients as defined in subdivision 2a and
128.27 intensive residential treatment services for clients as defined in subdivision 3, when the
128.28 services are provided by an entity certified under and meeting the standards in this section.

128.29 (b) Subject to federal approval, medical assistance covers medically necessary, intensive
128.30 residential treatment services when the services are provided by an entity licensed under
128.31 and meeting the standards in section 245I.23.

129.1 (c) The provider entity must make reasonable and good faith efforts to report individual
129.2 client outcomes to the commissioner, using instruments and protocols approved by the
129.3 commissioner.

129.4 Sec. 58. Minnesota Statutes 2020, section 256B.0622, subdivision 2, is amended to read:

129.5 Subd. 2. **Definitions.** (a) For purposes of this section, the following terms have the
129.6 meanings given them.

129.7 (b) "ACT team" means the group of interdisciplinary mental health staff who work as
129.8 a team to provide assertive community treatment.

129.9 (c) "Assertive community treatment" means intensive nonresidential treatment and
129.10 rehabilitative mental health services provided according to the assertive community treatment
129.11 model. Assertive community treatment provides a single, fixed point of responsibility for
129.12 treatment, rehabilitation, and support needs for clients. Services are offered 24 hours per
129.13 day, seven days per week, in a community-based setting.

129.14 (d) "Individual treatment plan" means ~~the document that results from a person-centered~~
129.15 ~~planning process of determining real-life outcomes with clients and developing strategies~~
129.16 ~~to achieve those outcomes~~ a plan described under section 245I.10, subdivisions 7 and 8.

129.17 ~~(e) "Assertive engagement" means the use of collaborative strategies to engage clients~~
129.18 ~~to receive services.~~

129.19 ~~(f) "Benefits and finance support" means assisting clients in capably managing financial~~
129.20 ~~affairs. Services include, but are not limited to, assisting clients in applying for benefits;~~
129.21 ~~assisting with redetermination of benefits; providing financial crisis management; teaching~~
129.22 ~~and supporting budgeting skills and asset development; and coordinating with a client's~~
129.23 ~~representative payee, if applicable.~~

129.24 ~~(g) "Co-occurring disorder treatment" means the treatment of co-occurring mental illness~~
129.25 ~~and substance use disorders and is characterized by assertive outreach, stage-wise~~
129.26 ~~comprehensive treatment, treatment goal setting, and flexibility to work within each stage~~
129.27 ~~of treatment. Services include, but are not limited to, assessing and tracking clients' stages~~
129.28 ~~of change readiness and treatment; applying the appropriate treatment based on stages of~~
129.29 ~~change, such as outreach and motivational interviewing techniques to work with clients in~~
129.30 ~~earlier stages of change readiness and cognitive behavioral approaches and relapse prevention~~
129.31 ~~to work with clients in later stages of change; and facilitating access to community supports.~~

129.32 ~~(h)~~ (e) "Crisis assessment and intervention" means mental health crisis response services
129.33 as defined in section 256B.0624, subdivision 2, ~~paragraphs (e) to (e).~~

130.1 ~~(i) "Employment services" means assisting clients to work at jobs of their choosing.~~
130.2 ~~Services must follow the principles of the individual placement and support (IPS)~~
130.3 ~~employment model, including focusing on competitive employment; emphasizing individual~~
130.4 ~~client preferences and strengths; ensuring employment services are integrated with mental~~
130.5 ~~health services; conducting rapid job searches and systematic job development according~~
130.6 ~~to client preferences and choices; providing benefits counseling; and offering all services~~
130.7 ~~in an individualized and time-unlimited manner. Services shall also include educating clients~~
130.8 ~~about opportunities and benefits of work and school and assisting the client in learning job~~
130.9 ~~skills, navigating the work place, and managing work relationships.~~

130.10 ~~(j) "Family psychoeducation and support" means services provided to the client's family~~
130.11 ~~and other natural supports to restore and strengthen the client's unique social and family~~
130.12 ~~relationships. Services include, but are not limited to, individualized psychoeducation about~~
130.13 ~~the client's illness and the role of the family and other significant people in the therapeutic~~
130.14 ~~process; family intervention to restore contact, resolve conflict, and maintain relationships~~
130.15 ~~with family and other significant people in the client's life; ongoing communication and~~
130.16 ~~collaboration between the ACT team and the family; introduction and referral to family~~
130.17 ~~self-help programs and advocacy organizations that promote recovery and family~~
130.18 ~~engagement, individual supportive counseling, parenting training, and service coordination~~
130.19 ~~to help clients fulfill parenting responsibilities; coordinating services for the child and~~
130.20 ~~restoring relationships with children who are not in the client's custody; and coordinating~~
130.21 ~~with child welfare and family agencies, if applicable. These services must be provided with~~
130.22 ~~the client's agreement and consent.~~

130.23 ~~(k) "Housing access support" means assisting clients to find, obtain, retain, and move~~
130.24 ~~to safe and adequate housing of their choice. Housing access support includes, but is not~~
130.25 ~~limited to, locating housing options with a focus on integrated independent settings; applying~~
130.26 ~~for housing subsidies, programs, or resources; assisting the client in developing relationships~~
130.27 ~~with local landlords; providing tenancy support and advocacy for the individual's tenancy~~
130.28 ~~rights at the client's home; and assisting with relocation.~~

130.29 ~~(f)~~ (f) "Individual treatment team" means a minimum of three members of the ACT team
130.30 who are responsible for consistently carrying out most of a client's assertive community
130.31 treatment services.

130.32 ~~(m) "Intensive residential treatment services treatment team" means all staff who provide~~
130.33 ~~intensive residential treatment services under this section to clients. At a minimum, this~~
130.34 ~~includes the clinical supervisor; mental health professionals as defined in section 245.462,~~
130.35 ~~subdivision 18, clauses (1) to (6); mental health practitioners as defined in section 245.462,~~

131.1 ~~subdivision 17; mental health rehabilitation workers under section 256B.0623, subdivision~~
131.2 ~~5, paragraph (a), clause (4); and mental health certified peer specialists under section~~
131.3 ~~256B.0615.~~

131.4 ~~(n) "Intensive residential treatment services" means short-term, time-limited services~~
131.5 ~~provided in a residential setting to clients who are in need of more restrictive settings and~~
131.6 ~~are at risk of significant functional deterioration if they do not receive these services. Services~~
131.7 ~~are designed to develop and enhance psychiatric stability, personal and emotional adjustment,~~
131.8 ~~self-sufficiency, and skills to live in a more independent setting. Services must be directed~~
131.9 ~~toward a targeted discharge date with specified client outcomes.~~

131.10 ~~(o) "Medication assistance and support" means assisting clients in accessing medication,~~
131.11 ~~developing the ability to take medications with greater independence, and providing~~
131.12 ~~medication setup. This includes the prescription, administration, and order of medication~~
131.13 ~~by appropriate medical staff.~~

131.14 ~~(p) "Medication education" means educating clients on the role and effects of medications~~
131.15 ~~in treating symptoms of mental illness and the side effects of medications.~~

131.16 ~~(q) "Overnight staff" means a member of the intensive residential treatment services~~
131.17 ~~team who is responsible during hours when clients are typically asleep.~~

131.18 ~~(r) "Mental health certified peer specialist services" has the meaning given in section~~
131.19 ~~256B.0615.~~

131.20 ~~(s) "Physical health services" means any service or treatment to meet the physical health~~
131.21 ~~needs of the client to support the client's mental health recovery. Services include, but are~~
131.22 ~~not limited to, education on primary health issues, including wellness education; medication~~
131.23 ~~administration and monitoring; providing and coordinating medical screening and follow-up;~~
131.24 ~~scheduling routine and acute medical and dental care visits; tobacco cessation strategies;~~
131.25 ~~assisting clients in attending appointments; communicating with other providers; and~~
131.26 ~~integrating all physical and mental health treatment.~~

131.27 ~~(t)~~ (g) "Primary team member" means the person who leads and coordinates the activities
131.28 of the individual treatment team and is the individual treatment team member who has
131.29 primary responsibility for establishing and maintaining a therapeutic relationship with the
131.30 client on a continuing basis.

131.31 ~~(u) "Rehabilitative mental health services" means mental health services that are~~
131.32 ~~rehabilitative and enable the client to develop and enhance psychiatric stability, social~~

132.1 ~~competencies, personal and emotional adjustment, independent living, parenting skills, and~~
132.2 ~~community skills, when these abilities are impaired by the symptoms of mental illness.~~

132.3 ~~(v) "Symptom management" means supporting clients in identifying and targeting the~~
132.4 ~~symptoms and occurrence patterns of their mental illness and developing strategies to reduce~~
132.5 ~~the impact of those symptoms.~~

132.6 ~~(w) "Therapeutic interventions" means empirically supported techniques to address~~
132.7 ~~specific symptoms and behaviors such as anxiety, psychotic symptoms, emotional~~
132.8 ~~dysregulation, and trauma symptoms. Interventions include empirically supported~~
132.9 ~~psychotherapies including, but not limited to, cognitive behavioral therapy, exposure therapy,~~
132.10 ~~acceptance and commitment therapy, interpersonal therapy, and motivational interviewing.~~

132.11 ~~(x) "Wellness self-management and prevention" means a combination of approaches to~~
132.12 ~~working with the client to build and apply skills related to recovery, and to support the client~~
132.13 ~~in participating in leisure and recreational activities, civic participation, and meaningful~~
132.14 ~~structure.~~

132.15 (h) "Certified rehabilitation specialist" means a staff person who is qualified according
132.16 to section 245I.04, subdivision 8.

132.17 (i) "Clinical trainee" means a staff person who is qualified according to section 245I.04,
132.18 subdivision 6.

132.19 (j) "Mental health certified peer specialist" means a staff person who is qualified
132.20 according to section 245I.04, subdivision 10.

132.21 (k) "Mental health practitioner" means a staff person who is qualified according to section
132.22 245I.04, subdivision 4.

132.23 (l) "Mental health professional" means a staff person who is qualified according to
132.24 section 245I.04, subdivision 2.

132.25 (m) "Mental health rehabilitation worker" means a staff person who is qualified according
132.26 to section 245I.04, subdivision 14.

132.27 Sec. 59. Minnesota Statutes 2020, section 256B.0622, subdivision 3a, is amended to read:

132.28 Subd. 3a. **Provider certification and contract requirements for assertive community**
132.29 **treatment.** (a) The assertive community treatment provider must:

132.30 (1) have a contract with the host county to provide assertive community treatment
132.31 services; and

133.1 (2) have each ACT team be certified by the state following the certification process and
133.2 procedures developed by the commissioner. The certification process determines whether
133.3 the ACT team meets the standards for assertive community treatment under this section as
133.4 ~~well as, the standards in chapter 245I as required in section 245I.011, subdivision 5, and~~
133.5 minimum program fidelity standards as measured by a nationally recognized fidelity tool
133.6 approved by the commissioner. Recertification must occur at least every three years.

133.7 (b) An ACT team certified under this subdivision must meet the following standards:

133.8 (1) have capacity to recruit, hire, manage, and train required ACT team members;

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

133.10 ~~(3) ensure adequate preservice and ongoing training for staff;~~

133.11 ~~(4) ensure that staff is capable of implementing culturally specific services that are~~
133.12 ~~culturally responsive and appropriate as determined by the client's culture, beliefs, values,~~
133.13 ~~and language as identified in the individual treatment plan;~~

133.14 ~~(5)~~ (3) ensure flexibility in service delivery to respond to the changing and intermittent
133.15 care needs of a client as identified by the client and the individual treatment plan;

133.16 ~~(6) develop and maintain client files, individual treatment plans, and contact charting;~~

133.17 ~~(7) develop and maintain staff training and personnel files;~~

133.18 ~~(8) submit information as required by the state;~~

133.19 ~~(9)~~ (4) keep all necessary records required by law;

133.20 ~~(10) comply with all applicable laws;~~

133.21 ~~(11)~~ (5) be an enrolled Medicaid provider; and

133.22 ~~(12)~~ (6) establish and maintain a quality assurance plan to determine specific service
133.23 outcomes and the client's satisfaction with services; and.

133.24 ~~(13) develop and maintain written policies and procedures regarding service provision~~
133.25 ~~and administration of the provider entity.~~

133.26 (c) The commissioner may intervene at any time and decertify an ACT team with cause.
133.27 The commissioner shall establish a process for decertification of an ACT team and shall
133.28 require corrective action, medical assistance repayment, or decertification of an ACT team
133.29 that no longer meets the requirements in this section or that fails to meet the clinical quality
133.30 standards or administrative standards provided by the commissioner in the application and
133.31 certification process. The decertification is subject to appeal to the state.

134.1 Sec. 60. Minnesota Statutes 2020, section 256B.0622, subdivision 4, is amended to read:

134.2 Subd. 4. **Provider entity licensure and contract requirements for intensive residential**
134.3 **treatment services.** ~~(a) The intensive residential treatment services provider entity must:~~

134.4 ~~(1) be licensed under Minnesota Rules, parts 9520.0500 to 9520.0670;~~

134.5 ~~(2) not exceed 16 beds per site; and~~

134.6 ~~(3) comply with the additional standards in this section.~~

134.7 ~~(b)~~ (a) The commissioner shall develop procedures for counties and providers to submit
134.8 other documentation as needed to allow the commissioner to determine whether the standards
134.9 in this section are met.

134.10 ~~(e)~~ (b) A provider entity must specify in the provider entity's application what geographic
134.11 area and populations will be served by the proposed program. A provider entity must
134.12 document that the capacity or program specialties of existing programs are not sufficient
134.13 to meet the service needs of the target population. A provider entity must submit evidence
134.14 of ongoing relationships with other providers and levels of care to facilitate referrals to and
134.15 from the proposed program.

134.16 ~~(d)~~ (c) A provider entity must submit documentation that the provider entity requested
134.17 a statement of need from each county board and tribal authority that serves as a local mental
134.18 health authority in the proposed service area. The statement of need must specify if the local
134.19 mental health authority supports or does not support the need for the proposed program and
134.20 the basis for this determination. If a local mental health authority does not respond within
134.21 60 days of the receipt of the request, the commissioner shall determine the need for the
134.22 program based on the documentation submitted by the provider entity.

134.23 Sec. 61. Minnesota Statutes 2020, section 256B.0622, subdivision 7, is amended to read:

134.24 Subd. 7. **Assertive community treatment service standards.** (a) ACT teams must offer
134.25 and have the capacity to directly provide the following services:

134.26 (1) assertive engagement using collaborative strategies to encourage clients to receive
134.27 services;

134.28 (2) benefits and finance support that assists clients to capably manage financial affairs.
134.29 Services include but are not limited to assisting clients in applying for benefits, assisting
134.30 with redetermination of benefits, providing financial crisis management, teaching and
134.31 supporting budgeting skills and asset development, and coordinating with a client's
134.32 representative payee, if applicable;

135.1 (3) co-occurring substance use disorder treatment as defined in section 245I.02,
135.2 subdivision 11;

135.3 (4) crisis assessment and intervention;

135.4 (5) employment services that assist clients to work at jobs of the clients' choosing.
135.5 Services must follow the principles of the individual placement and support employment
135.6 model, including focusing on competitive employment, emphasizing individual client
135.7 preferences and strengths, ensuring employment services are integrated with mental health
135.8 services, conducting rapid job searches and systematic job development according to client
135.9 preferences and choices, providing benefits counseling, and offering all services in an
135.10 individualized and time-unlimited manner. Services must also include educating clients
135.11 about opportunities and benefits of work and school and assisting the client in learning job
135.12 skills, navigating the workplace, workplace accommodations, and managing work
135.13 relationships;

135.14 (6) family psychoeducation and support provided to the client's family and other natural
135.15 supports to restore and strengthen the client's unique social and family relationships. Services
135.16 include but are not limited to individualized psychoeducation about the client's illness and
135.17 the role of the family and other significant people in the therapeutic process; family
135.18 intervention to restore contact, resolve conflict, and maintain relationships with family and
135.19 other significant people in the client's life; ongoing communication and collaboration between
135.20 the ACT team and the family; introduction and referral to family self-help programs and
135.21 advocacy organizations that promote recovery and family engagement, individual supportive
135.22 counseling, parenting training, and service coordination to help clients fulfill parenting
135.23 responsibilities; coordinating services for the child and restoring relationships with children
135.24 who are not in the client's custody; and coordinating with child welfare and family agencies,
135.25 if applicable. These services must be provided with the client's agreement and consent;

135.26 (7) housing access support that assists clients to find, obtain, retain, and move to safe
135.27 and adequate housing of their choice. Housing access support includes but is not limited to
135.28 locating housing options with a focus on integrated independent settings; applying for
135.29 housing subsidies, programs, or resources; assisting the client in developing relationships
135.30 with local landlords; providing tenancy support and advocacy for the individual's tenancy
135.31 rights at the client's home; and assisting with relocation;

135.32 (8) medication assistance and support that assists clients in accessing medication,
135.33 developing the ability to take medications with greater independence, and providing

136.1 medication setup. Medication assistance and support includes assisting the client with the
136.2 prescription, administration, and ordering of medication by appropriate medical staff;

136.3 (9) medication education that educates clients on the role and effects of medications in
136.4 treating symptoms of mental illness and the side effects of medications;

136.5 (10) mental health certified peer specialists services according to section 256B.0615;

136.6 (11) physical health services to meet the physical health needs of the client to support
136.7 the client's mental health recovery. Services include but are not limited to education on
136.8 primary health and wellness issues, medication administration and monitoring, providing
136.9 and coordinating medical screening and follow-up, scheduling routine and acute medical
136.10 and dental care visits, tobacco cessation strategies, assisting clients in attending appointments,
136.11 communicating with other providers, and integrating all physical and mental health treatment;

136.12 (12) rehabilitative mental health services as defined in section 245I.02, subdivision 33;

136.13 (13) symptom management that supports clients in identifying and targeting the symptoms
136.14 and occurrence patterns of their mental illness and developing strategies to reduce the impact
136.15 of those symptoms;

136.16 (14) therapeutic interventions to address specific symptoms and behaviors such as
136.17 anxiety, psychotic symptoms, emotional dysregulation, and trauma symptoms. Interventions
136.18 include empirically supported psychotherapies including but not limited to cognitive
136.19 behavioral therapy, exposure therapy, acceptance and commitment therapy, interpersonal
136.20 therapy, and motivational interviewing;

136.21 (15) wellness self-management and prevention that includes a combination of approaches
136.22 to working with the client to build and apply skills related to recovery, and to support the
136.23 client in participating in leisure and recreational activities, civic participation, and meaningful
136.24 structure; and

136.25 (16) other services based on client needs as identified in a client's assertive community
136.26 treatment individual treatment plan.

136.27 (b) ACT teams must ensure the provision of all services necessary to meet a client's
136.28 needs as identified in the client's individual treatment plan.

136.29 Sec. 62. Minnesota Statutes 2020, section 256B.0622, subdivision 7a, is amended to read:

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

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

136.32 (1) the team leader:

137.1 (i) shall be a ~~licensed mental health professional who is qualified under Minnesota Rules,~~
137.2 ~~part 9505.0371, subpart 5, item A.~~ Individuals who are not licensed but who are eligible
137.3 for licensure and are otherwise qualified may also fulfill this role but must obtain full
137.4 licensure within 24 months of assuming the role of team leader;

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

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

137.12 (iv) must be available to provide overall ~~clinical oversight~~ treatment supervision to the
137.13 ACT team after regular business hours and on weekends and holidays. The team leader may
137.14 delegate this duty to another qualified member of the ACT team;

137.15 (2) the psychiatric care provider:

137.16 (i) must be a ~~licensed psychiatrist certified by the American Board of Psychiatry and~~
137.17 ~~Neurology or eligible for board certification or certified by the American Osteopathic Board~~
137.18 ~~of Neurology and Psychiatry or eligible for board certification, or a psychiatric nurse who~~
137.19 ~~is qualified under Minnesota Rules, part 9505.0371, subpart 5, item A~~ mental health
137.20 professional permitted to prescribe psychiatric medications as part of the mental health
137.21 professional's scope of practice. The psychiatric care provider must have demonstrated
137.22 clinical experience working with individuals with serious and persistent mental illness;

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

137.28 (iii) shall fulfill the following functions for assertive community treatment clients:
137.29 provide assessment and treatment of clients' symptoms and response to medications, including
137.30 side effects; provide brief therapy to clients; provide diagnostic and medication education
137.31 to clients, with medication decisions based on shared decision making; monitor clients'
137.32 nonpsychiatric medical conditions and nonpsychiatric medications; and conduct home and
137.33 community visits;

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

138.4 (v) shall have a minimum full-time equivalency that is prorated at a rate of 16 hours per
138.5 50 clients. Part-time psychiatric care providers shall have designated hours to work on the
138.6 team, with sufficient blocks of time on consistent days to carry out the provider's clinical,
138.7 supervisory, and administrative responsibilities. No more than two psychiatric care providers
138.8 may share this role;

138.9 (vi) may not provide specific roles and responsibilities by telemedicine unless approved
138.10 by the commissioner; and

138.11 (vii) shall provide psychiatric backup to the program after regular business hours and
138.12 on weekends and holidays. The psychiatric care provider may delegate this duty to another
138.13 qualified psychiatric provider;

138.14 (3) the nursing staff:

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

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

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

138.27 (4) the co-occurring disorder specialist:

138.28 (i) shall be a full-time equivalent co-occurring disorder specialist who has received
138.29 specific training on co-occurring disorders that is consistent with national evidence-based
138.30 practices. The training must include practical knowledge of common substances and how
138.31 they affect mental illnesses, the ability to assess substance use disorders and the client's
138.32 stage of treatment, motivational interviewing, and skills necessary to provide counseling to
138.33 clients at all different stages of change and treatment. The co-occurring disorder specialist

139.1 may also be an individual who is a licensed alcohol and drug counselor as described in
139.2 section 148F.01, subdivision 5, or a counselor who otherwise meets the training, experience,
139.3 and other requirements in section 245G.11, subdivision 5. No more than two co-occurring
139.4 disorder specialists may occupy this role; and

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

139.8 (5) the vocational specialist:

139.9 (i) shall be a full-time vocational specialist who has at least one-year experience providing
139.10 employment services or advanced education that involved field training in vocational services
139.11 to individuals with mental illness. An individual who does not meet these qualifications
139.12 may also serve as the vocational specialist upon completing a training plan approved by the
139.13 commissioner;

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

139.17 (iii) ~~should~~ must not refer individuals to receive any type of vocational services or linkage
139.18 by providers outside of the ACT team;

139.19 (6) the mental health certified peer specialist:

139.20 (i) shall be a full-time equivalent ~~mental health certified peer specialist as defined in~~
139.21 ~~section 256B.0615~~. No more than two individuals can share this position. The mental health
139.22 certified peer specialist is a fully integrated team member who provides highly individualized
139.23 services in the community and promotes the self-determination and shared decision-making
139.24 abilities of clients. This requirement may be waived due to workforce shortages upon
139.25 approval of the commissioner;

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

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

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

140.4 (8) additional staff:

140.5 (i) shall be based on team size. Additional treatment team staff may include licensed
140.6 mental health professionals as defined in Minnesota Rules, part 9505.0371, subpart 5, item
140.7 A; clinical trainees; certified rehabilitation specialists; mental health practitioners as defined
140.8 in section 245.462, subdivision 17; a mental health practitioner working as a clinical trainee
140.9 according to Minnesota Rules, part 9505.0371, subpart 5, item C; or mental health
140.10 rehabilitation workers as defined in section 256B.0623, subdivision 5, paragraph (a), clause
140.11 (4). These individuals shall have the knowledge, skills, and abilities required by the
140.12 population served to carry out rehabilitation and support functions; and

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

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

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

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

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

140.29 Sec. 63. Minnesota Statutes 2020, section 256B.0622, subdivision 7b, is amended to read:

140.30 Subd. 7b. **Assertive community treatment program size and opportunities.** (a) Each
140.31 ACT team shall maintain an annual average caseload that does not exceed 100 clients.
140.32 Staff-to-client ratios shall be based on team size as follows:

141.1 (1) a small ACT team must:

141.2 (i) employ at least six but no more than seven full-time treatment team staff, excluding
141.3 the program assistant and the psychiatric care provider;

141.4 (ii) serve an annual average maximum of no more than 50 clients;

141.5 (iii) ensure at least one full-time equivalent position for every eight clients served;

141.6 (iv) schedule ACT team staff for at least eight-hour shift coverage on weekdays and
141.7 on-call duty to provide crisis services and deliver services after hours when staff are not
141.8 working;

141.9 (v) provide crisis services during business hours if the small ACT team does not have
141.10 sufficient staff numbers to operate an after-hours on-call system. During all other hours,
141.11 the ACT team may arrange for coverage for crisis assessment and intervention services
141.12 through a reliable crisis-intervention provider as long as there is a mechanism by which the
141.13 ACT team communicates routinely with the crisis-intervention provider and the on-call
141.14 ACT team staff are available to see clients face-to-face when necessary or if requested by
141.15 the crisis-intervention services provider;

141.16 (vi) adjust schedules and provide staff to carry out the needed service activities in the
141.17 evenings or on weekend days or holidays, when necessary;

141.18 (vii) arrange for and provide psychiatric backup during all hours the psychiatric care
141.19 provider is not regularly scheduled to work. If availability of the ACT team's psychiatric
141.20 care provider during all hours is not feasible, alternative psychiatric prescriber backup must
141.21 be arranged and a mechanism of timely communication and coordination established in
141.22 writing; and

141.23 (viii) be composed of, at minimum, one full-time team leader, at least 16 hours each
141.24 week per 50 clients of psychiatric provider time, or equivalent if fewer clients, one full-time
141.25 equivalent nursing, one full-time ~~substance abuse~~ co-occurring disorder specialist, one
141.26 full-time equivalent mental health certified peer specialist, one full-time vocational specialist,
141.27 one full-time program assistant, and at least one additional full-time ACT team member
141.28 who has mental health professional, certified rehabilitation specialist, clinical trainee, or
141.29 mental health practitioner status; and

141.30 (2) a midsize ACT team shall:

141.31 (i) be composed of, at minimum, one full-time team leader, at least 16 hours of psychiatry
141.32 time for 51 clients, with an additional two hours for every six clients added to the team, 1.5
141.33 to two full-time equivalent nursing staff, one full-time ~~substance abuse~~ co-occurring disorder

142.1 specialist, one full-time equivalent mental health certified peer specialist, one full-time
142.2 vocational specialist, one full-time program assistant, and at least 1.5 to two additional
142.3 full-time equivalent ACT members, with at least one dedicated full-time staff member with
142.4 mental health professional status. Remaining team members may have mental health
142.5 professional, certified rehabilitation specialist, clinical trainee, or mental health practitioner
142.6 status;

142.7 (ii) employ seven or more treatment team full-time equivalents, excluding the program
142.8 assistant and the psychiatric care provider;

142.9 (iii) serve an annual average maximum caseload of 51 to 74 clients;

142.10 (iv) ensure at least one full-time equivalent position for every nine clients served;

142.11 (v) schedule ACT team staff for a minimum of ten-hour shift coverage on weekdays
142.12 and six- to eight-hour shift coverage on weekends and holidays. In addition to these minimum
142.13 specifications, staff are regularly scheduled to provide the necessary services on a
142.14 client-by-client basis in the evenings and on weekends and holidays;

142.15 (vi) schedule ACT team staff on-call duty to provide crisis services and deliver services
142.16 when staff are not working;

142.17 (vii) have the authority to arrange for coverage for crisis assessment and intervention
142.18 services through a reliable crisis-intervention provider as long as there is a mechanism by
142.19 which the ACT team communicates routinely with the crisis-intervention provider and the
142.20 on-call ACT team staff are available to see clients face-to-face when necessary or if requested
142.21 by the crisis-intervention services provider; and

142.22 (viii) arrange for and provide psychiatric backup during all hours the psychiatric care
142.23 provider is not regularly scheduled to work. If availability of the psychiatric care provider
142.24 during all hours is not feasible, alternative psychiatric prescriber backup must be arranged
142.25 and a mechanism of timely communication and coordination established in writing;

142.26 (3) a large ACT team must:

142.27 (i) be composed of, at minimum, one full-time team leader, at least 32 hours each week
142.28 per 100 clients, or equivalent of psychiatry time, three full-time equivalent nursing staff,
142.29 one full-time ~~substance abuse~~ co-occurring disorder specialist, one full-time equivalent
142.30 mental health certified peer specialist, one full-time vocational specialist, one full-time
142.31 program assistant, and at least two additional full-time equivalent ACT team members, with
142.32 at least one dedicated full-time staff member with mental health professional status.

143.1 Remaining team members may have mental health professional or mental health practitioner
143.2 status;

143.3 (ii) employ nine or more treatment team full-time equivalents, excluding the program
143.4 assistant and psychiatric care provider;

143.5 (iii) serve an annual average maximum caseload of 75 to 100 clients;

143.6 (iv) ensure at least one full-time equivalent position for every nine individuals served;

143.7 (v) schedule staff to work two eight-hour shifts, with a minimum of two staff on the
143.8 second shift providing services at least 12 hours per day weekdays. For weekends and
143.9 holidays, the team must operate and schedule ACT team staff to work one eight-hour shift,
143.10 with a minimum of two staff each weekend day and every holiday;

143.11 (vi) schedule ACT team staff on-call duty to provide crisis services and deliver services
143.12 when staff are not working; and

143.13 (vii) arrange for and provide psychiatric backup during all hours the psychiatric care
143.14 provider is not regularly scheduled to work. If availability of the ACT team psychiatric care
143.15 provider during all hours is not feasible, alternative psychiatric backup must be arranged
143.16 and a mechanism of timely communication and coordination established in writing.

143.17 (b) An ACT team of any size may have a staff-to-client ratio that is lower than the
143.18 requirements described in paragraph (a) upon approval by the commissioner, but may not
143.19 exceed a one-to-ten staff-to-client ratio.

143.20 Sec. 64. Minnesota Statutes 2020, section 256B.0622, subdivision 7d, is amended to read:

143.21 Subd. 7d. **Assertive community treatment assessment and individual treatment**
143.22 **plan.** (a) An initial assessment, ~~including a diagnostic assessment that meets the requirements~~
143.23 ~~of Minnesota Rules, part 9505.0372, subpart 1, and a 30-day treatment plan~~ shall be
143.24 completed the day of the client's admission to assertive community treatment by the ACT
143.25 team leader or the psychiatric care provider, with participation by designated ACT team
143.26 members and the client. The initial assessment must include obtaining or completing a
143.27 standard diagnostic assessment according to section 245I.10, subdivision 6, and completing
143.28 a 30-day individual treatment plan. The team leader, psychiatric care provider, or other
143.29 mental health professional designated by the team leader or psychiatric care provider, must
143.30 update the client's diagnostic assessment at least annually.

144.1 (b) ~~An initial~~ A functional assessment must be completed ~~within ten days of intake and~~
144.2 ~~updated every six months for assertive community treatment, or prior to discharge from the~~
144.3 ~~service, whichever comes first~~ according to section 245I.10, subdivision 9.

144.4 ~~(c) Within 30 days of the client's assertive community treatment admission, the ACT~~
144.5 ~~team shall complete an in-depth assessment of the domains listed under section 245.462,~~
144.6 ~~subdivision 11a.~~

144.7 ~~(d) Each part of the in-depth~~ functional assessment areas shall be completed by each
144.8 respective team specialist or an ACT team member with skill and knowledge in the area
144.9 being assessed. ~~The assessments are based upon all available information, including that~~
144.10 ~~from client interview family and identified natural supports, and written summaries from~~
144.11 ~~other agencies, including police, courts, county social service agencies, outpatient facilities,~~
144.12 ~~and inpatient facilities, where applicable.~~

144.13 ~~(e)~~ (c) Between 30 and 45 days after the client's admission to assertive community
144.14 treatment, the entire ACT team must hold a comprehensive case conference, where all team
144.15 members, including the psychiatric provider, present information discovered from the
144.16 completed ~~in-depth~~ assessments and provide treatment recommendations. The conference
144.17 must serve as the basis for the first ~~six-month~~ individual treatment plan, which must be
144.18 written by the primary team member.

144.19 ~~(f)~~ (d) The client's psychiatric care provider, primary team member, and individual
144.20 treatment team members shall assume responsibility for preparing the written narrative of
144.21 the results from the psychiatric and social functioning history timeline and the comprehensive
144.22 assessment.

144.23 ~~(g)~~ (e) The primary team member and individual treatment team members shall be
144.24 assigned by the team leader in collaboration with the psychiatric care provider by the time
144.25 of the first treatment planning meeting or 30 days after admission, whichever occurs first.

144.26 ~~(h)~~ (f) Individual treatment plans must be developed through the following treatment
144.27 planning process:

144.28 (1) The individual treatment plan shall be developed in collaboration with the client and
144.29 the client's preferred natural supports, and guardian, if applicable and appropriate. The ACT
144.30 team shall evaluate, together with each client, the client's needs, strengths, and preferences
144.31 and develop the individual treatment plan collaboratively. The ACT team shall make every
144.32 effort to ensure that the client and the client's family and natural supports, with the client's
144.33 consent, are in attendance at the treatment planning meeting, are involved in ongoing

145.1 meetings related to treatment, and have the necessary supports to fully participate. The
145.2 client's participation in the development of the individual treatment plan shall be documented.

145.3 (2) The client and the ACT team shall work together to formulate and prioritize the
145.4 issues, set goals, research approaches and interventions, and establish the plan. The plan is
145.5 individually tailored so that the treatment, rehabilitation, and support approaches and
145.6 interventions achieve optimum symptom reduction, help fulfill the personal needs and
145.7 aspirations of the client, take into account the cultural beliefs and realities of the individual,
145.8 and improve all the aspects of psychosocial functioning that are important to the client. The
145.9 process supports strengths, rehabilitation, and recovery.

145.10 (3) Each client's individual treatment plan shall identify service needs, strengths and
145.11 capacities, and barriers, and set specific and measurable short- and long-term goals for each
145.12 service need. The individual treatment plan must clearly specify the approaches and
145.13 interventions necessary for the client to achieve the individual goals, when the interventions
145.14 shall happen, and identify which ACT team member shall carry out the approaches and
145.15 interventions.

145.16 (4) The primary team member and the individual treatment team, together with the client
145.17 and the client's family and natural supports with the client's consent, are responsible for
145.18 reviewing and rewriting the treatment goals and individual treatment plan whenever there
145.19 is a major decision point in the client's course of treatment or at least every six months.

145.20 (5) The primary team member shall prepare a summary that thoroughly describes in
145.21 writing the client's and the individual treatment team's evaluation of the client's progress
145.22 and goal attainment, the effectiveness of the interventions, and the satisfaction with services
145.23 since the last individual treatment plan. The client's most recent diagnostic assessment must
145.24 be included with the treatment plan summary.

145.25 (6) The individual treatment plan and review must be ~~signed~~ approved or acknowledged
145.26 by the client, the primary team member, the team leader, the psychiatric care provider, and
145.27 all individual treatment team members. A copy of the ~~signed~~ approved individual treatment
145.28 plan ~~is~~ must be made available to the client.

145.29 Sec. 65. Minnesota Statutes 2020, section 256B.0623, subdivision 1, is amended to read:

145.30 Subdivision 1. **Scope.** Subject to federal approval, medical assistance covers medically
145.31 necessary adult rehabilitative mental health services as defined in subdivision 2, subject to
145.32 federal approval, if provided to recipients as defined in subdivision 3 and provided by a
145.33 qualified provider entity meeting the standards in this section and by a qualified individual

146.1 ~~provider working within the provider's scope of practice and identified in the recipient's~~
146.2 ~~individual treatment plan as defined in section 245.462, subdivision 14, and if determined~~
146.3 ~~to be medically necessary according to section 62Q.53~~ when the services are provided by
146.4 an entity meeting the standards in this section. The provider entity must make reasonable
146.5 and good faith efforts to report individual client outcomes to the commissioner, using
146.6 instruments and protocols approved by the commissioner.

146.7 Sec. 66. Minnesota Statutes 2020, section 256B.0623, subdivision 2, is amended to read:

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

146.10 (a) "Adult rehabilitative mental health services" means ~~mental health services which are~~
146.11 ~~rehabilitative and enable the recipient to develop and enhance psychiatric stability, social~~
146.12 ~~competencies, personal and emotional adjustment, independent living, parenting skills, and~~
146.13 ~~community skills, when these abilities are impaired by the symptoms of mental illness.~~
146.14 ~~Adult rehabilitative mental health services are also appropriate when provided to enable a~~
146.15 ~~recipient to retain stability and functioning, if the recipient would be at risk of significant~~
146.16 ~~functional decompensation or more restrictive service settings without these services~~ the
146.17 services described in section 245I.02, subdivision 33.

146.18 ~~(1) Adult rehabilitative mental health services instruct, assist, and support the recipient~~
146.19 ~~in areas such as: interpersonal communication skills, community resource utilization and~~
146.20 ~~integration skills, crisis assistance, relapse prevention skills, health care directives, budgeting~~
146.21 ~~and shopping skills, healthy lifestyle skills and practices, cooking and nutrition skills,~~
146.22 ~~transportation skills, medication education and monitoring, mental illness symptom~~
146.23 ~~management skills, household management skills, employment-related skills, parenting~~
146.24 ~~skills, and transition to community living services.~~

146.25 ~~(2) These services shall be provided to the recipient on a one-to-one basis in the recipient's~~
146.26 ~~home or another community setting or in groups.~~

146.27 (b) "Medication education services" means services provided individually or in groups
146.28 which focus on educating the recipient about mental illness and symptoms; the role and
146.29 effects of medications in treating symptoms of mental illness; and the side effects of
146.30 medications. Medication education is coordinated with medication management services
146.31 and does not duplicate it. Medication education services are provided by physicians, advanced
146.32 practice registered nurses, pharmacists, physician assistants, or registered nurses.

147.1 (c) "Transition to community living services" means services which maintain continuity
147.2 of contact between the rehabilitation services provider and the recipient and which facilitate
147.3 discharge from a hospital, residential treatment program ~~under Minnesota Rules, chapter~~
147.4 ~~9505~~, board and lodging facility, or nursing home. Transition to community living services
147.5 are not intended to provide other areas of adult rehabilitative mental health services.

147.6 Sec. 67. Minnesota Statutes 2020, section 256B.0623, subdivision 3, is amended to read:

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

147.8 (1) is age 18 or older;

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

147.11 (3) has substantial disability and functional impairment in three or more of the areas
147.12 listed in section ~~245.462, subdivision 11a~~ 245I.10, subdivision 9, clause (4), so that
147.13 self-sufficiency is markedly reduced; and

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

147.18 Sec. 68. Minnesota Statutes 2020, section 256B.0623, subdivision 4, is amended to read:

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

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

147.25 (c) A noncounty provider entity must obtain additional certification from each county
147.26 in which it will provide services. The additional certification must be based on the adequacy
147.27 of the entity's knowledge of that county's local health and human service system, and the
147.28 ability of the entity to coordinate its services with the other services available in that county.
147.29 A county-operated entity must obtain this additional certification from any other county in
147.30 which it will provide services.

147.31 (d) State-level recertification must occur at least every three years.

148.1 (e) The commissioner may intervene at any time and decertify providers with cause.
148.2 The decertification is subject to appeal to the state. A county board may recommend that
148.3 the state decertify a provider for cause.

148.4 (f) The adult rehabilitative mental health services provider entity must meet the following
148.5 standards:

148.6 (1) have capacity to recruit, hire, manage, and train ~~mental health professionals, mental~~
148.7 ~~health practitioners, and mental health rehabilitation workers~~ qualified staff;

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

148.9 ~~(3) ensure adequate preservice and inservice and ongoing training for staff;~~

148.10 ~~(4)~~ (3) ensure that ~~mental health professionals, mental health practitioners, and mental~~
148.11 ~~health rehabilitation workers~~ staff are skilled in the delivery of the specific adult rehabilitative
148.12 mental health services provided to the individual eligible recipient;

148.13 ~~(5) ensure that staff is capable of implementing culturally specific services that are~~
148.14 ~~culturally competent and appropriate as determined by the recipient's culture, beliefs, values,~~
148.15 ~~and language as identified in the individual treatment plan;~~

148.16 ~~(6)~~ (4) ensure enough flexibility in service delivery to respond to the changing and
148.17 intermittent care needs of a recipient as identified by the recipient and the individual treatment
148.18 plan;

148.19 ~~(7) ensure that the mental health professional or mental health practitioner, who is under~~
148.20 ~~the clinical supervision of a mental health professional, involved in a recipient's services~~
148.21 ~~participates in the development of the individual treatment plan;~~

148.22 ~~(8)~~ (5) assist the recipient in arranging needed crisis assessment, intervention, and
148.23 stabilization services;

148.24 ~~(9)~~ (6) ensure that services are coordinated with other recipient mental health services
148.25 providers and the county mental health authority and the federally recognized American
148.26 Indian authority and necessary others after obtaining the consent of the recipient. Services
148.27 must also be coordinated with the recipient's case manager or care coordinator if the recipient
148.28 is receiving case management or care coordination services;

148.29 ~~(10) develop and maintain recipient files, individual treatment plans, and contact charting;~~

148.30 ~~(11) develop and maintain staff training and personnel files;~~

148.31 ~~(12) submit information as required by the state;~~

149.1 ~~(13) establish and maintain a quality assurance plan to evaluate the outcome of services~~
149.2 ~~provided;~~

149.3 ~~(14) (7) keep all necessary records required by law;~~

149.4 ~~(15) (8) deliver services as required by section 245.461;~~

149.5 ~~(16) comply with all applicable laws;~~

149.6 ~~(17) (9) be an enrolled Medicaid provider; and~~

149.7 ~~(18) (10) maintain a quality assurance plan to determine specific service outcomes and~~
149.8 ~~the recipient's satisfaction with services; and.~~

149.9 ~~(19) develop and maintain written policies and procedures regarding service provision~~
149.10 ~~and administration of the provider entity.~~

149.11 Sec. 69. Minnesota Statutes 2020, section 256B.0623, subdivision 5, is amended to read:

149.12 Subd. 5. **Qualifications of provider staff.** ~~(a)~~ Adult rehabilitative mental health services
149.13 must be provided by qualified individual provider staff of a certified provider entity.

149.14 Individual provider staff must be qualified ~~under one of the following criteria~~ as:

149.15 (1) a mental health professional ~~as defined in section 245.462, subdivision 18, clauses~~
149.16 ~~(1) to (6). If the recipient has a current diagnostic assessment by a licensed mental health~~
149.17 ~~professional as defined in section 245.462, subdivision 18, clauses (1) to (6), recommending~~
149.18 ~~receipt of adult mental health rehabilitative services, the definition of mental health~~
149.19 ~~professional for purposes of this section includes a person who is qualified under section~~
149.20 ~~245.462, subdivision 18, clause (7), and who holds a current and valid national certification~~
149.21 ~~as a certified rehabilitation counselor or certified psychosocial rehabilitation practitioner~~
149.22 qualified according to section 245I.04, subdivision 2;

149.23 (2) a certified rehabilitation specialist qualified according to section 245I.04, subdivision
149.24 8;

149.25 (3) a clinical trainee qualified according to section 245I.04, subdivision 6;

149.26 (4) a mental health practitioner as defined in section 245.462, subdivision 17. The mental
149.27 health practitioner must work under the clinical supervision of a mental health professional
149.28 qualified according to section 245I.04, subdivision 4;

149.29 ~~(3) (5) a mental health certified peer specialist under section 256B.0615. The certified~~
149.30 ~~peer specialist must work under the clinical supervision of a mental health professional~~
149.31 qualified according to section 245I.04, subdivision 10; or

150.1 ~~(4) (6) a mental health rehabilitation worker qualified according to section 245I.04,~~
150.2 ~~subdivision 14. A mental health rehabilitation worker means a staff person working under~~
150.3 ~~the direction of a mental health practitioner or mental health professional and under the~~
150.4 ~~clinical supervision of a mental health professional in the implementation of rehabilitative~~
150.5 ~~mental health services as identified in the recipient's individual treatment plan who:~~

150.6 ~~(i) is at least 21 years of age;~~

150.7 ~~(ii) has a high school diploma or equivalent;~~

150.8 ~~(iii) has successfully completed 30 hours of training during the two years immediately~~
150.9 ~~prior to the date of hire, or before provision of direct services, in all of the following areas:~~
150.10 ~~recovery from mental illness, mental health de-escalation techniques, recipient rights,~~
150.11 ~~recipient-centered individual treatment planning, behavioral terminology, mental illness,~~
150.12 ~~co-occurring mental illness and substance abuse, psychotropic medications and side effects,~~
150.13 ~~functional assessment, local community resources, adult vulnerability, recipient~~
150.14 ~~confidentiality; and~~

150.15 ~~(iv) meets the qualifications in paragraph (b).~~

150.16 ~~(b) In addition to the requirements in paragraph (a), a mental health rehabilitation worker~~
150.17 ~~must also meet the qualifications in clause (1), (2), or (3):~~

150.18 ~~(1) has an associates of arts degree, two years of full-time postsecondary education, or~~
150.19 ~~a total of 15 semester hours or 23 quarter hours in behavioral sciences or related fields; is~~
150.20 ~~a registered nurse; or within the previous ten years has:~~

150.21 ~~(i) three years of personal life experience with serious mental illness;~~

150.22 ~~(ii) three years of life experience as a primary caregiver to an adult with a serious mental~~
150.23 ~~illness, traumatic brain injury, substance use disorder, or developmental disability; or~~

150.24 ~~(iii) 2,000 hours of supervised work experience in the delivery of mental health services~~
150.25 ~~to adults with a serious mental illness, traumatic brain injury, substance use disorder, or~~
150.26 ~~developmental disability;~~

150.27 ~~(2)(i) is fluent in the non-English language or competent in the culture of the ethnic~~
150.28 ~~group to which at least 20 percent of the mental health rehabilitation worker's clients belong;~~

150.29 ~~(ii) receives during the first 2,000 hours of work, monthly documented individual clinical~~
150.30 ~~supervision by a mental health professional;~~

151.1 ~~(iii) has 18 hours of documented field supervision by a mental health professional or~~
151.2 ~~mental health practitioner during the first 160 hours of contact work with recipients, and at~~
151.3 ~~least six hours of field supervision quarterly during the following year;~~

151.4 ~~(iv) has review and cosignature of charting of recipient contacts during field supervision~~
151.5 ~~by a mental health professional or mental health practitioner; and~~

151.6 ~~(v) has 15 hours of additional continuing education on mental health topics during the~~
151.7 ~~first year of employment and 15 hours during every additional year of employment; or~~

151.8 ~~(3) for providers of crisis residential services, intensive residential treatment services,~~
151.9 ~~partial hospitalization, and day treatment services:~~

151.10 ~~(i) satisfies clause (2), items (ii) to (iv); and~~

151.11 ~~(ii) has 40 hours of additional continuing education on mental health topics during the~~
151.12 ~~first year of employment.~~

151.13 ~~(c) A mental health rehabilitation worker who solely acts and is scheduled as overnight~~
151.14 ~~staff is not required to comply with paragraph (a), clause (4), item (iv).~~

151.15 ~~(d) For purposes of this subdivision, "behavioral sciences or related fields" means an~~
151.16 ~~education from an accredited college or university and includes but is not limited to social~~
151.17 ~~work, psychology, sociology, community counseling, family social science, child~~
151.18 ~~development, child psychology, community mental health, addiction counseling, counseling~~
151.19 ~~and guidance, special education, and other fields as approved by the commissioner.~~

151.20 Sec. 70. Minnesota Statutes 2020, section 256B.0623, subdivision 6, is amended to read:

151.21 **Subd. 6. Required training and supervision.** ~~(a) Mental health rehabilitation workers~~
151.22 ~~must receive ongoing continuing education training of at least 30 hours every two years in~~
151.23 ~~areas of mental illness and mental health services and other areas specific to the population~~
151.24 ~~being served. Mental health rehabilitation workers must also be subject to the ongoing~~
151.25 ~~direction and clinical supervision standards in paragraphs (c) and (d).~~

151.26 ~~(b) Mental health practitioners must receive ongoing continuing education training as~~
151.27 ~~required by their professional license; or if the practitioner is not licensed, the practitioner~~
151.28 ~~must receive ongoing continuing education training of at least 30 hours every two years in~~
151.29 ~~areas of mental illness and mental health services. Mental health practitioners must meet~~
151.30 ~~the ongoing clinical supervision standards in paragraph (c).~~

151.31 ~~(c) Clinical supervision may be provided by a full- or part-time qualified professional~~
151.32 ~~employed by or under contract with the provider entity. Clinical supervision may be provided~~

- 152.1 ~~by interactive videoconferencing according to procedures developed by the commissioner.~~
152.2 ~~A mental health professional providing clinical supervision of staff delivering adult~~
152.3 ~~rehabilitative mental health services must provide the following guidancee:~~
- 152.4 ~~(1) review the information in the recipient's file;~~
152.5 ~~(2) review and approve initial and updates of individual treatment plans;~~
- 152.6 ~~(a) A treatment supervisor providing treatment supervision required under section 245I.06~~
152.7 ~~must:~~
- 152.8 ~~(3) (1) meet with mental health rehabilitation workers and practitioners, individually or~~
152.9 ~~in small groups, staff receiving treatment supervision at least monthly to discuss treatment~~
152.10 ~~topics of interest to the workers and practitioners;~~
- 152.11 ~~(4) meet with mental health rehabilitation workers and practitioners, individually or in~~
152.12 ~~small groups, at least monthly to discuss and treatment plans of recipients, and approve by~~
152.13 ~~signature and document in the recipient's file any resulting plan updates; and~~
- 152.14 ~~(5) (2) meet at least monthly with the directing clinical trainee or mental health~~
152.15 ~~practitioner, if there is one, to review needs of the adult rehabilitative mental health services~~
152.16 ~~program, review staff on-site observations and evaluate mental health rehabilitation workers,~~
152.17 ~~plan staff training, review program evaluation and development, and consult with the~~
152.18 ~~directing clinical trainee or mental health practitioner; and.~~
- 152.19 ~~(6) be available for urgent consultation as the individual recipient needs or the situation~~
152.20 ~~necessitates.~~
- 152.21 ~~(d) (b) An adult rehabilitative mental health services provider entity must have a treatment~~
152.22 ~~director who is a mental health practitioner or mental health professional clinical trainee,~~
152.23 ~~certified rehabilitation specialist, or mental health practitioner. The treatment director must~~
152.24 ~~ensure the following:~~
- 152.25 ~~(1) while delivering direct services to recipients, a newly hired mental health rehabilitation~~
152.26 ~~worker must be directly observed delivering services to recipients by a mental health~~
152.27 ~~practitioner or mental health professional for at least six hours per 40 hours worked during~~
152.28 ~~the first 160 hours that the mental health rehabilitation worker works ensure the direct~~
152.29 ~~observation of mental health rehabilitation workers required under section 245I.06,~~
152.30 ~~subdivision 3, is provided;~~
- 152.31 ~~(2) the mental health rehabilitation worker must receive ongoing on-site direct service~~
152.32 ~~observation by a mental health professional or mental health practitioner for at least six~~
152.33 ~~hours for every six months of employment;~~

153.1 ~~(3) progress notes are reviewed from on-site service observation prepared by the mental~~
153.2 ~~health rehabilitation worker and mental health practitioner for accuracy and consistency~~
153.3 ~~with actual recipient contact and the individual treatment plan and goals;~~

153.4 ~~(4)~~ (2) ensure immediate availability by phone or in person for consultation by a mental
153.5 health professional, certified rehabilitation specialist, clinical trainee, or a mental health
153.6 practitioner to the mental health rehabilitation services worker during service provision;

153.7 ~~(5) oversee the identification of changes in individual recipient treatment strategies,~~
153.8 ~~revise the plan, and communicate treatment instructions and methodologies as appropriate~~
153.9 ~~to ensure that treatment is implemented correctly;~~

153.10 ~~(6)~~ (3) model service practices which: respect the recipient, include the recipient in
153.11 planning and implementation of the individual treatment plan, recognize the recipient's
153.12 strengths, collaborate and coordinate with other involved parties and providers;

153.13 ~~(7)~~ (4) ensure that clinical trainees, mental health practitioners, and mental health
153.14 rehabilitation workers are able to effectively communicate with the recipients, significant
153.15 others, and providers; and

153.16 ~~(8)~~ (5) oversee the record of the results of ~~on-site~~ direct observation and ~~charting~~, progress
153.17 note evaluation, and corrective actions taken to modify the work of the clinical trainees,
153.18 mental health practitioners, and mental health rehabilitation workers.

153.19 ~~(e)~~ (c) A clinical trainee or mental health practitioner who is providing treatment direction
153.20 for a provider entity must receive treatment supervision at least monthly ~~from a mental~~
153.21 ~~health professional~~ to:

153.22 (1) identify and plan for general needs of the recipient population served;

153.23 (2) identify and plan to address provider entity program needs and effectiveness;

153.24 (3) identify and plan provider entity staff training and personnel needs and issues; and

153.25 (4) plan, implement, and evaluate provider entity quality improvement programs.

153.26 Sec. 71. Minnesota Statutes 2020, section 256B.0623, subdivision 9, is amended to read:

153.27 Subd. 9. **Functional assessment.** (a) Providers of adult rehabilitative mental health
153.28 services must complete a written functional assessment ~~as defined in section 245.462,~~
153.29 ~~subdivision 11a~~ according to section 245I.10, subdivision 9, for each recipient. ~~The functional~~
153.30 ~~assessment must be completed within 30 days of intake, and reviewed and updated at least~~
153.31 ~~every six months after it is developed, unless there is a significant change in the functioning~~
153.32 ~~of the recipient. If there is a significant change in functioning, the assessment must be~~

154.1 ~~updated. A single functional assessment can meet case management and adult rehabilitative~~
154.2 ~~mental health services requirements if agreed to by the recipient. Unless the recipient refuses,~~
154.3 ~~the recipient must have significant participation in the development of the functional~~
154.4 ~~assessment.~~

154.5 (b) When a provider of adult rehabilitative mental health services completes a written
154.6 functional assessment, the provider must also complete a level of care assessment as defined
154.7 in section 245I.02, subdivision 19, for the recipient.

154.8 Sec. 72. Minnesota Statutes 2020, section 256B.0623, subdivision 12, is amended to read:

154.9 Subd. 12. **Additional requirements.** (a) Providers of adult rehabilitative mental health
154.10 services must comply with the requirements relating to referrals for case management in
154.11 section 245.467, subdivision 4.

154.12 (b) Adult rehabilitative mental health services are provided for most recipients in the
154.13 recipient's home and community. Services may also be provided at the home of a relative
154.14 or significant other, job site, psychosocial clubhouse, drop-in center, social setting, classroom,
154.15 or other places in the community. Except for "transition to community services," the place
154.16 of service does not include a regional treatment center, nursing home, residential treatment
154.17 facility licensed under Minnesota Rules, parts 9520.0500 to 9520.0670 (Rule 36), or section
154.18 245I.23, or an acute care hospital.

154.19 (c) Adult rehabilitative mental health services may be provided in group settings if
154.20 appropriate to each participating recipient's needs and individual treatment plan. A group
154.21 is defined as two to ten clients, at least one of whom is a recipient, who is concurrently
154.22 receiving a service which is identified in this section. The service and group must be specified
154.23 in the recipient's individual treatment plan. No more than two qualified staff may bill
154.24 Medicaid for services provided to the same group of recipients. If two adult rehabilitative
154.25 mental health workers bill for recipients in the same group session, they must each bill for
154.26 different recipients.

154.27 (d) Adult rehabilitative mental health services are appropriate if provided to enable a
154.28 recipient to retain stability and functioning, when the recipient is at risk of significant
154.29 functional decompensation or requiring more restrictive service settings without these
154.30 services.

154.31 (e) Adult rehabilitative mental health services instruct, assist, and support the recipient
154.32 in areas including: interpersonal communication skills, community resource utilization and
154.33 integration skills, crisis planning, relapse prevention skills, health care directives, budgeting

155.1 and shopping skills, healthy lifestyle skills and practices, cooking and nutrition skills,
155.2 transportation skills, medication education and monitoring, mental illness symptom
155.3 management skills, household management skills, employment-related skills, parenting
155.4 skills, and transition to community living services.

155.5 (f) Community intervention, including consultation with relatives, guardians, friends,
155.6 employers, treatment providers, and other significant individuals, is appropriate when
155.7 directed exclusively to the treatment of the client.

155.8 Sec. 73. Minnesota Statutes 2020, section 256B.0625, subdivision 3b, is amended to read:

155.9 Subd. 3b. **Telemedicine services.** (a) Medical assistance covers medically necessary
155.10 services and consultations delivered by a licensed health care provider via telemedicine in
155.11 the same manner as if the service or consultation was delivered in person. Coverage is
155.12 limited to three telemedicine services per enrollee per calendar week, except as provided
155.13 in paragraph (f). Telemedicine services shall be paid at the full allowable rate.

155.14 (b) The commissioner shall establish criteria that a health care provider must attest to
155.15 in order to demonstrate the safety or efficacy of delivering a particular service via
155.16 telemedicine. The attestation may include that the health care provider:

155.17 (1) has identified the categories or types of services the health care provider will provide
155.18 via telemedicine;

155.19 (2) has written policies and procedures specific to telemedicine services that are regularly
155.20 reviewed and updated;

155.21 (3) has policies and procedures that adequately address patient safety before, during,
155.22 and after the telemedicine service is rendered;

155.23 (4) has established protocols addressing how and when to discontinue telemedicine
155.24 services; and

155.25 (5) has an established quality assurance process related to telemedicine services.

155.26 (c) As a condition of payment, a licensed health care provider must document each
155.27 occurrence of a health service provided by telemedicine to a medical assistance enrollee.
155.28 Health care service records for services provided by telemedicine must meet the requirements
155.29 set forth in Minnesota Rules, part 9505.2175, subparts 1 and 2, and must document:

155.30 (1) the type of service provided by telemedicine;

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

156.1 (3) the licensed health care provider's basis for determining that telemedicine is an
156.2 appropriate and effective means for delivering the service to the enrollee;

156.3 (4) the mode of transmission of the telemedicine service and records evidencing that a
156.4 particular mode of transmission was utilized;

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

156.6 (6) if the claim for payment is based on a physician's telemedicine consultation with
156.7 another physician, the written opinion from the consulting physician providing the
156.8 telemedicine consultation; and

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

156.11 (d) For purposes of this subdivision, unless otherwise covered under this chapter,
156.12 "telemedicine" is defined as the delivery of health care services or consultations while the
156.13 patient is at an originating site and the licensed health care provider is at a distant site. A
156.14 communication between licensed health care providers, or a licensed health care provider
156.15 and a patient that consists solely of a telephone conversation, e-mail, or facsimile transmission
156.16 does not constitute telemedicine consultations or services. Telemedicine may be provided
156.17 by means of real-time two-way, interactive audio and visual communications, including the
156.18 application of secure video conferencing or store-and-forward technology to provide or
156.19 support health care delivery, which facilitate the assessment, diagnosis, consultation,
156.20 treatment, education, and care management of a patient's health care.

156.21 (e) For purposes of this section, "licensed health care provider" means a licensed health
156.22 care provider under section 62A.671, subdivision 6, a community paramedic as defined
156.23 under section 144E.001, subdivision 5f, ~~or a clinical trainee qualified according to section~~
156.24 245I.04, subdivision 6, a mental health practitioner ~~defined under section 245.462,~~
156.25 ~~subdivision 17, or 245.4871, subdivision 26, working under the general supervision of a~~
156.26 ~~mental health professional~~ qualified according to section 245I.04, subdivision 4, and a
156.27 community health worker who meets the criteria under subdivision 49, paragraph (a); "health
156.28 care provider" is defined under section 62A.671, subdivision 3; and "originating site" is
156.29 defined under section 62A.671, subdivision 7.

156.30 (f) The limit on coverage of three telemedicine services per enrollee per calendar week
156.31 does not apply if:

156.32 (1) the telemedicine services provided by the licensed health care provider are for the
156.33 treatment and control of tuberculosis; and

157.1 (2) the services are provided in a manner consistent with the recommendations and best
157.2 practices specified by the Centers for Disease Control and Prevention and the commissioner
157.3 of health.

157.4 Sec. 74. Minnesota Statutes 2020, section 256B.0625, subdivision 5, is amended to read:

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

157.8 (a) The provider is ~~licensed under Minnesota Rules, parts 9520.0750 to 9520.0870~~
157.9 certified as a mental health clinic under section 245I.20.

157.10 (b) ~~The provider provides mental health services under the clinical supervision of a~~ The
157.11 treatment supervision required by section 245I.06 is provided by a mental health professional
157.12 who is licensed for independent practice at the doctoral level or by a board-certified
157.13 psychiatrist or a psychiatrist who is eligible for board certification. ~~Clinical supervision has~~
157.14 ~~the meaning given in Minnesota Rules, part 9505.0370, subpart 6.~~

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

157.17 (d) The provider must have a sliding fee scale that meets the requirements in section
157.18 245.481, and agree to serve within the limits of its capacity all individuals residing in its
157.19 service delivery area.

157.20 (e) At a minimum, the provider must provide the following outpatient mental health
157.21 services: diagnostic assessment; explanation of findings; family, group, and individual
157.22 psychotherapy, including crisis intervention psychotherapy services, ~~multiple family group~~
157.23 ~~psychotherapy~~, psychological testing, and medication management. In addition, the provider
157.24 must provide or be capable of providing upon request of the local mental health authority
157.25 day treatment services, multiple family group psychotherapy, and professional home-based
157.26 mental health services. The provider must have the capacity to provide such services to
157.27 specialized populations such as the elderly, families with children, persons who are seriously
157.28 and persistently mentally ill, and children who are seriously emotionally disturbed.

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

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

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

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

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

158.13 Sec. 75. Minnesota Statutes 2020, section 256B.0625, subdivision 19c, is amended to
158.14 read:

158.15 Subd. 19c. **Personal care.** Medical assistance covers personal care assistance services
158.16 provided by an individual who is qualified to provide the services according to subdivision
158.17 19a and sections 256B.0651 to 256B.0654, provided in accordance with a plan, and
158.18 supervised by a qualified professional.

158.19 "Qualified professional" means a mental health professional ~~as defined in section 245.462,~~
158.20 ~~subdivision 18, clauses (1) to (6), or 245.4871, subdivision 27, clauses (1) to (6);~~ a registered
158.21 nurse as defined in sections 148.171 to 148.285, a licensed social worker as defined in
158.22 sections 148E.010 and 148E.055, or a qualified designated coordinator under section
158.23 245D.081, subdivision 2. The qualified professional shall perform the duties required in
158.24 section 256B.0659.

158.25 Sec. 76. Minnesota Statutes 2020, section 256B.0625, subdivision 28a, is amended to
158.26 read:

158.27 Subd. 28a. **Licensed physician assistant services.** (a) Medical assistance covers services
158.28 performed by a licensed physician assistant if the service is otherwise covered under this
158.29 chapter as a physician service and if the service is within the scope of practice of a licensed
158.30 physician assistant as defined in section 147A.09.

158.31 (b) Licensed physician assistants, who are supervised by a physician certified by the
158.32 American Board of Psychiatry and Neurology or eligible for board certification in psychiatry,

159.1 may bill for medication management and evaluation and management services provided to
159.2 medical assistance enrollees in inpatient hospital settings, and in outpatient settings after
159.3 the licensed physician assistant completes 2,000 hours of clinical experience in the evaluation
159.4 and treatment of mental health, consistent with their authorized scope of practice, as defined
159.5 in section 147A.09, with the exception of performing psychotherapy or diagnostic
159.6 assessments or providing ~~clinical~~ treatment supervision.

159.7 Sec. 77. Minnesota Statutes 2020, section 256B.0625, subdivision 42, is amended to read:

159.8 Subd. 42. **Mental health professional.** Notwithstanding Minnesota Rules, part
159.9 9505.0175, subpart 28, the definition of a mental health professional ~~shall include a person~~
159.10 ~~who is qualified as specified in~~ according to section 245.462, subdivision 18, clauses (1) to
159.11 ~~(6); or 245.4871, subdivision 27, clauses (1) to (6)~~ 245I.04, subdivision 2, for the purpose
159.12 of this section and Minnesota Rules, parts 9505.0170 to 9505.0475.

159.13 Sec. 78. Minnesota Statutes 2020, section 256B.0625, subdivision 48, is amended to read:

159.14 Subd. 48. **Psychiatric consultation to primary care practitioners.** Medical assistance
159.15 covers consultation provided by a ~~psychiatrist, a psychologist, an advanced practice registered~~
159.16 ~~nurse certified in psychiatric mental health, a licensed independent clinical social worker,~~
159.17 ~~as defined in section 245.462, subdivision 18, clause (2), or a licensed marriage and family~~
159.18 ~~therapist, as defined in section 245.462, subdivision 18, clause (5)~~ mental health professional
159.19 qualified according to section 245I.04, subdivision 2, except a licensed professional clinical
159.20 counselor licensed under section 148B.5301, via telephone, e-mail, facsimile, or other means
159.21 of communication to primary care practitioners, including pediatricians. The need for
159.22 consultation and the receipt of the consultation must be documented in the patient record
159.23 maintained by the primary care practitioner. If the patient consents, and subject to federal
159.24 limitations and data privacy provisions, the consultation may be provided without the patient
159.25 present.

159.26 Sec. 79. Minnesota Statutes 2020, section 256B.0625, subdivision 49, is amended to read:

159.27 Subd. 49. **Community health worker.** (a) Medical assistance covers the care
159.28 coordination and patient education services provided by a community health worker if the
159.29 community health worker has:

159.30 ~~(1)~~ received a certificate from the Minnesota State Colleges and Universities System
159.31 approved community health worker curriculum; ~~or.~~

160.1 ~~(2) at least five years of supervised experience with an enrolled physician, registered~~
160.2 ~~nurse, advanced practice registered nurse, mental health professional as defined in section~~
160.3 ~~245.462, subdivision 18, clauses (1) to (6), and section 245.4871, subdivision 27, clauses~~
160.4 ~~(1) to (5), or dentist, or at least five years of supervised experience by a certified public~~
160.5 ~~health nurse operating under the direct authority of an enrolled unit of government.~~

160.6 ~~Community health workers eligible for payment under clause (2) must complete the~~
160.7 ~~certification program by January 1, 2010, to continue to be eligible for payment.~~

160.8 (b) Community health workers must work under the supervision of a medical assistance
160.9 enrolled physician, registered nurse, advanced practice registered nurse, mental health
160.10 professional ~~as defined in section 245.462, subdivision 18, clauses (1) to (6), and section~~
160.11 ~~245.4871, subdivision 27, clauses (1) to (5),~~ or dentist, or work under the supervision of a
160.12 certified public health nurse operating under the direct authority of an enrolled unit of
160.13 government.

160.14 (c) Care coordination and patient education services covered under this subdivision
160.15 include, but are not limited to, services relating to oral health and dental care.

160.16 Sec. 80. Minnesota Statutes 2020, section 256B.0625, subdivision 56a, is amended to
160.17 read:

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

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

160.23 (2) does not require the security of a public detention facility and is not considered an
160.24 inmate of a public institution as defined in Code of Federal Regulations, title 42, section
160.25 435.1010;

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

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

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

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

161.7 (1) ~~a licensed mental health professional as defined in section 245.462, subdivision 18,~~
161.8 ~~clauses (1) to (6);~~

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

161.11 (3) ~~a mental health practitioner as defined in section 245.462, subdivision 17~~ qualified
161.12 according to section 245I.04, subdivision 4, working under the clinical treatment supervision
161.13 of a mental health professional according to section 245I.06;

161.14 ~~(3) (4) a mental health certified peer specialist under section 256B.0615~~ qualified
161.15 according to section 245I.04, subdivision 10, working under the clinical treatment supervision
161.16 of a mental health professional according to section 245I.06;

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

161.19 (5) a recovery peer qualified under section 245G.11, subdivision 8, working under the
161.20 supervision of an individual qualified as an alcohol and drug counselor under section
161.21 245G.11, subdivision 5.

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

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

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

- 162.1 Sec. 81. Minnesota Statutes 2020, section 256B.0757, subdivision 4c, is amended to read:
- 162.2 Subd. 4c. **Behavioral health home services staff qualifications.** (a) A behavioral health
162.3 home services provider must maintain staff with required professional qualifications
162.4 appropriate to the setting.
- 162.5 (b) If behavioral health home services are offered in a mental health setting, the
162.6 integration specialist must be a registered nurse licensed under the Minnesota Nurse Practice
162.7 Act, sections 148.171 to 148.285.
- 162.8 (c) If behavioral health home services are offered in a primary care setting, the integration
162.9 specialist must be a mental health professional ~~as defined in~~ qualified according to section
162.10 ~~245.462, subdivision 18, clauses (1) to (6), or 245.4871, subdivision 27, clauses (1) to (6)~~
162.11 245I.04, subdivision 2.
- 162.12 (d) If behavioral health home services are offered in either a primary care setting or
162.13 mental health setting, the systems navigator must be a mental health practitioner ~~as defined~~
162.14 ~~in~~ qualified according to section 245.462, subdivision 17 245I.04, subdivision 4, or a
162.15 community health worker as defined in section 256B.0625, subdivision 49.
- 162.16 (e) If behavioral health home services are offered in either a primary care setting or
162.17 mental health setting, the qualified health home specialist must be one of the following:
- 162.18 (1) a mental health certified peer support specialist as defined in qualified according to
162.19 ~~section 256B.0615~~ 245I.04, subdivision 10;
- 162.20 (2) a mental health certified family peer support specialist as defined in qualified
162.21 according to section 256B.0616 245I.04, subdivision 12;
- 162.22 (3) a case management associate as defined in section 245.462, subdivision 4, paragraph
162.23 (g), or 245.4871, subdivision 4, paragraph (j);
- 162.24 (4) a mental health rehabilitation worker ~~as defined in~~ qualified according to section
162.25 ~~256B.0623, subdivision 5, clause (4)~~ 245I.04, subdivision 14;
- 162.26 (5) a community paramedic as defined in section 144E.28, subdivision 9;
- 162.27 (6) a peer recovery specialist as defined in section 245G.07, subdivision 1, clause (5);
162.28 or
- 162.29 (7) a community health worker as defined in section 256B.0625, subdivision 49.

- 163.1 Sec. 82. Minnesota Statutes 2020, section 256B.0941, subdivision 1, is amended to read:
- 163.2 Subdivision 1. **Eligibility.** (a) An individual who is eligible for mental health treatment
163.3 services in a psychiatric residential treatment facility must meet all of the following criteria:
- 163.4 (1) before admission, services are determined to be medically necessary according to
163.5 Code of Federal Regulations, title 42, section 441.152;
- 163.6 (2) is younger than 21 years of age at the time of admission. Services may continue until
163.7 the individual meets criteria for discharge or reaches 22 years of age, whichever occurs
163.8 first;
- 163.9 (3) has a mental health diagnosis as defined in the most recent edition of the Diagnostic
163.10 and Statistical Manual for Mental Disorders, as well as clinical evidence of severe aggression,
163.11 or a finding that the individual is a risk to self or others;
- 163.12 (4) has functional impairment and a history of difficulty in functioning safely and
163.13 successfully in the community, school, home, or job; an inability to adequately care for
163.14 one's physical needs; or caregivers, guardians, or family members are unable to safely fulfill
163.15 the individual's needs;
- 163.16 (5) requires psychiatric residential treatment under the direction of a physician to improve
163.17 the individual's condition or prevent further regression so that services will no longer be
163.18 needed;
- 163.19 (6) utilized and exhausted other community-based mental health services, or clinical
163.20 evidence indicates that such services cannot provide the level of care needed; and
- 163.21 (7) was referred for treatment in a psychiatric residential treatment facility by a ~~qualified~~
163.22 mental health professional ~~licensed as defined in~~ qualified according to section 245.4871,
163.23 ~~subdivision 27, clauses (1) to (6)~~ 245I.04, subdivision 2.
- 163.24 (b) The commissioner shall provide oversight and review the use of referrals for clients
163.25 admitted to psychiatric residential treatment facilities to ensure that eligibility criteria,
163.26 clinical services, and treatment planning reflect clinical, state, and federal standards for
163.27 psychiatric residential treatment facility level of care. The commissioner shall coordinate
163.28 the production of a statewide list of children and youth who meet the medical necessity
163.29 criteria for psychiatric residential treatment facility level of care and who are awaiting
163.30 admission. The commissioner and any recipient of the list shall not use the statewide list to
163.31 direct admission of children and youth to specific facilities.

164.1 Sec. 83. Minnesota Statutes 2020, section 256B.0943, subdivision 1, is amended to read:

164.2 Subdivision 1. **Definitions.** For purposes of this section, the following terms have the
164.3 meanings given them.

164.4 (a) "Children's therapeutic services and supports" means the flexible package of mental
164.5 health services for children who require varying therapeutic and rehabilitative levels of
164.6 intervention to treat a diagnosed emotional disturbance, as defined in section 245.4871,
164.7 subdivision 15, or a diagnosed mental illness, as defined in section 245.462, subdivision
164.8 20. The services are time-limited interventions that are delivered using various treatment
164.9 modalities and combinations of services designed to reach treatment outcomes identified
164.10 in the individual treatment plan.

164.11 ~~(b) "Clinical supervision" means the overall responsibility of the mental health~~
164.12 ~~professional for the control and direction of individualized treatment planning, service~~
164.13 ~~delivery, and treatment review for each client. A mental health professional who is an~~
164.14 ~~enrolled Minnesota health care program provider accepts full professional responsibility~~
164.15 ~~for a supervisee's actions and decisions, instructs the supervisee in the supervisee's work,~~
164.16 ~~and oversees or directs the supervisee's work.~~

164.17 ~~(e)~~ (b) "Clinical trainee" means a ~~mental health practitioner who meets the qualifications~~
164.18 ~~specified in Minnesota Rules, part 9505.0371, subpart 5, item C~~ staff person who is qualified
164.19 according to section 245I.04, subdivision 6.

164.20 ~~(d)~~ (c) "Crisis assistance planning" has the meaning given in section 245.4871, subdivision
164.21 9a. ~~Crisis assistance entails the development of a written plan to assist a child's family to~~
164.22 ~~contend with a potential crisis and is distinct from the immediate provision of crisis~~
164.23 ~~intervention services.~~

164.24 ~~(e)~~ (d) "Culturally competent provider" means a provider who understands and can
164.25 utilize to a client's benefit the client's culture when providing services to the client. A provider
164.26 may be culturally competent because the provider is of the same cultural or ethnic group
164.27 as the client or the provider has developed the knowledge and skills through training and
164.28 experience to provide services to culturally diverse clients.

164.29 ~~(f)~~ (e) "Day treatment program" for children means a site-based structured mental health
164.30 program consisting of psychotherapy for three or more individuals and individual or group
164.31 skills training provided by a ~~multidisciplinary~~ team, under the clinical treatment supervision
164.32 of a mental health professional.

165.1 ~~(g)~~ (f) "Standard diagnostic assessment" ~~has the meaning given in Minnesota Rules, part~~
165.2 ~~9505.0372, subpart 1~~ means the assessment described in 245I.10, subdivision 6.

165.3 ~~(h)~~ (g) "Direct service time" means the time that a mental health professional, clinical
165.4 trainee, mental health practitioner, or mental health behavioral aide spends face-to-face with
165.5 a client and the client's family or providing covered telemedicine services. Direct service
165.6 time includes time in which the provider obtains a client's history, develops a client's
165.7 treatment plan, records individual treatment outcomes, or provides service components of
165.8 children's therapeutic services and supports. Direct service time does not include time doing
165.9 work before and after providing direct services, including scheduling or maintaining clinical
165.10 records.

165.11 ~~(i)~~ (h) "Direction of mental health behavioral aide" means the activities of a mental
165.12 health professional, clinical trainee, or mental health practitioner in guiding the mental
165.13 health behavioral aide in providing services to a client. The direction of a mental health
165.14 behavioral aide must be based on the client's ~~individualized~~ individual treatment plan and
165.15 meet the requirements in subdivision 6, paragraph (b), clause (5).

165.16 ~~(j)~~ (i) "Emotional disturbance" has the meaning given in section 245.4871, subdivision
165.17 15.

165.18 ~~(k)~~ (j) "Individual behavioral plan" means a plan of intervention, treatment, and services
165.19 for a child written by a mental health professional or a clinical trainee or mental health
165.20 practitioner, ~~under the clinical treatment~~ supervision of a mental health professional, to
165.21 guide the work of the mental health behavioral aide. The individual behavioral plan may
165.22 be incorporated into the child's individual treatment plan so long as the behavioral plan is
165.23 separately communicable to the mental health behavioral aide.

165.24 ~~(l)~~ (k) "Individual treatment plan" ~~has the meaning given in Minnesota Rules, part~~
165.25 ~~9505.0371, subpart 7~~ means the plan described under section 245I.10, subdivisions 7 and
165.26 8.

165.27 ~~(m)~~ (l) "Mental health behavioral aide services" means medically necessary one-on-one
165.28 activities performed by a ~~trained paraprofessional qualified as provided in subdivision 7,~~
165.29 ~~paragraph (b), clause (3)~~ mental health behavioral aide qualified according to section 245I.04,
165.30 subdivision 16, to assist a child retain or generalize psychosocial skills as previously trained
165.31 by a mental health professional, clinical trainee, or mental health practitioner and as described
165.32 in the child's individual treatment plan and individual behavior plan. Activities involve
165.33 working directly with the child or child's family as provided in subdivision 9, paragraph
165.34 (b), clause (4).

166.1 (m) "Mental health certified family peer specialist" means a staff person who is qualified
166.2 according to section 245I.04, subdivision 12.

166.3 (n) "~~Mental health practitioner~~" ~~has the meaning given in section 245.462, subdivision~~
166.4 ~~17, except that a practitioner working in a day treatment setting may qualify as a mental~~
166.5 ~~health practitioner if the practitioner holds a bachelor's degree in one of the behavioral~~
166.6 ~~sciences or related fields from an accredited college or university, and: (1) has at least 2,000~~
166.7 ~~hours of clinically supervised experience in the delivery of mental health services to clients~~
166.8 ~~with mental illness; (2) is fluent in the language, other than English, of the cultural group~~
166.9 ~~that makes up at least 50 percent of the practitioner's clients, completes 40 hours of training~~
166.10 ~~on the delivery of services to clients with mental illness, and receives clinical supervision~~
166.11 ~~from a mental health professional at least once per week until meeting the required 2,000~~
166.12 ~~hours of supervised experience; or (3) receives 40 hours of training on the delivery of~~
166.13 ~~services to clients with mental illness within six months of employment, and clinical~~
166.14 ~~supervision from a mental health professional at least once per week until meeting the~~
166.15 ~~required 2,000 hours of supervised experience~~ means a staff person who is qualified according
166.16 to section 245I.04, subdivision 4.

166.17 (o) "~~Mental health professional~~" means ~~an individual as defined in Minnesota Rules,~~
166.18 ~~part 9505.0370, subpart 18~~ a staff person who is qualified according to section 245I.04,
166.19 subdivision 2.

166.20 (p) "Mental health service plan development" includes:

166.21 (1) the development, review, and revision of a child's individual treatment plan, as
166.22 ~~provided in Minnesota Rules, part 9505.0371, subpart 7,~~ including involvement of the client
166.23 or client's parents, primary caregiver, or other person authorized to consent to mental health
166.24 services for the client, and including arrangement of treatment and support activities specified
166.25 in the individual treatment plan; and

166.26 (2) administering and reporting the standardized outcome measurement instruments,
166.27 determined and updated by the commissioner measurements in section 245I.10, subdivision
166.28 6, paragraph (d), clauses (3) and (4), and other standardized outcome measurements approved
166.29 by the commissioner, as periodically needed to evaluate the effectiveness of treatment ~~for~~
166.30 ~~children receiving clinical services and reporting outcome measures, as required by the~~
166.31 ~~commissioner.~~

166.32 (q) "Mental illness," for persons at least age 18 but under age 21, has the meaning given
166.33 in section 245.462, subdivision 20, paragraph (a).

167.1 (r) "Psychotherapy" means the treatment of mental or emotional disorders or
167.2 maladjustment by psychological means. Psychotherapy may be provided in many modalities
167.3 in accordance with Minnesota Rules, part 9505.0372, subpart 6, including patient and/or
167.4 family psychotherapy; family psychotherapy; psychotherapy for crisis; group psychotherapy;
167.5 or multiple-family psychotherapy. Beginning with the American Medical Association's
167.6 Current Procedural Terminology, standard edition, 2014, the procedure "individual
167.7 psychotherapy" is replaced with "patient and/or family psychotherapy," a substantive change
167.8 that permits the therapist to work with the client's family without the client present to obtain
167.9 information about the client or to explain the client's treatment plan to the family.
167.10 Psychotherapy is appropriate for crisis response when a child has become dysregulated or
167.11 experienced new trauma since the diagnostic assessment was completed and needs
167.12 psychotherapy to address issues not currently included in the child's individual treatment
167.13 plan described in section 256B.0671, subdivision 11.

167.14 (s) "Rehabilitative services" or "psychiatric rehabilitation services" means a series or
167.15 multidisciplinary combination of psychiatric and psychosocial interventions to: (1) restore
167.16 a child or adolescent to an age-appropriate developmental trajectory that had been disrupted
167.17 by a psychiatric illness; or (2) enable the child to self-monitor, compensate for, cope with,
167.18 counteract, or replace psychosocial skills deficits or maladaptive skills acquired over the
167.19 course of a psychiatric illness. Psychiatric rehabilitation services for children combine
167.20 coordinated psychotherapy to address internal psychological, emotional, and intellectual
167.21 processing deficits, and skills training to restore personal and social functioning. Psychiatric
167.22 rehabilitation services establish a progressive series of goals with each achievement building
167.23 upon a prior achievement. ~~Continuing progress toward goals is expected, and rehabilitative~~
167.24 ~~potential ceases when successive improvement is not observable over a period of time.~~

167.25 (t) "Skills training" means individual, family, or group training, delivered by or under
167.26 the supervision of a mental health professional, designed to facilitate the acquisition of
167.27 psychosocial skills that are medically necessary to rehabilitate the child to an age-appropriate
167.28 developmental trajectory heretofore disrupted by a psychiatric illness or to enable the child
167.29 to self-monitor, compensate for, cope with, counteract, or replace skills deficits or
167.30 maladaptive skills acquired over the course of a psychiatric illness. Skills training is subject
167.31 to the service delivery requirements under subdivision 9, paragraph (b), clause (2).

167.32 (u) "Treatment supervision" means the supervision described in section 245I.06.

168.1 Sec. 84. Minnesota Statutes 2020, section 256B.0943, subdivision 2, is amended to read:

168.2 Subd. 2. **Covered service components of children's therapeutic services and**
168.3 **supports.** (a) Subject to federal approval, medical assistance covers medically necessary
168.4 children's therapeutic services and supports ~~as defined in this section that~~ when the services
168.5 are provided by an eligible provider entity certified under subdivision 4 provides to a client
168.6 eligible under subdivision 3 and meeting the standards in this section. The provider entity
168.7 must make reasonable and good faith efforts to report individual client outcomes to the
168.8 commissioner, using instruments and protocols approved by the commissioner.

168.9 (b) The service components of children's therapeutic services and supports are:

168.10 (1) patient and/or family psychotherapy, family psychotherapy, psychotherapy for crisis,
168.11 and group psychotherapy;

168.12 (2) individual, family, or group skills training provided by a mental health professional,
168.13 clinical trainee, or mental health practitioner;

168.14 (3) crisis ~~assistance~~ planning;

168.15 (4) mental health behavioral aide services;

168.16 (5) direction of a mental health behavioral aide;

168.17 (6) mental health service plan development; and

168.18 (7) children's day treatment.

168.19 Sec. 85. Minnesota Statutes 2020, section 256B.0943, subdivision 3, is amended to read:

168.20 Subd. 3. **Determination of client eligibility.** (a) A client's eligibility to receive children's
168.21 therapeutic services and supports under this section shall be determined based on a standard
168.22 diagnostic assessment by a mental health professional or a ~~mental health practitioner who~~
168.23 ~~meets the requirements of a clinical trainee as defined in Minnesota Rules, part 9505.0371,~~
168.24 ~~subpart 5, item C,~~ clinical trainee that is performed within one year before the initial start
168.25 of service. The standard diagnostic assessment must ~~meet the requirements for a standard~~
168.26 ~~or extended diagnostic assessment as defined in Minnesota Rules, part 9505.0372, subpart~~
168.27 ~~1, items B and C,~~ and:

168.28 (1) ~~include current diagnoses, including any differential diagnosis, in accordance with~~
168.29 ~~all criteria for a complete diagnosis and diagnostic profile as specified in the current edition~~
168.30 ~~of the Diagnostic and Statistical Manual of the American Psychiatric Association, or, for~~
168.31 ~~children under age five, as specified in the current edition of the Diagnostic Classification~~
168.32 ~~of Mental Health Disorders of Infancy and Early Childhood;~~

169.1 ~~(2)~~ (1) determine whether a child under age 18 has a diagnosis of emotional disturbance
169.2 or, if the person is between the ages of 18 and 21, whether the person has a mental illness;

169.3 ~~(3)~~ (2) document children's therapeutic services and supports as medically necessary to
169.4 address an identified disability, functional impairment, and the individual client's needs and
169.5 goals; and

169.6 ~~(4)~~ (3) be used in the development of the ~~individualized~~ individual treatment plan; and

169.7 ~~(5) be completed annually until age 18. For individuals between age 18 and 21, unless~~
169.8 ~~a client's mental health condition has changed markedly since the client's most recent~~
169.9 ~~diagnostic assessment, annual updating is necessary. For the purpose of this section,~~
169.10 ~~"updating" means an adult diagnostic update as defined in Minnesota Rules, part 9505.0371,~~
169.11 ~~subpart 2, item E.~~

169.12 (b) Notwithstanding paragraph (a), a client may be determined to be eligible for up to
169.13 five days of day treatment under this section based on a hospital's medical history and
169.14 presentation examination of the client.

169.15 Sec. 86. Minnesota Statutes 2020, section 256B.0943, subdivision 4, is amended to read:

169.16 Subd. 4. **Provider entity certification.** (a) The commissioner shall establish an initial
169.17 provider entity application and certification process and recertification process to determine
169.18 whether a provider entity has an administrative and clinical infrastructure that meets the
169.19 requirements in subdivisions 5 and 6. A provider entity must be certified for the three core
169.20 rehabilitation services of psychotherapy, skills training, and crisis ~~assistance~~ planning. The
169.21 commissioner shall recertify a provider entity at least every three years. The commissioner
169.22 shall establish a process for decertification of a provider entity and shall require corrective
169.23 action, medical assistance repayment, or decertification of a provider entity that no longer
169.24 meets the requirements in this section or that fails to meet the clinical quality standards or
169.25 administrative standards provided by the commissioner in the application and certification
169.26 process.

169.27 (b) For purposes of this section, a provider entity must meet the standards in this section
169.28 and chapter 245I, as required in section 245I.011, subdivision 5, and be:

169.29 (1) an Indian health services facility or a facility owned and operated by a tribe or tribal
169.30 organization operating as a 638 facility under Public Law 93-638 certified by the state;

169.31 (2) a county-operated entity certified by the state; or

169.32 (3) a noncounty entity certified by the state.

170.1 Sec. 87. Minnesota Statutes 2020, section 256B.0943, subdivision 5, is amended to read:

170.2 Subd. 5. **Provider entity administrative infrastructure requirements.** ~~(a) To be an~~
170.3 ~~eligible provider entity under this section, a provider entity must have an administrative~~
170.4 ~~infrastructure that establishes authority and accountability for decision making and oversight~~
170.5 ~~of functions, including finance, personnel, system management, clinical practice, and~~
170.6 ~~individual treatment outcomes measurement. An eligible provider entity shall demonstrate~~
170.7 ~~the availability, by means of employment or contract, of at least one backup mental health~~
170.8 ~~professional in the event of the primary mental health professional's absence. The provider~~
170.9 ~~must have written policies and procedures that it reviews and updates every three years and~~
170.10 ~~distributes to staff initially and upon each subsequent update.~~

170.11 ~~(b) The administrative infrastructure written~~ In addition to the policies and procedures
170.12 required under section 245I.03, the policies and procedures must include:

170.13 ~~(1) personnel procedures, including a process for: (i) recruiting, hiring, training, and~~
170.14 ~~retention of culturally and linguistically competent providers; (ii) conducting a criminal~~
170.15 ~~background check on all direct service providers and volunteers; (iii) investigating, reporting,~~
170.16 ~~and acting on violations of ethical conduct standards; (iv) investigating, reporting, and acting~~
170.17 ~~on violations of data privacy policies that are compliant with federal and state laws; (v)~~
170.18 ~~utilizing volunteers, including screening applicants, training and supervising volunteers,~~
170.19 ~~and providing liability coverage for volunteers; and (vi) documenting that each mental~~
170.20 ~~health professional, mental health practitioner, or mental health behavioral aide meets the~~
170.21 ~~applicable provider qualification criteria, training criteria under subdivision 8, and clinical~~
170.22 ~~supervision or direction of a mental health behavioral aide requirements under subdivision~~
170.23 ~~6;~~

170.24 ~~(2)~~ (1) fiscal procedures, including internal fiscal control practices and a process for
170.25 collecting revenue that is compliant with federal and state laws; and

170.26 ~~(3)~~ (2) a client-specific treatment outcomes measurement system, including baseline
170.27 measures, to measure a client's progress toward achieving mental health rehabilitation goals.
170.28 ~~Effective July 1, 2017, to be eligible for medical assistance payment, a provider entity must~~
170.29 ~~report individual client outcomes to the commissioner, using instruments and protocols~~
170.30 ~~approved by the commissioner; and~~

170.31 ~~(4) a process to establish and maintain individual client records. The client's records~~
170.32 ~~must include:~~

170.33 ~~(i) the client's personal information;~~

171.1 ~~(ii) forms applicable to data privacy;~~

171.2 ~~(iii) the client's diagnostic assessment, updates, results of tests, individual treatment~~
171.3 ~~plan, and individual behavior plan, if necessary;~~

171.4 ~~(iv) documentation of service delivery as specified under subdivision 6;~~

171.5 ~~(v) telephone contacts;~~

171.6 ~~(vi) discharge plan; and~~

171.7 ~~(vii) if applicable, insurance information.~~

171.8 (c) A provider entity that uses a restrictive procedure with a client must meet the
171.9 requirements of section 245.8261.

171.10 Sec. 88. Minnesota Statutes 2020, section 256B.0943, subdivision 5a, is amended to read:

171.11 Subd. 5a. **Background studies.** The requirements for background studies under ~~this~~
171.12 section 245I.011, subdivision 4, paragraph (d), may be met by a children's therapeutic
171.13 services and supports services agency through the commissioner's NETStudy system as
171.14 provided under sections 245C.03, subdivision 7, and 245C.10, subdivision 8.

171.15 Sec. 89. Minnesota Statutes 2020, section 256B.0943, subdivision 6, is amended to read:

171.16 Subd. 6. **Provider entity clinical infrastructure requirements.** (a) To be an eligible
171.17 provider entity under this section, a provider entity must have a clinical infrastructure that
171.18 utilizes diagnostic assessment, ~~individualized~~ individual treatment plans, service delivery,
171.19 and individual treatment plan review that are culturally competent, child-centered, and
171.20 family-driven to achieve maximum benefit for the client. The provider entity must review,
171.21 and update as necessary, the clinical policies and procedures every three years, must distribute
171.22 the policies and procedures to staff initially and upon each subsequent update, and must
171.23 train staff accordingly.

171.24 (b) The clinical infrastructure written policies and procedures must include policies and
171.25 procedures for meeting the requirements in this subdivision:

171.26 (1) providing or obtaining a client's standard diagnostic assessment, including a standard
171.27 ~~diagnostic assessment performed by an outside or independent clinician, that identifies acute~~
171.28 ~~and chronic clinical disorders, co-occurring medical conditions, and sources of psychological~~
171.29 ~~and environmental problems, including baselines, and a functional assessment. The functional~~
171.30 ~~assessment component must clearly summarize the client's individual strengths and needs.~~
171.31 When required components of the standard diagnostic assessment, ~~such as baseline measures,~~

172.1 are not provided in an outside or independent assessment or ~~when baseline measures cannot~~
172.2 ~~be attained in a one-session standard diagnostic assessment~~ immediately, the provider entity
172.3 must determine the missing information within 30 days and amend the child's standard
172.4 diagnostic assessment or incorporate the ~~baselines~~ information into the child's individual
172.5 treatment plan;

172.6 (2) developing an individual treatment plan ~~that:~~₂

172.7 ~~(i) is based on the information in the client's diagnostic assessment and baselines;~~

172.8 ~~(ii) identified goals and objectives of treatment, treatment strategy, schedule for~~
172.9 ~~accomplishing treatment goals and objectives, and the individuals responsible for providing~~
172.10 ~~treatment services and supports;~~

172.11 ~~(iii) is developed after completion of the client's diagnostic assessment by a mental health~~
172.12 ~~professional or clinical trainee and before the provision of children's therapeutic services~~
172.13 ~~and supports;~~

172.14 ~~(iv) is developed through a child-centered, family-driven, culturally appropriate planning~~
172.15 ~~process, including allowing parents and guardians to observe or participate in individual~~
172.16 ~~and family treatment services, assessment, and treatment planning;~~

172.17 ~~(v) is reviewed at least once every 90 days and revised to document treatment progress~~
172.18 ~~on each treatment objective and next goals or, if progress is not documented, to document~~
172.19 ~~changes in treatment; and~~

172.20 ~~(vi) is signed by the clinical supervisor and by the client or by the client's parent or other~~
172.21 ~~person authorized by statute to consent to mental health services for the client. A client's~~
172.22 ~~parent may approve the client's individual treatment plan by secure electronic signature or~~
172.23 ~~by documented oral approval that is later verified by written signature;~~

172.24 (3) developing an individual behavior plan that documents treatment strategies and
172.25 describes interventions to be provided by the mental health behavioral aide. The individual
172.26 behavior plan must include:

172.27 (i) detailed instructions on the ~~treatment strategies to be provided~~ psychosocial skills to
172.28 be practiced;

172.29 (ii) time allocated to each treatment strategy intervention;

172.30 (iii) methods of documenting the child's behavior;

172.31 (iv) methods of monitoring the child's progress in reaching objectives; and

173.1 (v) goals to increase or decrease targeted behavior as identified in the individual treatment
173.2 plan;

173.3 (4) providing clinical treatment supervision plans for ~~mental health practitioners and~~
173.4 ~~mental health behavioral aides. A mental health professional must document the clinical~~
173.5 ~~supervision the professional provides by cosigning individual treatment plans and making~~
173.6 ~~entries in the client's record on supervisory activities. The clinical supervisor also shall~~
173.7 ~~document supervisee-specific supervision in the supervisee's personnel file. Clinical staff~~
173.8 according to section 245I.06. Treatment supervision does not include the authority to make
173.9 or terminate court-ordered placements of the child. A clinical treatment supervisor must be
173.10 available for urgent consultation as required by the individual client's needs or the situation.
173.11 ~~Clinical supervision may occur individually or in a small group to discuss treatment and~~
173.12 ~~review progress toward goals. The focus of clinical supervision must be the client's treatment~~
173.13 ~~needs and progress and the mental health practitioner's or behavioral aide's ability to provide~~
173.14 ~~services;~~

173.15 (4a) meeting day treatment program conditions in items (i) ~~to (iii)~~ and (ii):

173.16 (i) the clinical treatment supervisor must be present and available on the premises more
173.17 than 50 percent of the time in a provider's standard working week during which the supervisee
173.18 is providing a mental health service; and

173.19 ~~(ii) the diagnosis and the client's individual treatment plan or a change in the diagnosis~~
173.20 ~~or individual treatment plan must be made by or reviewed, approved, and signed by the~~
173.21 ~~clinical supervisor; and~~

173.22 ~~(iii)~~ (ii) every 30 days, the clinical treatment supervisor must review and sign the record
173.23 indicating the supervisor has reviewed the client's care for all activities in the preceding
173.24 30-day period;

173.25 (4b) meeting the clinical treatment supervision standards in items (i) ~~to (iv)~~ and (ii) for
173.26 all other services provided under CTSS:

173.27 ~~(i) medical assistance shall reimburse for services provided by a mental health practitioner~~
173.28 ~~who is delivering services that fall within the scope of the practitioner's practice and who~~
173.29 ~~is supervised by a mental health professional who accepts full professional responsibility;~~

173.30 ~~(ii) medical assistance shall reimburse for services provided by a mental health behavioral~~
173.31 ~~aide who is delivering services that fall within the scope of the aide's practice and who is~~
173.32 ~~supervised by a mental health professional who accepts full professional responsibility and~~
173.33 ~~has an approved plan for clinical supervision of the behavioral aide. Plans must be developed~~

174.1 ~~in accordance with supervision standards defined in Minnesota Rules, part 9505.0371,~~
174.2 ~~subpart 4, items A to D;~~

174.3 ~~(iii)~~ (i) the mental health professional is required to be present at the site of service
174.4 delivery for observation as clinically appropriate when the clinical trainee, mental health
174.5 practitioner₂, or mental health behavioral aide is providing CTSS services; and

174.6 ~~(iv)~~ (ii) when conducted, the on-site presence of the mental health professional must be
174.7 documented in the child's record and signed by the mental health professional who accepts
174.8 full professional responsibility;

174.9 (5) providing direction to a mental health behavioral aide. For entities that employ mental
174.10 health behavioral aides, the ~~clinical~~ treatment supervisor must be employed by the provider
174.11 entity or other provider certified to provide mental health behavioral aide services to ensure
174.12 necessary and appropriate oversight for the client's treatment and continuity of care. The
174.13 ~~mental health professional or mental health practitioner~~ staff giving direction must begin
174.14 with the goals on the ~~individualized~~ individual treatment plan, and instruct the mental health
174.15 behavioral aide on how to implement therapeutic activities and interventions that will lead
174.16 to goal attainment. The ~~professional or practitioner~~ staff giving direction must also instruct
174.17 the mental health behavioral aide about the client's diagnosis, functional status, and other
174.18 characteristics that are likely to affect service delivery. Direction must also include
174.19 determining that the mental health behavioral aide has the skills to interact with the client
174.20 and the client's family in ways that convey personal and cultural respect and that the aide
174.21 actively solicits information relevant to treatment from the family. The aide must be able
174.22 to clearly explain or demonstrate the activities the aide is doing with the client and the
174.23 activities' relationship to treatment goals. Direction is more didactic than is supervision and
174.24 requires the ~~professional or practitioner~~ staff providing it to continuously evaluate the mental
174.25 health behavioral aide's ability to carry out the activities of the ~~individualized~~ individual
174.26 treatment plan and the ~~individualized~~ individual behavior plan. When providing direction,
174.27 the ~~professional or practitioner~~ staff must:

174.28 (i) review progress notes prepared by the mental health behavioral aide for accuracy and
174.29 consistency with diagnostic assessment, treatment plan, and behavior goals and the
174.30 ~~professional or practitioner~~ staff must approve and sign the progress notes;

174.31 (ii) identify changes in treatment strategies, revise the individual behavior plan, and
174.32 communicate treatment instructions and methodologies as appropriate to ensure that treatment
174.33 is implemented correctly;

175.1 (iii) demonstrate family-friendly behaviors that support healthy collaboration among
175.2 the child, the child's family, and providers as treatment is planned and implemented;

175.3 (iv) ensure that the mental health behavioral aide is able to effectively communicate
175.4 with the child, the child's family, and the provider; ~~and~~

175.5 (v) record the results of any evaluation and corrective actions taken to modify the work
175.6 of the mental health behavioral aide; and

175.7 (vi) ensure the immediate accessibility of a mental health professional, clinical trainee,
175.8 or mental health practitioner to the behavioral aide during service delivery;

175.9 (6) providing service delivery that implements the individual treatment plan and meets
175.10 the requirements under subdivision 9; and

175.11 (7) individual treatment plan review. The review must determine the extent to which
175.12 the services have met each of the goals and objectives in the treatment plan. The review
175.13 must assess the client's progress and ensure that services and treatment goals continue to
175.14 be necessary and appropriate to the client and the client's family or foster family. ~~Revision~~
175.15 ~~of the individual treatment plan does not require a new diagnostic assessment unless the~~
175.16 ~~client's mental health status has changed markedly. The updated treatment plan must be~~
175.17 ~~signed by the clinical supervisor and by the client, if appropriate, and by the client's parent~~
175.18 ~~or other person authorized by statute to give consent to the mental health services for the~~
175.19 ~~child.~~

175.20 Sec. 90. Minnesota Statutes 2020, section 256B.0943, subdivision 7, is amended to read:

175.21 Subd. 7. **Qualifications of individual and team providers.** (a) An individual or team
175.22 provider working within the scope of the provider's practice or qualifications may provide
175.23 service components of children's therapeutic services and supports that are identified as
175.24 medically necessary in a client's individual treatment plan.

175.25 (b) An individual provider must be qualified as a:

175.26 (1) ~~a mental health professional as defined in subdivision 1, paragraph (e); or~~

175.27 (2) a clinical trainee;

175.28 (3) mental health practitioner or clinical trainee. ~~The mental health practitioner or clinical~~
175.29 ~~trainee must work under the clinical supervision of a mental health professional; or~~

175.30 (4) mental health certified family peer specialist; or

176.1 ~~(3) a (5) mental health behavioral aide working under the clinical supervision of a mental~~
176.2 ~~health professional to implement the rehabilitative mental health services previously~~
176.3 ~~introduced by a mental health professional or practitioner and identified in the client's~~
176.4 ~~individual treatment plan and individual behavior plan.~~

176.5 ~~(A) A level I mental health behavioral aide must:~~

176.6 ~~(i) be at least 18 years old;~~

176.7 ~~(ii) have a high school diploma or commissioner of education-selected high school~~
176.8 ~~equivalency certification or two years of experience as a primary caregiver to a child with~~
176.9 ~~severe emotional disturbance within the previous ten years; and~~

176.10 ~~(iii) meet preservice and continuing education requirements under subdivision 8.~~

176.11 ~~(B) A level II mental health behavioral aide must:~~

176.12 ~~(i) be at least 18 years old;~~

176.13 ~~(ii) have an associate or bachelor's degree or 4,000 hours of experience in delivering~~
176.14 ~~clinical services in the treatment of mental illness concerning children or adolescents or~~
176.15 ~~complete a certificate program established under subdivision 8a; and~~

176.16 ~~(iii) meet preservice and continuing education requirements in subdivision 8.~~

176.17 (c) A day treatment multidisciplinary team must include at least one mental health
176.18 professional or clinical trainee and one mental health practitioner.

176.19 Sec. 91. Minnesota Statutes 2020, section 256B.0943, subdivision 9, is amended to read:

176.20 Subd. 9. **Service delivery criteria.** (a) In delivering services under this section, a certified
176.21 provider entity must ensure that:

176.22 (1) ~~each individual provider's caseload size permits the provider to deliver services to~~
176.23 ~~both clients with severe, complex needs and clients with less intensive needs. the provider's~~
176.24 caseload size should reasonably enable the provider to play an active role in service planning,
176.25 monitoring, and delivering services to meet the client's and client's family's needs, as specified
176.26 in each client's individual treatment plan;

176.27 (2) site-based programs, including day treatment programs, provide staffing and facilities
176.28 to ensure the client's health, safety, and protection of rights, and that the programs are able
176.29 to implement each client's individual treatment plan; and

176.30 (3) a day treatment program is provided to a group of clients by a multidisciplinary team
176.31 under the clinical treatment supervision of a mental health professional. The day treatment

177.1 program must be provided in and by: (i) an outpatient hospital accredited by the Joint
177.2 Commission on Accreditation of Health Organizations and licensed under sections 144.50
177.3 to 144.55; (ii) a community mental health center under section 245.62; or (iii) an entity that
177.4 is certified under subdivision 4 to operate a program that meets the requirements of section
177.5 245.4884, subdivision 2, and Minnesota Rules, parts 9505.0170 to 9505.0475. The day
177.6 treatment program must stabilize the client's mental health status while developing and
177.7 improving the client's independent living and socialization skills. The goal of the day
177.8 treatment program must be to reduce or relieve the effects of mental illness and provide
177.9 training to enable the client to live in the community. The program must be available
177.10 year-round at least three to five days per week, two or three hours per day, unless the normal
177.11 five-day school week is shortened by a holiday, weather-related cancellation, or other
177.12 districtwide reduction in a school week. A child transitioning into or out of day treatment
177.13 must receive a minimum treatment of one day a week for a two-hour time block. The
177.14 two-hour time block must include at least one hour of patient and/or family or group
177.15 psychotherapy. The remainder of the structured treatment program may include patient
177.16 and/or family or group psychotherapy, and individual or group skills training, if included
177.17 in the client's individual treatment plan. Day treatment programs are not part of inpatient
177.18 or residential treatment services. When a day treatment group that meets the minimum group
177.19 size requirement temporarily falls below the minimum group size because of a member's
177.20 temporary absence, medical assistance covers a group session conducted for the group
177.21 members in attendance. A day treatment program may provide fewer than the minimally
177.22 required hours for a particular child during a billing period in which the child is transitioning
177.23 into, or out of, the program.

177.24 (b) To be eligible for medical assistance payment, a provider entity must deliver the
177.25 service components of children's therapeutic services and supports in compliance with the
177.26 following requirements:

177.27 (1) ~~patient and/or family, family, and group psychotherapy must be delivered as specified~~
177.28 ~~in Minnesota Rules, part 9505.0372, subpart 6.~~ psychotherapy to address the child's
177.29 underlying mental health disorder must be documented as part of the child's ongoing
177.30 treatment. A provider must deliver, or arrange for, medically necessary psychotherapy,
177.31 unless the child's parent or caregiver chooses not to receive it. When a provider delivering
177.32 other services to a child under this section deems it not medically necessary to provide
177.33 psychotherapy to the child for a period of 90 days or longer, the provider entity must
177.34 document the medical reasons why psychotherapy is not necessary. When a provider
177.35 determines that a child needs psychotherapy but psychotherapy cannot be delivered due to

178.1 a shortage of licensed mental health professionals in the child's community, the provider
178.2 must document the lack of access in the child's medical record;

178.3 (2) individual, family, or group skills training ~~must be provided by a mental health~~
178.4 ~~professional or a mental health practitioner who is delivering services that fall within the~~
178.5 ~~scope of the provider's practice and is supervised by a mental health professional who~~
178.6 ~~accepts full professional responsibility for the training.~~ Skills training is subject to the
178.7 following requirements:

178.8 (i) a mental health professional, clinical trainee, or mental health practitioner shall provide
178.9 skills training;

178.10 (ii) skills training delivered to a child or the child's family must be targeted to the specific
178.11 deficits or maladaptations of the child's mental health disorder and must be prescribed in
178.12 the child's individual treatment plan;

178.13 (iii) the mental health professional delivering or supervising the delivery of skills training
178.14 must document any underlying psychiatric condition and must document how skills training
178.15 is being used in conjunction with psychotherapy to address the underlying condition;

178.16 (iv) skills training delivered to the child's family must teach skills needed by parents to
178.17 enhance the child's skill development, to help the child utilize daily life skills taught by a
178.18 mental health professional, clinical trainee, or mental health practitioner, and to develop or
178.19 maintain a home environment that supports the child's progressive use of skills;

178.20 (v) group skills training may be provided to multiple recipients who, because of the
178.21 nature of their emotional, behavioral, or social dysfunction, can derive mutual benefit from
178.22 interaction in a group setting, which must be staffed as follows:

178.23 (A) one mental health professional ~~or one~~, clinical trainee, or mental health practitioner
178.24 ~~under supervision of a licensed mental health professional~~ must work with a group of three
178.25 to eight clients; or

178.26 (B) any combination of two mental health professionals, two clinical trainees, or mental
178.27 ~~health practitioners under supervision of a licensed mental health professional, or one mental~~
178.28 ~~health professional or clinical trainee and one mental health practitioner~~ must work with a
178.29 group of nine to 12 clients;

178.30 (vi) a mental health professional, clinical trainee, or mental health practitioner must have
178.31 taught the psychosocial skill before a mental health behavioral aide may practice that skill
178.32 with the client; and

179.1 (vii) for group skills training, when a skills group that meets the minimum group size
179.2 requirement temporarily falls below the minimum group size because of a group member's
179.3 temporary absence, the provider may conduct the session for the group members in
179.4 attendance;

179.5 (3) crisis ~~assistance~~ planning to a child and family must include development of a written
179.6 plan that anticipates the particular factors specific to the child that may precipitate a
179.7 psychiatric crisis for the child in the near future. The written plan must document actions
179.8 that the family should be prepared to take to resolve or stabilize a crisis, such as advance
179.9 arrangements for direct intervention and support services to the child and the child's family.
179.10 Crisis ~~assistance~~ planning must include preparing resources designed to address abrupt or
179.11 substantial changes in the functioning of the child or the child's family when sudden change
179.12 in behavior or a loss of usual coping mechanisms is observed, or the child begins to present
179.13 a danger to self or others;

179.14 (4) mental health behavioral aide services must be medically necessary treatment services,
179.15 identified in the child's individual treatment plan and individual behavior plan, ~~which are~~
179.16 ~~performed minimally by a paraprofessional qualified according to subdivision 7, paragraph~~
179.17 ~~(b), clause (3),~~ and which are designed to improve the functioning of the child in the
179.18 progressive use of developmentally appropriate psychosocial skills. Activities involve
179.19 working directly with the child, child-peer groupings, or child-family groupings to practice,
179.20 repeat, reintroduce, and master the skills defined in subdivision 1, paragraph (t), as previously
179.21 taught by a mental health professional, clinical trainee, or mental health practitioner including:

179.22 (i) providing cues or prompts in skill-building peer-to-peer or parent-child interactions
179.23 so that the child progressively recognizes and responds to the cues independently;

179.24 (ii) performing as a practice partner or role-play partner;

179.25 (iii) reinforcing the child's accomplishments;

179.26 (iv) generalizing skill-building activities in the child's multiple natural settings;

179.27 (v) assigning further practice activities; and

179.28 (vi) intervening as necessary to redirect the child's target behavior and to de-escalate
179.29 behavior that puts the child or other person at risk of injury.

179.30 To be eligible for medical assistance payment, mental health behavioral aide services must
179.31 be delivered to a child who has been diagnosed with an emotional disturbance or a mental
179.32 illness, as provided in subdivision 1, paragraph (a). The mental health behavioral aide must
179.33 implement treatment strategies in the individual treatment plan and the individual behavior

180.1 plan as developed by the mental health professional, clinical trainee, or mental health
180.2 practitioner providing direction for the mental health behavioral aide. The mental health
180.3 behavioral aide must document the delivery of services in written progress notes. Progress
180.4 notes must reflect implementation of the treatment strategies, as performed by the mental
180.5 health behavioral aide and the child's responses to the treatment strategies; and

180.6 ~~(5) direction of a mental health behavioral aide must include the following:~~

180.7 ~~(i) ongoing face-to-face observation of the mental health behavioral aide delivering~~
180.8 ~~services to a child by a mental health professional or mental health practitioner for at least~~
180.9 ~~a total of one hour during every 40 hours of service provided to a child; and~~

180.10 ~~(ii) immediate accessibility of the mental health professional, clinical trainee, or mental~~
180.11 ~~health practitioner to the mental health behavioral aide during service provision;~~

180.12 ~~(6)~~ (5) mental health service plan development must be performed in consultation with
180.13 the child's family and, when appropriate, with other key participants in the child's life by
180.14 the child's treating mental health professional or clinical trainee or by a mental health
180.15 practitioner and approved by the treating mental health professional. Treatment plan drafting
180.16 consists of development, review, and revision by face-to-face or electronic communication.
180.17 The provider must document events, including the time spent with the family and other key
180.18 participants in the child's life to ~~review, revise, and sign~~ approve the individual treatment
180.19 plan. ~~Notwithstanding Minnesota Rules, part 9505.0371, subpart 7, Medical assistance~~
180.20 ~~covers service plan development before completion of the child's individual treatment plan.~~
180.21 Service plan development is covered only if a treatment plan is completed for the child. If
180.22 upon review it is determined that a treatment plan was not completed for the child, the
180.23 commissioner shall recover the payment for the service plan development; and.

180.24 ~~(7) to be eligible for payment, a diagnostic assessment must be complete with regard to~~
180.25 ~~all required components, including multiple assessment appointments required for an~~
180.26 ~~extended diagnostic assessment and the written report. Dates of the multiple assessment~~
180.27 ~~appointments must be noted in the client's clinical record.~~

180.28 Sec. 92. Minnesota Statutes 2020, section 256B.0943, subdivision 11, is amended to read:

180.29 Subd. 11. **Documentation and billing.** (a) A provider entity must document the services
180.30 it provides under this section. The provider entity must ensure that documentation complies
180.31 with Minnesota Rules, parts 9505.2175 and 9505.2197. Services billed under this section
180.32 that are not documented according to this subdivision shall be subject to monetary recovery

181.1 by the commissioner. Billing for covered service components under subdivision 2, paragraph
181.2 (b), must not include anything other than direct service time.

181.3 ~~(b) An individual mental health provider must promptly document the following in a~~
181.4 ~~client's record after providing services to the client:~~

181.5 ~~(1) each occurrence of the client's mental health service, including the date, type, start~~
181.6 ~~and stop times, scope of the service as described in the child's individual treatment plan,~~
181.7 ~~and outcome of the service compared to baselines and objectives;~~

181.8 ~~(2) the name, dated signature, and credentials of the person who delivered the service;~~

181.9 ~~(3) contact made with other persons interested in the client, including representatives~~
181.10 ~~of the courts, corrections systems, or schools. The provider must document the name and~~
181.11 ~~date of each contact;~~

181.12 ~~(4) any contact made with the client's other mental health providers, case manager,~~
181.13 ~~family members, primary caregiver, legal representative, or the reason the provider did not~~
181.14 ~~contact the client's family members, primary caregiver, or legal representative, if applicable;~~

181.15 ~~(5) required clinical supervision directly related to the identified client's services and~~
181.16 ~~needs, as appropriate, with co-signatures of the supervisor and supervisee; and~~

181.17 ~~(6) the date when services are discontinued and reasons for discontinuation of services.~~

181.18 Sec. 93. Minnesota Statutes 2020, section 256B.0946, subdivision 1, is amended to read:

181.19 Subdivision 1. **Required covered service components.** ~~(a) Effective May 23, 2013,~~
181.20 ~~and~~ Subject to federal approval, medical assistance covers medically necessary intensive
181.21 treatment services ~~described under paragraph (b) that~~ when the services are provided by a
181.22 provider entity eligible under subdivision 3 to a client eligible under subdivision 2 who is
181.23 placed in a foster home licensed under Minnesota Rules, parts 2960.3000 to 2960.3340, or
181.24 placed in a foster home licensed under the regulations established by a federally recognized
181.25 Minnesota tribe certified under and meeting the standards in this section. The provider entity
181.26 must make reasonable and good faith efforts to report individual client outcomes to the
181.27 commissioner, using instruments and protocols approved by the commissioner.

181.28 (b) Intensive treatment services to children with mental illness residing in foster family
181.29 settings that comprise specific required service components provided in clauses (1) to (5)
181.30 are reimbursed by medical assistance when they meet the following standards:

182.1 (1) psychotherapy provided by a mental health professional as ~~defined in Minnesota~~
182.2 ~~Rules, part 9505.0371, subpart 5, item A,~~ or a clinical trainee, ~~as defined in Minnesota~~
182.3 ~~Rules, part 9505.0371, subpart 5, item C;~~

182.4 (2) ~~crisis assistance provided according to standards for children's therapeutic services~~
182.5 ~~and supports in section 256B.0943~~ planning;

182.6 (3) individual, family, and group psychoeducation services, ~~defined in subdivision 1a,~~
182.7 ~~paragraph (c),~~ provided by a mental health professional or a clinical trainee;

182.8 (4) clinical care consultation, ~~as defined in subdivision 1a,~~ and provided by a mental
182.9 health professional or a clinical trainee; and

182.10 (5) service delivery payment requirements as provided under subdivision 4.

182.11 Sec. 94. Minnesota Statutes 2020, section 256B.0946, subdivision 1a, is amended to read:

182.12 Subd. 1a. **Definitions.** For the purposes of this section, the following terms have the
182.13 meanings given them.

182.14 (a) "Clinical care consultation" means communication from a treating clinician to other
182.15 providers working with the same client to inform, inquire, and instruct regarding the client's
182.16 symptoms, strategies for effective engagement, care and intervention needs, and treatment
182.17 expectations across service settings, including but not limited to the client's school, social
182.18 services, day care, probation, home, primary care, medication prescribers, disabilities
182.19 services, and other mental health providers and to direct and coordinate clinical service
182.20 components provided to the client and family.

182.21 ~~(b) "Clinical supervision" means the documented time a clinical supervisor and supervisee~~
182.22 ~~spend together to discuss the supervisee's work, to review individual client cases, and for~~
182.23 ~~the supervisee's professional development. It includes the documented oversight and~~
182.24 ~~supervision responsibility for planning, implementation, and evaluation of services for a~~
182.25 ~~client's mental health treatment.~~

182.26 ~~(c) "Clinical supervisor" means the mental health professional who is responsible for~~
182.27 ~~clinical supervision.~~

182.28 ~~(d) (b) "Clinical trainee" has the meaning given in Minnesota Rules, part 9505.0371,~~
182.29 ~~subpart 5, item C; means a staff person who is qualified according to section 245I.04,~~
182.30 subdivision 6.

183.1 ~~(e) (c)~~ "Crisis assistance planning" has the meaning given in section 245.4871, subdivision
183.2 9a, ~~including the development of a plan that addresses prevention and intervention strategies~~
183.3 ~~to be used in a potential crisis, but does not include actual crisis intervention.~~

183.4 ~~(f) (d)~~ "Culturally appropriate" means providing mental health services in a manner that
183.5 incorporates the child's cultural influences, ~~as defined in Minnesota Rules, part 9505.0370,~~
183.6 ~~subpart 9,~~ into interventions as a way to maximize resiliency factors and utilize cultural
183.7 strengths and resources to promote overall wellness.

183.8 ~~(g) (e)~~ "Culture" means the distinct ways of living and understanding the world that are
183.9 used by a group of people and are transmitted from one generation to another or adopted
183.10 by an individual.

183.11 ~~(h) (f)~~ "Standard diagnostic assessment" ~~has the meaning given in Minnesota Rules, part~~
183.12 ~~9505.0370, subpart 11~~ means the assessment described in section 245I.10, subdivision 6.

183.13 ~~(i) (g)~~ "Family" means a person who is identified by the client or the client's parent or
183.14 guardian as being important to the client's mental health treatment. Family may include,
183.15 but is not limited to, parents, foster parents, children, spouse, committed partners, former
183.16 spouses, persons related by blood or adoption, persons who are a part of the client's
183.17 permanency plan, or persons who are presently residing together as a family unit.

183.18 ~~(j) (h)~~ "Foster care" has the meaning given in section 260C.007, subdivision 18.

183.19 ~~(k) (i)~~ "Foster family setting" means the foster home in which the license holder resides.

183.20 ~~(l) (j)~~ "Individual treatment plan" ~~has the meaning given in Minnesota Rules, part~~
183.21 ~~9505.0370, subpart 15~~ means the plan described in section 245I.10, subdivisions 7 and 8.

183.22 ~~(m) "Mental health practitioner" has the meaning given in section 245.462, subdivision~~
183.23 ~~17, and a mental health practitioner working as a clinical trainee according to Minnesota~~
183.24 ~~Rules, part 9505.0371, subpart 5, item C.~~

183.25 ~~(n) (k)~~ "Mental health certified family peer specialist" means a staff person who is qualified
183.26 according to section 245I.04, subdivision 12.

183.27 ~~(o) (l)~~ "Mental health professional" ~~has the meaning given in Minnesota Rules, part~~
183.28 ~~9505.0370, subpart 18~~ means a staff person who is qualified according to section 245I.04,
183.29 subdivision 2.

183.30 ~~(p) (m)~~ "Mental illness" has the meaning given in ~~Minnesota Rules, part 9505.0370,~~
183.31 ~~subpart 20~~ section 245I.02, subdivision 29.

183.32 ~~(q) (n)~~ "Parent" has the meaning given in section 260C.007, subdivision 25.

184.1 ~~(q)~~ (o) "Psychoeducation services" means information or demonstration provided to an
184.2 individual, family, or group to explain, educate, and support the individual, family, or group
184.3 in understanding a child's symptoms of mental illness, the impact on the child's development,
184.4 and needed components of treatment and skill development so that the individual, family,
184.5 or group can help the child to prevent relapse, prevent the acquisition of comorbid disorders,
184.6 and achieve optimal mental health and long-term resilience.

184.7 ~~(r)~~ (p) "Psychotherapy" ~~has the meaning given in Minnesota Rules, part 9505.0370,~~
184.8 ~~subpart 27~~ means the treatment described in section 256B.0671, subdivision 11.

184.9 ~~(s)~~ (q) "Team consultation and treatment planning" means the coordination of treatment
184.10 plans and consultation among providers in a group concerning the treatment needs of the
184.11 child, including disseminating the child's treatment service schedule to all members of the
184.12 service team. Team members must include all mental health professionals working with the
184.13 child, a parent, the child unless the team lead or parent deem it clinically inappropriate, and
184.14 at least two of the following: an individualized education program case manager; probation
184.15 agent; children's mental health case manager; child welfare worker, including adoption or
184.16 guardianship worker; primary care provider; foster parent; and any other member of the
184.17 child's service team.

184.18 (r) "Trauma" has the meaning given in section 245I.02, subdivision 38.

184.19 (s) "Treatment supervision" means the supervision described under section 245I.06.

184.20 Sec. 95. Minnesota Statutes 2020, section 256B.0946, subdivision 2, is amended to read:

184.21 Subd. 2. **Determination of client eligibility.** An eligible recipient is an individual, from
184.22 birth through age 20, who is currently placed in a foster home licensed under Minnesota
184.23 Rules, parts 2960.3000 to 2960.3340, or placed in a foster home licensed under the
184.24 regulations established by a federally recognized Minnesota tribe, and has received: (1) a
184.25 standard diagnostic assessment and an evaluation of level of care needed, as defined in
184.26 paragraphs (a) and (b), within 180 days before the start of service that documents that
184.27 intensive treatment services are medically necessary within a foster family setting to
184.28 ameliorate identified symptoms and functional impairments; and (2) a level of care
184.29 assessment as defined in section 245I.02, subdivision 19, that demonstrates that the individual
184.30 requires intensive intervention without 24-hour medical monitoring, and a functional
184.31 assessment as defined in section 245I.02, subdivision 17. The level of care assessment and
184.32 the functional assessment must include information gathered from the placing county, tribe,
184.33 or case manager.

185.1 ~~(a) The diagnostic assessment must:~~

185.2 ~~(1) meet criteria described in Minnesota Rules, part 9505.0372, subpart 1, and be~~
185.3 ~~conducted by a mental health professional or a clinical trainee;~~

185.4 ~~(2) determine whether or not a child meets the criteria for mental illness, as defined in~~
185.5 ~~Minnesota Rules, part 9505.0370, subpart 20;~~

185.6 ~~(3) document that intensive treatment services are medically necessary within a foster~~
185.7 ~~family setting to ameliorate identified symptoms and functional impairments;~~

185.8 ~~(4) be performed within 180 days before the start of service; and~~

185.9 ~~(5) be completed as either a standard or extended diagnostic assessment annually to~~
185.10 ~~determine continued eligibility for the service.~~

185.11 ~~(b) The evaluation of level of care must be conducted by the placing county, tribe, or~~
185.12 ~~case manager in conjunction with the diagnostic assessment as described by Minnesota~~
185.13 ~~Rules, part 9505.0372, subpart 1, item B, using a validated tool approved by the~~
185.14 ~~commissioner of human services and not subject to the rulemaking process, consistent with~~
185.15 ~~section 245.4885, subdivision 1, paragraph (d), the result of which evaluation demonstrates~~
185.16 ~~that the child requires intensive intervention without 24-hour medical monitoring. The~~
185.17 ~~commissioner shall update the list of approved level of care tools annually and publish on~~
185.18 ~~the department's website.~~

185.19 Sec. 96. Minnesota Statutes 2020, section 256B.0946, subdivision 3, is amended to read:

185.20 Subd. 3. **Eligible mental health services providers.** (a) Eligible providers for intensive
185.21 children's mental health services in a foster family setting must be certified by the state and
185.22 have a service provision contract with a county board or a reservation tribal council and
185.23 must be able to demonstrate the ability to provide all of the services required in this section
185.24 and meet the standards in chapter 245I, as required in section 245I.011, subdivision 5.

185.25 (b) For purposes of this section, a provider agency must be:

185.26 (1) a county-operated entity certified by the state;

185.27 (2) an Indian Health Services facility operated by a tribe or tribal organization under
185.28 funding authorized by United States Code, title 25, sections 450f to 450n, or title 3 of the
185.29 Indian Self-Determination Act, Public Law 93-638, section 638 (facilities or providers); or

185.30 (3) a noncounty entity.

186.1 (c) Certified providers that do not meet the service delivery standards required in this
186.2 section shall be subject to a decertification process.

186.3 (d) For the purposes of this section, all services delivered to a client must be provided
186.4 by a mental health professional or a clinical trainee.

186.5 Sec. 97. Minnesota Statutes 2020, section 256B.0946, subdivision 4, is amended to read:

186.6 Subd. 4. **Service delivery payment requirements.** (a) To be eligible for payment under
186.7 this section, a provider must develop and practice written policies and procedures for
186.8 intensive treatment in foster care, consistent with subdivision 1, paragraph (b), and comply
186.9 with the following requirements in paragraphs (b) to ~~(n)~~ (l).

186.10 ~~(b) A qualified clinical supervisor, as defined in and performing in compliance with~~
186.11 ~~Minnesota Rules, part 9505.0371, subpart 5, item D, must supervise the treatment and~~
186.12 ~~provision of services described in this section.~~

186.13 ~~(c) Each client receiving treatment services must receive an extended diagnostic~~
186.14 ~~assessment, as described in Minnesota Rules, part 9505.0372, subpart 1, item C, within 30~~
186.15 ~~days of enrollment in this service unless the client has a previous extended diagnostic~~
186.16 ~~assessment that the client, parent, and mental health professional agree still accurately~~
186.17 ~~describes the client's current mental health functioning.~~

186.18 ~~(d)~~ (b) Each previous and current mental health, school, and physical health treatment
186.19 provider must be contacted to request documentation of treatment and assessments that the
186.20 eligible client has received. This information must be reviewed and incorporated into the
186.21 standard diagnostic assessment and team consultation and treatment planning review process.

186.22 ~~(e)~~ (c) Each client receiving treatment must be assessed for a trauma history, and the
186.23 client's treatment plan must document how the results of the assessment will be incorporated
186.24 into treatment.

186.25 (d) The level of care assessment as defined in section 245I.02, subdivision 19, and
186.26 functional assessment as defined in section 245I.02, subdivision 17, must be updated at
186.27 least every 90 days or prior to discharge from the service, whichever comes first.

186.28 ~~(f)~~ (e) Each client receiving treatment services must have an individual treatment plan
186.29 that is reviewed, evaluated, and signed approved every 90 days using the team consultation
186.30 and treatment planning process, ~~as defined in subdivision 1a, paragraph (s).~~

186.31 ~~(g)~~ (f) Clinical care consultation, as defined in subdivision 1a, paragraph (a), must be
186.32 provided in accordance with the client's individual treatment plan.

187.1 ~~(h)~~ (g) Each client must have a crisis ~~assistance~~ plan within ten days of initiating services
187.2 and must have access to clinical phone support 24 hours per day, seven days per week,
187.3 during the course of treatment. The crisis plan must demonstrate coordination with the local
187.4 or regional mobile crisis intervention team.

187.5 ~~(i)~~ (h) Services must be delivered and documented at least three days per week, equaling
187.6 at least six hours of treatment per week, unless reduced units of service are specified on the
187.7 treatment plan as part of transition or on a discharge plan to another service or level of care.
187.8 ~~Documentation must comply with Minnesota Rules, parts 9505.2175 and 9505.2197.~~

187.9 ~~(j)~~ (i) Location of service delivery must be in the client's home, day care setting, school,
187.10 or other community-based setting that is specified on the client's individualized treatment
187.11 plan.

187.12 ~~(k)~~ (j) Treatment must be developmentally and culturally appropriate for the client.

187.13 ~~(l)~~ (k) Services must be delivered in continual collaboration and consultation with the
187.14 client's medical providers and, in particular, with prescribers of psychotropic medications,
187.15 including those prescribed on an off-label basis. Members of the service team must be aware
187.16 of the medication regimen and potential side effects.

187.17 ~~(m)~~ (l) Parents, siblings, foster parents, and members of the child's permanency plan
187.18 must be involved in treatment and service delivery unless otherwise noted in the treatment
187.19 plan.

187.20 ~~(n)~~ (m) Transition planning for the child must be conducted starting with the first
187.21 treatment plan and must be addressed throughout treatment to support the child's permanency
187.22 plan and postdischarge mental health service needs.

187.23 Sec. 98. Minnesota Statutes 2020, section 256B.0946, subdivision 6, is amended to read:

187.24 Subd. 6. **Excluded services.** (a) Services in clauses (1) to (7) are not covered under this
187.25 section and are not eligible for medical assistance payment as components of intensive
187.26 treatment in foster care services, but may be billed separately:

187.27 (1) inpatient psychiatric hospital treatment;

187.28 (2) mental health targeted case management;

187.29 (3) partial hospitalization;

187.30 (4) medication management;

187.31 (5) children's mental health day treatment services;

- 188.1 (6) crisis response services under section ~~256B.0944~~ 256B.0624; and
- 188.2 (7) transportation; and
- 188.3 (8) mental health certified family peer specialist services under section 256B.0616.

188.4 (b) Children receiving intensive treatment in foster care services are not eligible for

188.5 medical assistance reimbursement for the following services while receiving intensive

188.6 treatment in foster care:

- 188.7 (1) psychotherapy and skills training components of children's therapeutic services and
- 188.8 supports under section ~~256B.0625, subdivision 35b~~ 256B.0943;
- 188.9 (2) mental health behavioral aide services as defined in section 256B.0943, subdivision
- 188.10 1, paragraph ~~(m)~~ (l);
- 188.11 (3) home and community-based waiver services;
- 188.12 (4) mental health residential treatment; and
- 188.13 (5) room and board costs as defined in section 256I.03, subdivision 6.

188.14 Sec. 99. Minnesota Statutes 2020, section 256B.0947, subdivision 1, is amended to read:

188.15 Subdivision 1. **Scope.** ~~Effective November 1, 2011, and~~ Subject to federal approval,

188.16 medical assistance covers medically necessary, intensive nonresidential rehabilitative mental

188.17 health services ~~as defined in subdivision 2, for recipients as defined in subdivision 3,~~ when

188.18 the services are provided by an entity meeting the standards in this section. The provider

188.19 entity must make reasonable and good faith efforts to report individual client outcomes to

188.20 the commissioner, using instruments and protocols approved by the commissioner.

188.21 Sec. 100. Minnesota Statutes 2020, section 256B.0947, subdivision 2, is amended to read:

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

188.23 given them.

188.24 (a) "Intensive nonresidential rehabilitative mental health services" means child

188.25 rehabilitative mental health services as defined in section 256B.0943, except that these

188.26 services are provided by a multidisciplinary staff using a total team approach consistent

188.27 with assertive community treatment, as adapted for youth, and are directed to recipients

188.28 ~~ages 16, 17, 18, 19, or 20 with a serious mental illness or co-occurring mental illness and~~

188.29 ~~substance abuse addiction~~ who require intensive services to prevent admission to an inpatient

188.30 psychiatric hospital or placement in a residential treatment facility or who require intensive

188.31 services to step down from inpatient or residential care to community-based care.

189.1 (b) "~~Co-occurring mental illness and substance abuse-addiction~~ use disorder" means a
189.2 dual diagnosis of at least one form of mental illness and at least one substance use disorder.
189.3 Substance use disorders include alcohol or drug abuse or dependence, excluding nicotine
189.4 use.

189.5 (c) "Standard diagnostic assessment" ~~has the meaning given to it in Minnesota Rules,~~
189.6 ~~part 9505.0370, subpart 11. A diagnostic assessment must be provided according to~~
189.7 ~~Minnesota Rules, part 9505.0372, subpart 1, and for this section must incorporate a~~
189.8 ~~determination of the youth's necessary level of care using a standardized functional~~
189.9 ~~assessment instrument approved and periodically updated by the commissioner~~ means the
189.10 assessment described in section 245I.10, subdivision 6.

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

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

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

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

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

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

189.26 (3) the side effects of medications.

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

189.30 (h) "~~Peer specialist~~" ~~means an employed team member who is a mental health certified~~
189.31 ~~peer specialist according to section 256B.0615 and also a former children's mental health~~
189.32 ~~consumer who:~~

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

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

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

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

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

190.10 ~~(6) meets the following criteria:~~

190.11 ~~(i) is at least 22 years of age;~~

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

190.14 ~~(iii) is a former consumer of child and adolescent mental health services, or a former or~~
190.15 ~~current consumer of adult mental health services for a period of at least two years;~~

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

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

190.19 ~~(vi) is willing to disclose the individual's own mental health history to team members~~
190.20 ~~and clients; and~~

190.21 ~~(vii) must be free of substance use problems for at least one year.~~

190.22 ~~(e) "Mental health professional" means a staff person who is qualified according to~~
190.23 ~~section 245I.04, subdivision 2.~~

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

190.26 ~~(g) (g) "Substance use disorders" means one or more of the disorders defined in the~~
190.27 ~~diagnostic and statistical manual of mental disorders, current edition.~~

190.28 ~~(k) (h) "Transition services" means:~~

190.29 ~~(1) activities, materials, consultation, and coordination that ensures continuity of the~~
190.30 ~~client's care in advance of and in preparation for the client's move from one stage of care~~

191.1 or life to another by maintaining contact with the client and assisting the client to establish
191.2 provider relationships;

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

191.4 (3) establishing communication between sending and receiving entities;

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

191.6 (5) establishing and enforcing procedures and schedules.

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

191.11 ~~(h)~~ (i) "Treatment team" means all staff who provide services to recipients under this
191.12 section.

191.13 ~~(m)~~ (j) "Family peer specialist" means a staff person who is qualified under section
191.14 256B.0616.

191.15 Sec. 101. Minnesota Statutes 2020, section 256B.0947, subdivision 3, is amended to read:

191.16 Subd. 3. **Client eligibility.** An eligible recipient is an individual who:

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

191.18 (2) is diagnosed with a serious mental illness or co-occurring mental illness and substance
191.19 ~~abuse-addiction~~ use disorder, for which intensive nonresidential rehabilitative mental health
191.20 services are needed;

191.21 (3) has received a ~~level of care determination, using an instrument approved by the~~
191.22 ~~commissioner~~ level of care assessment as defined in section 245I.02, subdivision 19, that
191.23 indicates a need for intensive integrated intervention without 24-hour medical monitoring
191.24 and a need for extensive collaboration among multiple providers;

191.25 (4) has received a functional assessment as defined in section 245I.02, subdivision 17,
191.26 that indicates functional impairment and a history of difficulty in functioning safely and
191.27 successfully in the community, school, home, or job; or who is likely to need services from
191.28 the adult mental health system within the next two years; and

191.29 (5) has had a recent standard diagnostic assessment, as provided in Minnesota Rules,
191.30 ~~part 9505.0372, subpart 1, by a mental health professional who is qualified under Minnesota~~
191.31 ~~Rules, part 9505.0371, subpart 5, item A,~~ that documents that intensive nonresidential

192.1 rehabilitative mental health services are medically necessary to ameliorate identified
192.2 symptoms and functional impairments and to achieve individual transition goals.

192.3 Sec. 102. Minnesota Statutes 2020, section 256B.0947, subdivision 3a, is amended to
192.4 read:

192.5 Subd. 3a. **Required service components.** ~~(a) Subject to federal approval, medical~~
192.6 ~~assistance covers all medically necessary intensive nonresidential rehabilitative mental~~
192.7 ~~health services and supports, as defined in this section, under a single daily rate per client.~~
192.8 ~~Services and supports must be delivered by an eligible provider under subdivision 5 to an~~
192.9 ~~eligible client under subdivision 3.~~

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

192.13 (1) individual, family, and group psychotherapy;

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

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

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

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

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

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

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

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

193.4 (10) coordination with, or performance of, crisis intervention and stabilization services
193.5 as defined in section ~~256B.0944~~ 256B.0624;

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

193.8 ~~(12)~~ (11) transition services as defined in this section;

193.9 ~~(13) integrated dual disorders treatment as defined in this section~~ (12) co-occurring
193.10 substance use disorder treatment as defined in section 245I.02, subdivision 11; and

193.11 ~~(14)~~ (13) housing access support that assists clients to find, obtain, retain, and move to
193.12 safe and adequate housing. Housing access support does not provide monetary assistance
193.13 for rent, damage deposits, or application fees.

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

193.16 ~~(1)~~ client access to crisis intervention services, as defined in section ~~256B.0944~~
193.17 256B.0624, and available 24 hours per day and seven days per week;

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

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

193.22 Sec. 103. Minnesota Statutes 2020, section 256B.0947, subdivision 5, is amended to read:

193.23 Subd. 5. **Standards for intensive nonresidential rehabilitative providers.** (a) Services
193.24 ~~must be provided by a provider entity as provided in subdivision 4~~ meet the standards in
193.25 this section and chapter 245I as required in section 245I.011, subdivision 5.

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

193.29 (1) ~~The core treatment team is an entity that operates under the direction of an~~
193.30 ~~independently licensed mental health professional, who is qualified under Minnesota Rules,~~
193.31 ~~part 9505.0371, subpart 5, item A, and that assumes comprehensive clinical responsibility~~

194.1 ~~for clients.~~ Based on professional qualifications and client needs, clinically qualified core
194.2 team members are assigned on a rotating basis as the client's lead worker to coordinate a
194.3 client's care. The core team must comprise at least four full-time equivalent direct care staff
194.4 and must minimally include, ~~but is not limited to:~~

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

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

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

194.13 (iv) a mental health certified peer specialist as defined in subdivision 2, paragraph (h)
194.14 who is qualified according to section 245I.04, subdivision 10, and is also a former children's
194.15 mental health consumer.

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

194.17 (i) additional mental health professionals;

194.18 (ii) a vocational specialist;

194.19 (iii) an educational specialist with knowledge and experience working with youth
194.20 regarding special education requirements and goals, special education plans, and coordination
194.21 of educational activities with health care activities;

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

194.23 (v) a clinical trainee qualified according to section 245I.04, subdivision 6;

194.24 (vi) a mental health practitioner, ~~as defined in section 245.4871, subdivision 26~~ qualified
194.25 according to section 245I.04, subdivision 4;

194.26 ~~(vi)~~ (vii) a case management service provider, as defined in section 245.4871, subdivision
194.27 4;

194.28 ~~(vii)~~ (viii) a housing access specialist; and

194.29 ~~(viii)~~ (ix) a family peer specialist as defined in subdivision 2, paragraph (m).

194.30 (3) A treatment team may include, in addition to those in clause (1) or (2), ad hoc
194.31 members not employed by the team who consult on a specific client and who must accept

195.1 overall clinical direction from the treatment team for the duration of the client's placement
195.2 with the treatment team and must be paid by the provider agency at the rate for a typical
195.3 session by that provider with that client or at a rate negotiated with the client-specific
195.4 member. Client-specific treatment team members may include:

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

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

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

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

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

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

195.15 (c) The ~~clinical~~ treatment supervisor shall be an active member of the treatment team
195.16 and shall function as a practicing clinician at least on a part-time basis. The treatment team
195.17 shall meet with the ~~clinical~~ treatment supervisor at least weekly to discuss recipients' progress
195.18 and make rapid adjustments to meet recipients' needs. The team meeting must include
195.19 client-specific case reviews and general treatment discussions among team members.
195.20 Client-specific case reviews and planning must be documented in the individual client's
195.21 treatment record.

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

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

195.27 (f) Nonclinical staff shall have prompt access in person or by telephone to a mental
195.28 health practitioner, clinical trainee, or mental health professional. The provider shall have
195.29 the capacity to promptly and appropriately respond to emergent needs and make any
195.30 necessary staffing adjustments to ensure the health and safety of clients.

195.31 (g) The intensive nonresidential rehabilitative mental health services provider shall
195.32 participate in evaluation of the assertive community treatment for youth (Youth ACT) model

196.1 as conducted by the commissioner, including the collection and reporting of data and the
196.2 reporting of performance measures as specified by contract with the commissioner.

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

196.4 Sec. 104. Minnesota Statutes 2020, section 256B.0947, subdivision 6, is amended to read:

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

196.7 (a) The treatment team must use team treatment, not an individual treatment model.

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

196.9 (c) Services must be age-appropriate and meet the specific needs of the client.

196.10 (d) ~~The initial functional assessment must be completed within ten days of intake and~~
196.11 level of care assessment as defined in section 245I.02, subdivision 19, and functional
196.12 assessment as defined in section 245I.02, subdivision 17, must be updated at least every six
196.13 ~~months~~ 90 days or prior to discharge from the service, whichever comes first.

196.14 (e) An individual treatment plan must be completed for each client, according to section
196.15 245I.10, subdivisions 7 and 8, and, additionally, must:

196.16 ~~(1) be based on the information in the client's diagnostic assessment and baselines;~~

196.17 ~~(2) identify goals and objectives of treatment, a treatment strategy, a schedule for~~
196.18 ~~accomplishing treatment goals and objectives, and the individuals responsible for providing~~
196.19 ~~treatment services and supports;~~

196.20 ~~(3) be developed after completion of the client's diagnostic assessment by a mental health~~
196.21 ~~professional or clinical trainee and before the provision of children's therapeutic services~~
196.22 ~~and supports;~~

196.23 ~~(4) be developed through a child-centered, family-driven, culturally appropriate planning~~
196.24 ~~process, including allowing parents and guardians to observe or participate in individual~~
196.25 ~~and family treatment services, assessments, and treatment planning;~~

196.26 ~~(5) be reviewed at least once every six months and revised to document treatment progress~~
196.27 ~~on each treatment objective and next goals or, if progress is not documented, to document~~
196.28 ~~changes in treatment;~~

196.29 ~~(6) be signed by the clinical supervisor and by the client or by the client's parent or other~~
196.30 ~~person authorized by statute to consent to mental health services for the client. A client's~~

197.1 ~~parent may approve the client's individual treatment plan by secure electronic signature or~~
197.2 ~~by documented oral approval that is later verified by written signature;~~

197.3 ~~(7)~~ (1) be completed in consultation with the client's current therapist and key providers
197.4 and provide for ongoing consultation with the client's current therapist to ensure therapeutic
197.5 continuity and to facilitate the client's return to the community. For clients under the age of
197.6 18, the treatment team must consult with parents and guardians in developing the treatment
197.7 plan;

197.8 ~~(8)~~ (2) if a need for substance use disorder treatment is indicated by validated assessment:

197.9 (i) identify goals, objectives, and strategies of substance use disorder treatment;

197.10 (ii) develop a schedule for accomplishing substance use disorder treatment goals and
197.11 objectives; and

197.12 (iii) identify the individuals responsible for providing substance use disorder treatment
197.13 services and supports;

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

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

197.18 ~~(10)~~ (3) provide for the client's transition out of intensive nonresidential rehabilitative
197.19 mental health services by defining the team's actions to assist the client and subsequent
197.20 providers in the transition to less intensive or "stepped down" services; and

197.21 (4) notwithstanding section 245I.10, subdivision 8, be reviewed at least every 90 days
197.22 and revised to document treatment progress or, if progress is not documented, to document
197.23 changes in treatment.

197.24 (f) The treatment team shall actively and assertively engage the client's family members
197.25 and significant others by establishing communication and collaboration with the family and
197.26 significant others and educating the family and significant others about the client's mental
197.27 illness, symptom management, and the family's role in treatment, unless the team knows or
197.28 has reason to suspect that the client has suffered or faces a threat of suffering any physical
197.29 or mental injury, abuse, or neglect from a family member or significant other.

197.30 (g) For a client age 18 or older, the treatment team may disclose to a family member,
197.31 other relative, or a close personal friend of the client, or other person identified by the client,
197.32 the protected health information directly relevant to such person's involvement with the

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

198.11 (h) The treatment team shall provide interventions to promote positive interpersonal
198.12 relationships.

198.13 Sec. 105. Minnesota Statutes 2020, section 256B.0947, subdivision 7, is amended to read:

198.14 Subd. 7. **Medical assistance payment and rate setting.** (a) Payment for services in this
198.15 section must be based on one daily encounter rate per provider inclusive of the following
198.16 services received by an eligible client in a given calendar day: all rehabilitative services,
198.17 supports, and ancillary activities under this section, staff travel time to provide rehabilitative
198.18 services under this section, and crisis response services under section ~~256B.0944~~ 256B.0624.

198.19 (b) Payment must not be made to more than one entity for each client for services
198.20 provided under this section on a given day. If services under this section are provided by a
198.21 team that includes staff from more than one entity, the team shall determine how to distribute
198.22 the payment among the members.

198.23 (c) The commissioner shall establish regional cost-based rates for entities that will bill
198.24 medical assistance for nonresidential intensive rehabilitative mental health services. In
198.25 developing these rates, the commissioner shall consider:

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

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

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

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

198.30 and

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

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

199.3 Sec. 106. Minnesota Statutes 2020, section 256B.0949, subdivision 2, is amended to read:

199.4 Subd. 2. **Definitions.** (a) The terms used in this section have the meanings given in this
199.5 subdivision.

199.6 (b) "Agency" means the legal entity that is enrolled with Minnesota health care programs
199.7 as a medical assistance provider according to Minnesota Rules, part 9505.0195, to provide
199.8 EIDBI services and that has the legal responsibility to ensure that its employees or contractors
199.9 carry out the responsibilities defined in this section. Agency includes a licensed individual
199.10 professional who practices independently and acts as an agency.

199.11 (c) "Autism spectrum disorder or a related condition" or "ASD or a related condition"
199.12 means either autism spectrum disorder (ASD) as defined in the current version of the
199.13 Diagnostic and Statistical Manual of Mental Disorders (DSM) or a condition that is found
199.14 to be closely related to ASD, as identified under the current version of the DSM, and meets
199.15 all of the following criteria:

199.16 (1) is severe and chronic;

199.17 (2) results in impairment of adaptive behavior and function similar to that of a person
199.18 with ASD;

199.19 (3) requires treatment or services similar to those required for a person with ASD; and

199.20 (4) results in substantial functional limitations in three core developmental deficits of
199.21 ASD: social or interpersonal interaction; functional communication, including nonverbal
199.22 or social communication; and restrictive or repetitive behaviors or hyperreactivity or
199.23 hyporeactivity to sensory input; and may include deficits or a high level of support in one
199.24 or more of the following domains:

199.25 (i) behavioral challenges and self-regulation;

199.26 (ii) cognition;

199.27 (iii) learning and play;

199.28 (iv) self-care; or

199.29 (v) safety.

199.30 (d) "Person" means a person under 21 years of age.

200.1 (e) "Clinical supervision" means the overall responsibility for the control and direction
200.2 of EIDBI service delivery, including individual treatment planning, staff supervision,
200.3 individual treatment plan progress monitoring, and treatment review for each person. Clinical
200.4 supervision is provided by a qualified supervising professional (QSP) who takes full
200.5 professional responsibility for the service provided by each supervisee.

200.6 (f) "Commissioner" means the commissioner of human services, unless otherwise
200.7 specified.

200.8 (g) "Comprehensive multidisciplinary evaluation" or "CMDE" means a comprehensive
200.9 evaluation of a person to determine medical necessity for EIDBI services based on the
200.10 requirements in subdivision 5.

200.11 (h) "Department" means the Department of Human Services, unless otherwise specified.

200.12 (i) "Early intensive developmental and behavioral intervention benefit" or "EIDBI
200.13 benefit" means a variety of individualized, intensive treatment modalities approved and
200.14 published by the commissioner that are based in behavioral and developmental science
200.15 consistent with best practices on effectiveness.

200.16 (j) "Generalizable goals" means results or gains that are observed during a variety of
200.17 activities over time with different people, such as providers, family members, other adults,
200.18 and people, and in different environments including, but not limited to, clinics, homes,
200.19 schools, and the community.

200.20 (k) "Incident" means when any of the following occur:

200.21 (1) an illness, accident, or injury that requires first aid treatment;

200.22 (2) a bump or blow to the head; or

200.23 (3) an unusual or unexpected event that jeopardizes the safety of a person or staff,
200.24 including a person leaving the agency unattended.

200.25 (l) "Individual treatment plan" or "ITP" means the person-centered, individualized written
200.26 plan of care that integrates and coordinates person and family information from the CMDE
200.27 for a person who meets medical necessity for the EIDBI benefit. An individual treatment
200.28 plan must meet the standards in subdivision 6.

200.29 (m) "Legal representative" means the parent of a child who is under 18 years of age, a
200.30 court-appointed guardian, or other representative with legal authority to make decisions
200.31 about service for a person. For the purpose of this subdivision, "other representative with

201.1 legal authority to make decisions" includes a health care agent or an attorney-in-fact
201.2 authorized through a health care directive or power of attorney.

201.3 (n) "Mental health professional" ~~has the meaning given in~~ means a staff person who is
201.4 qualified according to section ~~245.4871, subdivision 27, clauses (1) to (6)~~ 245I.04,
201.5 subdivision 2.

201.6 (o) "Person-centered" means a service that both responds to the identified needs, interests,
201.7 values, preferences, and desired outcomes of the person or the person's legal representative
201.8 and respects the person's history, dignity, and cultural background and allows inclusion and
201.9 participation in the person's community.

201.10 (p) "Qualified EIDBI provider" means a person who is a QSP or a level I, level II, or
201.11 level III treatment provider.

201.12 Sec. 107. Minnesota Statutes 2020, section 256B.0949, subdivision 4, is amended to read:

201.13 Subd. 4. **Diagnosis.** (a) A diagnosis of ASD or a related condition must:

201.14 (1) be based upon current DSM criteria including direct observations of the person and
201.15 information from the person's legal representative or primary caregivers;

201.16 (2) be completed by either (i) a licensed physician or advanced practice registered nurse
201.17 or (ii) a mental health professional; and

201.18 (3) meet the requirements of ~~Minnesota Rules, part 9505.0372, subpart 1, items B and~~
201.19 € a standard diagnostic assessment according to section 245I.10, subdivision 6.

201.20 (b) Additional assessment information may be considered to complete a diagnostic
201.21 assessment including specialized tests administered through special education evaluations
201.22 and licensed school personnel, and from professionals licensed in the fields of medicine,
201.23 speech and language, psychology, occupational therapy, and physical therapy. A diagnostic
201.24 assessment may include treatment recommendations.

201.25 Sec. 108. Minnesota Statutes 2020, section 256B.0949, subdivision 5a, is amended to
201.26 read:

201.27 Subd. 5a. **Comprehensive multidisciplinary evaluation provider qualification.** A
201.28 CMDE provider must:

201.29 (1) be a licensed physician, advanced practice registered nurse, a mental health
201.30 professional, or a ~~mental health practitioner who meets the requirements of a clinical trainee~~

202.1 ~~as defined in Minnesota Rules, part 9505.0371, subpart 5, item C~~ who is qualified according
202.2 to section 245I.04, subdivision 6;

202.3 (2) have at least 2,000 hours of clinical experience in the evaluation and treatment of
202.4 people with ASD or a related condition or equivalent documented coursework at the graduate
202.5 level by an accredited university in the following content areas: ASD or a related condition
202.6 diagnosis, ASD or a related condition treatment strategies, and child development; and

202.7 (3) be able to diagnose, evaluate, or provide treatment within the provider's scope of
202.8 practice and professional license.

202.9 Sec. 109. Minnesota Statutes 2020, section 256B.25, subdivision 3, is amended to read:

202.10 Subd. 3. **Payment exceptions.** The limitation in subdivision 2 shall not apply to:

202.11 (1) payment of Minnesota supplemental assistance funds to recipients who reside in
202.12 facilities which are involved in litigation contesting their designation as an institution for
202.13 treatment of mental disease;

202.14 (2) payment or grants to a boarding care home or supervised living facility licensed by
202.15 the Department of Human Services under Minnesota Rules, parts 2960.0130 to 2960.0220
202.16 ~~or~~, 2960.0580 to 2960.0700, or 9520.0500 to 9520.0670, or under chapter 245G or 245I,
202.17 or payment to recipients who reside in these facilities;

202.18 (3) payments or grants to a boarding care home or supervised living facility which are
202.19 ineligible for certification under United States Code, title 42, sections 1396-1396p;

202.20 (4) payments or grants otherwise specifically authorized by statute or rule.

202.21 Sec. 110. Minnesota Statutes 2020, section 256B.761, is amended to read:

202.22 **256B.761 REIMBURSEMENT FOR MENTAL HEALTH SERVICES.**

202.23 (a) Effective for services rendered on or after July 1, 2001, payment for medication
202.24 management provided to psychiatric patients, outpatient mental health services, day treatment
202.25 services, home-based mental health services, and family community support services shall
202.26 be paid at the lower of (1) submitted charges, or (2) 75.6 percent of the 50th percentile of
202.27 1999 charges.

202.28 (b) Effective July 1, 2001, the medical assistance rates for outpatient mental health
202.29 services provided by an entity that operates: (1) a Medicare-certified comprehensive
202.30 outpatient rehabilitation facility; and (2) a facility that was certified prior to January 1, 1993,
202.31 with at least 33 percent of the clients receiving rehabilitation services in the most recent

203.1 calendar year who are medical assistance recipients, will be increased by 38 percent, when
203.2 those services are provided within the comprehensive outpatient rehabilitation facility and
203.3 provided to residents of nursing facilities owned by the entity.

203.4 ~~(e) The commissioner shall establish three levels of payment for mental health diagnostic~~
203.5 ~~assessment, based on three levels of complexity. The aggregate payment under the tiered~~
203.6 ~~rates must not exceed the projected aggregate payments for mental health diagnostic~~
203.7 ~~assessment under the previous single rate. The new rate structure is effective January 1,~~
203.8 ~~2011, or upon federal approval, whichever is later.~~

203.9 ~~(d)~~ (c) In addition to rate increases otherwise provided, the commissioner may restructure
203.10 coverage policy and rates to improve access to adult rehabilitative mental health services
203.11 under section 256B.0623 and related mental health support services under section 256B.021,
203.12 subdivision 4, paragraph (f), clause (2). For state fiscal years 2015 and 2016, the projected
203.13 state share of increased costs due to this paragraph is transferred from adult mental health
203.14 grants under sections 245.4661 and 256E.12. The transfer for fiscal year 2016 is a permanent
203.15 base adjustment for subsequent fiscal years. Payments made to managed care plans and
203.16 county-based purchasing plans under sections 256B.69, 256B.692, and 256L.12 shall reflect
203.17 the rate changes described in this paragraph.

203.18 ~~(e)~~ (d) Any ratables effective before July 1, 2015, do not apply to early intensive
203.19 developmental and behavioral intervention (EIDBI) benefits described in section 256B.0949.

203.20 Sec. 111. Minnesota Statutes 2020, section 256B.763, is amended to read:

203.21 **256B.763 CRITICAL ACCESS MENTAL HEALTH RATE INCREASE.**

203.22 (a) For services defined in paragraph (b) and rendered on or after July 1, 2007, payment
203.23 rates shall be increased by 23.7 percent over the rates in effect on January 1, 2006, for:

203.24 (1) psychiatrists and advanced practice registered nurses with a psychiatric specialty;

203.25 (2) community mental health centers under section 256B.0625, subdivision 5; and

203.26 (3) mental health clinics ~~and centers certified under Minnesota Rules, parts 9520.0750~~
203.27 ~~to 9520.0870~~ section 245I.20, or hospital outpatient psychiatric departments that are
203.28 designated as essential community providers under section 62Q.19.

203.29 (b) This increase applies to group skills training when provided as a component of
203.30 children's therapeutic services and support, psychotherapy, medication management,
203.31 evaluation and management, diagnostic assessment, explanation of findings, psychological
203.32 testing, neuropsychological services, direction of behavioral aides, and inpatient consultation.

204.1 (c) This increase does not apply to rates that are governed by section 256B.0625,
204.2 subdivision 30, or 256B.761, paragraph (b), other cost-based rates, rates that are negotiated
204.3 with the county, rates that are established by the federal government, or rates that increased
204.4 between January 1, 2004, and January 1, 2005.

204.5 (d) The commissioner shall adjust rates paid to prepaid health plans under contract with
204.6 the commissioner to reflect the rate increases provided in paragraphs (a), (e), and (f). The
204.7 prepaid health plan must pass this rate increase to the providers identified in paragraphs (a),
204.8 (e), (f), and (g).

204.9 (e) Payment rates shall be increased by 23.7 percent over the rates in effect on December
204.10 31, 2007, for:

204.11 (1) medication education services provided on or after January 1, 2008, by adult
204.12 rehabilitative mental health services providers certified under section 256B.0623; and

204.13 (2) mental health behavioral aide services provided on or after January 1, 2008, by
204.14 children's therapeutic services and support providers certified under section 256B.0943.

204.15 (f) For services defined in paragraph (b) and rendered on or after January 1, 2008, by
204.16 children's therapeutic services and support providers certified under section 256B.0943 and
204.17 not already included in paragraph (a), payment rates shall be increased by 23.7 percent over
204.18 the rates in effect on December 31, 2007.

204.19 (g) Payment rates shall be increased by 2.3 percent over the rates in effect on December
204.20 31, 2007, for individual and family skills training provided on or after January 1, 2008, by
204.21 children's therapeutic services and support providers certified under section 256B.0943.

204.22 (h) For services described in paragraphs (b), (e), and (g) and rendered on or after July
204.23 1, 2017, payment rates for mental health clinics ~~and centers certified under Minnesota Rules,~~
204.24 ~~parts 9520.0750 to 9520.0870~~ section 245I.20, that are not designated as essential community
204.25 providers under section 62Q.19 shall be equal to payment rates for mental health clinics
204.26 ~~and centers certified under Minnesota Rules, parts 9520.0750 to 9520.0870~~ section 245I.20,
204.27 that are designated as essential community providers under section 62Q.19. In order to
204.28 receive increased payment rates under this paragraph, a provider must demonstrate a
204.29 commitment to serve low-income and underserved populations by:

204.30 (1) charging for services on a sliding-fee schedule based on current poverty income
204.31 guidelines; and

204.32 (2) not restricting access or services because of a client's financial limitation.

205.1 Sec. 112. Minnesota Statutes 2020, section 256P.01, subdivision 6a, is amended to read:

205.2 Subd. 6a. **Qualified professional.** (a) For illness, injury, or incapacity, a "qualified
205.3 professional" means a licensed physician, physician assistant, advanced practice registered
205.4 nurse, physical therapist, occupational therapist, or licensed chiropractor, according to their
205.5 scope of practice.

205.6 (b) For developmental disability, learning disability, and intelligence testing, a "qualified
205.7 professional" means a licensed physician, physician assistant, advanced practice registered
205.8 nurse, licensed independent clinical social worker, licensed psychologist, certified school
205.9 psychologist, or certified psychometrist working under the supervision of a licensed
205.10 psychologist.

205.11 (c) For mental health, a "qualified professional" means a licensed physician, advanced
205.12 practice registered nurse, or qualified mental health professional under section ~~245.462,~~
205.13 ~~subdivision 18, clauses (1) to (6)~~ 245I.04, subdivision 2.

205.14 (d) For substance use disorder, a "qualified professional" means a licensed physician, a
205.15 qualified mental health professional under section 245.462, subdivision 18, clauses (1) to
205.16 (6), or an individual as defined in section 245G.11, subdivision 3, 4, or 5.

205.17 Sec. 113. Minnesota Statutes 2020, section 295.50, subdivision 9b, is amended to read:

205.18 Subd. 9b. **Patient services.** (a) "Patient services" means inpatient and outpatient services
205.19 and other goods and services provided by hospitals, surgical centers, or health care providers.
205.20 They include the following health care goods and services provided to a patient or consumer:

205.21 (1) bed and board;

205.22 (2) nursing services and other related services;

205.23 (3) use of hospitals, surgical centers, or health care provider facilities;

205.24 (4) medical social services;

205.25 (5) drugs, biologicals, supplies, appliances, and equipment;

205.26 (6) other diagnostic or therapeutic items or services;

205.27 (7) medical or surgical services;

205.28 (8) items and services furnished to ambulatory patients not requiring emergency care;

205.29 and

205.30 (9) emergency services.

206.1 (b) "Patient services" does not include:

206.2 (1) services provided to nursing homes licensed under chapter 144A;

206.3 (2) examinations for purposes of utilization reviews, insurance claims or eligibility,
206.4 litigation, and employment, including reviews of medical records for those purposes;

206.5 (3) services provided to and by community residential mental health facilities licensed
206.6 under section 245I.23 or Minnesota Rules, parts 9520.0500 to 9520.0670, and to and by
206.7 residential treatment programs for children with severe emotional disturbance licensed or
206.8 certified under chapter 245A;

206.9 (4) services provided under the following programs: day treatment services as defined
206.10 in section 245.462, subdivision 8; assertive community treatment as described in section
206.11 256B.0622; adult rehabilitative mental health services as described in section 256B.0623;
206.12 ~~adult~~ crisis response services as described in section 256B.0624; and children's therapeutic
206.13 services and supports as described in section 256B.0943; ~~and children's mental health crisis~~
206.14 ~~response services as described in section 256B.0944;~~

206.15 (5) services provided to and by community mental health centers as defined in section
206.16 245.62, subdivision 2;

206.17 (6) services provided to and by assisted living programs and congregate housing
206.18 programs;

206.19 (7) hospice care services;

206.20 (8) home and community-based waived services under chapter 256S and sections
206.21 256B.49 and 256B.501;

206.22 (9) targeted case management services under sections 256B.0621; 256B.0625,
206.23 subdivisions 20, 20a, 33, and 44; and 256B.094; and

206.24 (10) services provided to the following: supervised living facilities for persons with
206.25 developmental disabilities licensed under Minnesota Rules, parts 4665.0100 to 4665.9900;
206.26 housing with services establishments required to be registered under chapter 144D; board
206.27 and lodging establishments providing only custodial services that are licensed under chapter
206.28 157 and registered under section 157.17 to provide supportive services or health supervision
206.29 services; adult foster homes as defined in Minnesota Rules, part 9555.5105; day training
206.30 and habilitation services for adults with developmental disabilities as defined in section
206.31 252.41, subdivision 3; boarding care homes as defined in Minnesota Rules, part 4655.0100;
206.32 adult day care services as defined in section 245A.02, subdivision 2a; and home health

207.1 agencies as defined in Minnesota Rules, part 9505.0175, subpart 15, or licensed under
207.2 chapter 144A.

207.3 Sec. 114. Minnesota Statutes 2020, section 325F.721, subdivision 1, is amended to read:

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

207.6 (b) "Covered setting" means an unlicensed setting providing sleeping accommodations
207.7 to one or more adult residents, at least 80 percent of which are 55 years of age or older, and
207.8 offering or providing, for a fee, supportive services. For the purposes of this section, covered
207.9 setting does not mean:

207.10 (1) emergency shelter, transitional housing, or any other residential units serving
207.11 exclusively or primarily homeless individuals, as defined under section 116L.361;

207.12 (2) a nursing home licensed under chapter 144A;

207.13 (3) a hospital, certified boarding care, or supervised living facility licensed under sections
207.14 144.50 to 144.56;

207.15 (4) a lodging establishment licensed under chapter 157 and Minnesota Rules, parts
207.16 9520.0500 to 9520.0670, or under chapter 245D ~~or~~, 245G, or 245I;

207.17 (5) services and residential settings licensed under chapter 245A, including adult foster
207.18 care and services and settings governed under the standards in chapter 245D;

207.19 (6) private homes in which the residents are related by kinship, law, or affinity with the
207.20 providers of services;

207.21 (7) a duly organized condominium, cooperative, and common interest community, or
207.22 owners' association of the condominium, cooperative, and common interest community
207.23 where at least 80 percent of the units that comprise the condominium, cooperative, or
207.24 common interest community are occupied by individuals who are the owners, members, or
207.25 shareholders of the units;

207.26 (8) temporary family health care dwellings as defined in sections 394.307 and 462.3593;

207.27 (9) settings offering services conducted by and for the adherents of any recognized
207.28 church or religious denomination for its members exclusively through spiritual means or
207.29 by prayer for healing;

207.30 (10) housing financed pursuant to sections 462A.37 and 462A.375, units financed with
207.31 low-income housing tax credits pursuant to United States Code, title 26, section 42, and

208.1 units financed by the Minnesota Housing Finance Agency that are intended to serve
208.2 individuals with disabilities or individuals who are homeless, except for those developments
208.3 that market or hold themselves out as assisted living facilities and provide assisted living
208.4 services;

208.5 (11) rental housing developed under United States Code, title 42, section 1437, or United
208.6 States Code, title 12, section 1701q;

208.7 (12) rental housing designated for occupancy by only elderly or elderly and disabled
208.8 residents under United States Code, title 42, section 1437e, or rental housing for qualifying
208.9 families under Code of Federal Regulations, title 24, section 983.56;

208.10 (13) rental housing funded under United States Code, title 42, chapter 89, or United
208.11 States Code, title 42, section 8011; or

208.12 (14) an assisted living facility licensed under chapter 144G.

208.13 (c) "'I'm okay' check services" means providing a service to, by any means, check on
208.14 the safety of a resident.

208.15 (d) "Resident" means a person entering into written contract for housing and services
208.16 with a covered setting.

208.17 (e) "Supportive services" means:

208.18 (1) assistance with laundry, shopping, and household chores;

208.19 (2) housekeeping services;

208.20 (3) provision of meals or assistance with meals or food preparation;

208.21 (4) help with arranging, or arranging transportation to, medical, social, recreational,
208.22 personal, or social services appointments; or

208.23 (5) provision of social or recreational services.

208.24 Arranging for services does not include making referrals or contacting a service provider
208.25 in an emergency.

208.26 Sec. 115. **REPEALER.**

208.27 (a) Minnesota Statutes 2020, sections 245.462, subdivision 4a; 245.4879, subdivision
208.28 2; 245.62, subdivisions 3 and 4; 245.69, subdivision 2; 256B.0615, subdivision 2; 256B.0616,
208.29 subdivision 2; 256B.0622, subdivisions 3 and 5a; 256B.0623, subdivisions 7, 8, 10, and 11;
208.30 256B.0625, subdivisions 51, 35a, 35b, 61, 62, and 65; 256B.0943, subdivisions 8 and 10;
208.31 256B.0944; and 256B.0946, subdivision 5, are repealed.

- 209.1 (b) Minnesota Rules, parts 9505.0370; 9505.0371; 9505.0372; 9520.0010; 9520.0020;
209.2 9520.0030; 9520.0040; 9520.0050; 9520.0060; 9520.0070; 9520.0080; 9520.0090;
209.3 9520.0100; 9520.0110; 9520.0120; 9520.0130; 9520.0140; 9520.0150; 9520.0160;
209.4 9520.0170; 9520.0180; 9520.0190; 9520.0200; 9520.0210; 9520.0230; 9520.0750;
209.5 9520.0760; 9520.0770; 9520.0780; 9520.0790; 9520.0800; 9520.0810; 9520.0820;
209.6 9520.0830; 9520.0840; 9520.0850; 9520.0860; and 9520.0870, are repealed.

245.462 DEFINITIONS.

Subd. 4a. **Clinical supervision.** "Clinical supervision" means the oversight responsibility for individual treatment plans and individual mental health service delivery, including that provided by the case manager. Clinical supervision must be accomplished by full or part-time employment of or contracts with mental health professionals. Clinical supervision must be documented by the mental health professional cosigning individual treatment plans and by entries in the client's record regarding supervisory activities.

245.4879 EMERGENCY SERVICES.

Subd. 2. **Specific requirements.** (a) The county board shall require that all service providers of emergency services to the child with an emotional disturbance provide immediate direct access to a mental health professional during regular business hours. For evenings, weekends, and holidays, the service may be by direct toll-free telephone access to a mental health professional, a mental health practitioner, or until January 1, 1991, a designated person with training in human services who receives clinical supervision from a mental health professional.

(b) The commissioner may waive the requirement in paragraph (a) that the evening, weekend, and holiday service be provided by a mental health professional or mental health practitioner after January 1, 1991, if the county documents that:

(1) mental health professionals or mental health practitioners are unavailable to provide this service;

(2) services are provided by a designated person with training in human services who receives clinical supervision from a mental health professional; and

(3) the service provider is not also the provider of fire and public safety emergency services.

(c) The commissioner may waive the requirement in paragraph (b), clause (3), that the evening, weekend, and holiday service not be provided by the provider of fire and public safety emergency services if:

(1) every person who will be providing the first telephone contact has received at least eight hours of training on emergency mental health services reviewed by the state advisory council on mental health and then approved by the commissioner;

(2) every person who will be providing the first telephone contact will annually receive at least four hours of continued training on emergency mental health services reviewed by the state advisory council on mental health and then approved by the commissioner;

(3) the local social service agency has provided public education about available emergency mental health services and can assure potential users of emergency services that their calls will be handled appropriately;

(4) the local social service agency agrees to provide the commissioner with accurate data on the number of emergency mental health service calls received;

(5) the local social service agency agrees to monitor the frequency and quality of emergency services; and

(6) the local social service agency describes how it will comply with paragraph (d).

(d) When emergency service during nonbusiness hours is provided by anyone other than a mental health professional, a mental health professional must be available on call for an emergency assessment and crisis intervention services, and must be available for at least telephone consultation within 30 minutes.

245.62 COMMUNITY MENTAL HEALTH CENTER.

Subd. 3. **Clinical supervisor.** All community mental health center services shall be provided under the clinical supervision of a licensed psychologist licensed under sections 148.88 to 148.98, or a physician who is board certified or eligible for board certification in psychiatry, and who is licensed under section 147.02.

Subd. 4. **Rules.** The commissioner shall promulgate rules to establish standards for the designation of an agency as a community mental health center. These standards shall include, but are not limited to:

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(1) provision of mental health services in the prevention, identification, treatment and aftercare of emotional disorders, chronic and acute mental illness, developmental disabilities, and alcohol and drug abuse and dependency, including the services listed in section 245.61 except detoxification services;

(2) establishment of a community mental health center board pursuant to section 245.66; and

(3) approval pursuant to section 245.69, subdivision 2.

245.69 ADDITIONAL DUTIES OF COMMISSIONER.

Subd. 2. **Approval of centers and clinics.** The commissioner of human services has the authority to approve or disapprove public and private mental health centers and public and private mental health clinics for the purposes of section 62A.152, subdivision 2. For the purposes of this subdivision the commissioner shall promulgate rules in accordance with sections 14.001 to 14.69. The rules shall require each applicant to pay a fee to cover costs of processing applications and determining compliance with the rules and this subdivision. The commissioner may contract with any state agency, individual, corporation or association to which the commissioner shall delegate all but final approval and disapproval authority to determine compliance or noncompliance.

(a) Each approved mental health center and each approved mental health clinic shall have a multidisciplinary team of professional staff persons as required by rule. A mental health center or mental health clinic may provide the staffing required by rule by means of written contracts with professional persons or with other health care providers. Any personnel qualifications developed by rule shall be consistent with any personnel standards developed pursuant to chapter 214.

(b) Each approved mental health clinic and each approved mental health center shall establish a written treatment plan for each outpatient for whom services are reimbursable through insurance or public assistance. The treatment plan shall be developed in accordance with the rules and shall include a patient history, treatment goals, a statement of diagnosis and a treatment strategy. The clinic or center shall provide access to hospital admission as a bed patient as needed by any outpatient. The clinic or center shall ensure ongoing consultation among and availability of all members of the multidisciplinary team.

(c) As part of the required consultation, members of the multidisciplinary team shall meet at least twice monthly to conduct case reviews, peer consultations, treatment plan development and in-depth case discussion. Written minutes of these meetings shall be kept at the clinic or center for three years.

(d) Each approved center or clinic shall establish mechanisms for quality assurance and submit documentation concerning the mechanisms to the commissioner as required by rule, including:

(1) continuing education of each professional staff person;

(2) an ongoing internal utilization and peer review plan and procedures;

(3) mechanisms of staff supervision; and

(4) procedures for review by the commissioner or a delegate.

(e) The commissioner shall disapprove an applicant, or withdraw approval of a clinic or center, which the commissioner finds does not comply with the requirements of the rules or this subdivision. A clinic or center which is disapproved or whose approval is withdrawn is entitled to a contested case hearing and judicial review pursuant to sections 14.01 to 14.69.

(f) Data on individuals collected by approved clinics and centers, including written minutes of team meetings, is private data on individuals within the welfare system as provided in chapter 13.

(g) Each center or clinic that is approved and in compliance with the commissioner's existing rule on July 1, 1980, is approved for purposes of section 62A.152, subdivision 2, until rules are promulgated to implement this section.

256B.0615 MENTAL HEALTH CERTIFIED PEER SPECIALIST.

Subd. 2. **Establishment.** The commissioner of human services shall establish a certified peer specialist program model, which:

(1) provides nonclinical peer support counseling by certified peer specialists;

(2) provides a part of a wraparound continuum of services in conjunction with other community mental health services;

(3) is individualized to the consumer; and

(4) promotes socialization, recovery, self-sufficiency, self-advocacy, development of natural supports, and maintenance of skills learned in other support services.

256B.0616 MENTAL HEALTH CERTIFIED FAMILY PEER SPECIALIST.

Subd. 2. **Establishment.** The commissioner of human services shall establish a certified family peer specialists program model which:

(1) provides nonclinical family peer support counseling, building on the strengths of families and helping them achieve desired outcomes;

(2) collaborates with others providing care or support to the family;

(3) provides nonadversarial advocacy;

(4) promotes the individual family culture in the treatment milieu;

(5) links parents to other parents in the community;

(6) offers support and encouragement;

(7) assists parents in developing coping mechanisms and problem-solving skills;

(8) promotes resiliency, self-advocacy, development of natural supports, and maintenance of skills learned in other support services;

(9) establishes and provides peer-led parent support groups; and

(10) increases the child's ability to function better within the child's home, school, and community by educating parents on community resources, assisting with problem solving, and educating parents on mental illnesses.

256B.0622 ASSERTIVE COMMUNITY TREATMENT AND INTENSIVE RESIDENTIAL TREATMENT SERVICES.

Subd. 3. **Eligibility for intensive residential treatment services.** An eligible client for intensive residential treatment services is an individual who:

(1) is age 18 or older;

(2) is eligible for medical assistance;

(3) is diagnosed with a mental illness;

(4) because of a mental illness, 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;

(5) has one or more of the following: a history of recurring or prolonged inpatient hospitalizations in the past year, significant independent living instability, homelessness, or very frequent use of mental health and related services yielding poor outcomes; and

(6) in the written opinion of a licensed mental health professional, has the need for mental health services that cannot be met with other available community-based services, or is likely to experience a mental health crisis or require a more restrictive setting if intensive rehabilitative mental health services are not provided.

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

(b) The provider of intensive residential treatment services must have sufficient staff to provide 24-hour-per-day coverage to deliver the rehabilitative services described in the treatment plan and to safely supervise and direct the activities of clients, given the client's level of behavioral and psychiatric stability, cultural needs, and vulnerability. The provider must have the capacity within the facility to provide integrated services for chemical dependency, illness management services, and family education, when appropriate.

(c) At a minimum:

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

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

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

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

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

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

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

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

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

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

256B.0623 ADULT REHABILITATIVE MENTAL HEALTH SERVICES COVERED.

Subd. 7. **Personnel file.** The adult rehabilitative mental health services provider entity must maintain a personnel file on each staff. Each file must contain:

- (1) an annual performance review;
- (2) a summary of on-site service observations and charting review;
- (3) a criminal background check of all direct service staff;
- (4) evidence of academic degree and qualifications;
- (5) a copy of professional license;
- (6) any job performance recognition and disciplinary actions;
- (7) any individual staff written input into own personnel file;
- (8) all clinical supervision provided; and
- (9) documentation of compliance with continuing education requirements.

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 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.

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Subd. 10. **Individual treatment plan.** All providers of adult rehabilitative mental health services must develop and implement an individual treatment plan for each recipient. The provisions in clauses (1) and (2) apply:

(1) Individual treatment plan means a plan of intervention, treatment, and services for an individual recipient written by a mental health professional or by a mental health practitioner under the clinical supervision of a mental health professional. The individual treatment plan must be based on diagnostic and functional assessments. To the extent possible, the development and implementation of a treatment plan must be a collaborative process involving the recipient, and with the permission of the recipient, the recipient's family and others in the recipient's support system. Providers of adult rehabilitative mental health services must develop the individual treatment plan within 30 calendar days of intake. The treatment plan must be updated at least every six months thereafter, or more often when there is significant change in the recipient's situation or functioning, or in services or service methods to be used, or at the request of the recipient or the recipient's legal guardian.

(2) The individual treatment plan must include:

(i) a list of problems identified in the assessment;

(ii) the recipient's strengths and resources;

(iii) concrete, measurable goals to be achieved, including time frames for achievement;

(iv) specific objectives directed toward the achievement of each one of the goals;

(v) documentation of participants in the treatment planning. The recipient, if possible, must be a participant. The recipient or the recipient's legal guardian must sign the treatment plan, or documentation must be provided why this was not possible. A copy of the plan must be given to the recipient or legal guardian. Referral to formal services must be arranged, including specific providers where applicable;

(vi) cultural considerations, resources, and needs of the recipient must be included;

(vii) planned frequency and type of services must be initiated; and

(viii) clear progress notes on outcome of goals.

(3) The individual community support plan defined in section 245.462, subdivision 12, may serve as the individual treatment plan if there is involvement of a mental health case manager, and with the approval of the recipient. The individual community support plan must include the criteria in clause (2).

Subd. 11. **Recipient file.** Providers of adult rehabilitative mental health services must maintain a file for each recipient that contains the following information:

(1) diagnostic assessment or verification of its location that is current and that was reviewed by a mental health professional who is employed by or under contract with the provider entity;

(2) functional assessments;

(3) individual treatment plans signed by the recipient and the mental health professional, or if the recipient refused to sign the plan, the date and reason stated by the recipient as to why the recipient would not sign the plan;

(4) recipient history;

(5) signed release forms;

(6) recipient health information and current medications;

(7) emergency contacts for the recipient;

(8) case records which document the date of service, the place of service delivery, signature of the person providing the service, nature, extent and units of service, and place of service delivery;

(9) contacts, direct or by telephone, with recipient's family or others, other providers, or other resources for service coordination;

(10) summary of recipient case reviews by staff; and

(11) written information by the recipient that the recipient requests be included in the file.

256B.0625 COVERED SERVICES.

Subd. 51. **Intensive mental health outpatient treatment.** Medical assistance covers intensive mental health outpatient treatment for dialectical behavioral therapy. The commissioner shall establish:

- (1) certification procedures to ensure that providers of these services are qualified; and
- (2) treatment protocols including required service components and criteria for admission, continued treatment, and discharge.

Subd. 35a. **Children's mental health crisis response services.** Medical assistance covers children's mental health crisis response services according to section 256B.0944.

Subd. 35b. **Children's therapeutic services and supports.** Medical assistance covers children's therapeutic services and supports according to section 256B.0943.

Subd. 61. **Family psychoeducation services.** Effective July 1, 2013, or upon federal approval, whichever is later, medical assistance covers family psychoeducation services provided to a child up to age 21 with a diagnosed mental health condition when identified in the child's individual treatment plan and provided by a licensed mental health professional, as defined in Minnesota Rules, part 9505.0371, subpart 5, item A, or a clinical trainee, as defined in Minnesota Rules, part 9505.0371, subpart 5, item C, who has determined it medically necessary to involve family members in the child's care. For the purposes of this subdivision, "family psychoeducation services" means information or demonstration provided to an individual or family as part of an individual, family, multifamily group, or peer group session to explain, educate, and support the child and family in understanding a child's symptoms of mental illness, the impact on the child's development, and needed components of treatment and skill development so that the individual, family, or group can help the child to prevent relapse, prevent the acquisition of comorbid disorders, and achieve optimal mental health and long-term resilience.

Subd. 62. **Mental health clinical care consultation.** Effective July 1, 2013, or upon federal approval, whichever is later, medical assistance covers clinical care consultation for a person up to age 21 who is diagnosed with a complex mental health condition or a mental health condition that co-occurs with other complex and chronic conditions, when described in the person's individual treatment plan and provided by a licensed mental health professional, as defined in Minnesota Rules, part 9505.0371, subpart 5, item A, or a clinical trainee, as defined in Minnesota Rules, part 9505.0371, subpart 5, item C. For the purposes of this subdivision, "clinical care consultation" means communication from a treating mental health professional to other providers or educators not under the clinical supervision of the treating mental health professional who are working with the same client to inform, inquire, and instruct regarding the client's symptoms; strategies for effective engagement, care, and intervention needs; and treatment expectations across service settings; and to direct and coordinate clinical service components provided to the client and family.

Subd. 65. **Outpatient mental health services.** Medical assistance covers diagnostic assessment, explanation of findings, and psychotherapy according to Minnesota Rules, part 9505.0372, when the mental health services are performed by a mental health practitioner working as a clinical trainee according to section 245.462, subdivision 17, paragraph (g).

256B.0943 CHILDREN'S THERAPEUTIC SERVICES AND SUPPORTS.

Subd. 8. **Required preservice and continuing education.** (a) A provider entity shall establish a plan to provide preservice and continuing education for staff. The plan must clearly describe the type of training necessary to maintain current skills and obtain new skills and that relates to the provider entity's goals and objectives for services offered.

(b) A provider that employs a mental health behavioral aide under this section must require the mental health behavioral aide to complete 30 hours of preservice training. The preservice training must include parent team training. The preservice training must include 15 hours of in-person training of a mental health behavioral aide in mental health services delivery and eight hours of parent team training. Curricula for parent team training must be approved in advance by the commissioner. Components of parent team training include:

- (1) partnering with parents;
- (2) fundamentals of family support;
- (3) fundamentals of policy and decision making;

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(4) defining equal partnership;

(5) complexities of the parent and service provider partnership in multiple service delivery systems due to system strengths and weaknesses;

(6) sibling impacts;

(7) support networks; and

(8) community resources.

(c) A provider entity that employs a mental health practitioner and a mental health behavioral aide to provide children's therapeutic services and supports under this section must require the mental health practitioner and mental health behavioral aide to complete 20 hours of continuing education every two calendar years. The continuing education must be related to serving the needs of a child with emotional disturbance in the child's home environment and the child's family.

(d) The provider entity must document the mental health practitioner's or mental health behavioral aide's annual completion of the required continuing education. The documentation must include the date, subject, and number of hours of the continuing education, and attendance records, as verified by the staff member's signature, job title, and the instructor's name. The provider entity must keep documentation for each employee, including records of attendance at professional workshops and conferences, at a central location and in the employee's personnel file.

Subd. 10. **Service authorization.** Children's therapeutic services and supports are subject to authorization criteria and standards published by the commissioner according to section 256B.0625, subdivision 25.

256B.0944 CHILDREN'S MENTAL HEALTH CRISIS RESPONSE SERVICES.

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

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

(b) "Mental health emergency" means a child's behavioral, emotional, or psychiatric situation that causes an immediate need for mental health services and is consistent with section 62Q.55. A physician, mental health professional, or crisis mental health practitioner determines a mental health crisis or emergency for medical assistance reimbursement with input from the client and the client's family, if possible.

(c) "Mental health crisis assessment" means an immediate face-to-face assessment by a physician, mental health professional, or mental health practitioner under the clinical supervision of a mental health professional, following a screening that suggests the child 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. Mental health mobile crisis services must 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. Mental health mobile services must be provided on site by a mobile crisis intervention team outside of an inpatient hospital setting.

(e) "Mental health crisis stabilization services" means individualized mental health services provided to a recipient following crisis intervention services that are designed to restore the recipient to the recipient's prior functional level. The individual treatment plan recommending mental health crisis stabilization must be completed by the intervention team or by staff after an inpatient or urgent care visit. Mental health crisis stabilization services may be provided in the recipient's home, the home of a family member or friend of the recipient, schools, another community setting, or a short-term supervised, licensed residential program if the service is not included in the facility's cost pool or per diem. Mental health crisis stabilization is not reimbursable when provided as part of a partial hospitalization or day treatment program.

Subd. 2. **Medical assistance coverage.** Medical assistance covers medically necessary children's mental health crisis response services, subject to federal approval, if provided to an eligible recipient under subdivision 3, by a qualified provider entity under subdivision 4 or a qualified individual

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provider working within the provider's scope of practice, and identified in the recipient's individual crisis treatment plan under subdivision 8.

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

- (1) is eligible for medical assistance;
- (2) is under age 18 or between the ages of 18 and 21;
- (3) is screened as possibly experiencing a mental health crisis or mental health emergency where a mental health crisis assessment is needed;
- (4) is assessed as experiencing a mental health crisis or mental health emergency, and mental health mobile crisis intervention or mental health crisis stabilization services are determined to be medically necessary; and
- (5) meets the criteria for emotional disturbance or mental illness.

Subd. 4. **Provider entity standards.** (a) A crisis intervention and crisis stabilization provider entity must meet the administrative and clinical standards specified in section 256B.0943, subdivisions 5 and 6, meet the standards listed in paragraph (b), and be:

- (1) an Indian health service facility or facility owned and operated by a tribe or a tribal organization operating under Public Law 93-638 as a 638 facility;
- (2) a county board-operated entity; or
- (3) a provider entity that is under contract with the county board in the county where the potential crisis or emergency is occurring.

(b) The children's mental health crisis response services provider entity must:

- (1) ensure that mental health crisis assessment and mobile crisis intervention services are available 24 hours a day, seven days a week;
- (2) directly provide the services or, if services are subcontracted, the provider entity must maintain clinical responsibility for services and billing;
- (3) ensure that crisis intervention services are provided in a manner consistent with sections 245.487 to 245.4889; and
- (4) develop and maintain written policies and procedures regarding service provision that include safety of staff and recipients in high-risk situations.

Subd. 4a. **Alternative provider standards.** If a provider entity demonstrates that, due to geographic or other barriers, it is not feasible to provide mobile crisis intervention services 24 hours a day, seven days a week, according to the standards in subdivision 4, paragraph (b), clause (1), the commissioner may approve a crisis response provider based on an alternative plan proposed by a provider entity. The alternative plan must:

- (1) result in increased access and a reduction in disparities in the availability of crisis services; and
- (2) provide mobile services outside of the usual nine-to-five office hours and on weekends and holidays.

Subd. 5. **Mobile crisis intervention staff qualifications.** (a) To provide children's mental health mobile crisis intervention services, a mobile crisis intervention team must include:

- (1) at least two mental health professionals as defined in section 256B.0943, subdivision 1, paragraph (o); or
- (2) a combination of at least one mental health professional and one mental health practitioner as defined in section 245.4871, subdivision 26, with the required mental health crisis training and under the clinical supervision of a mental health professional on the team.

(b) The team must have at least two people with at least one member providing on-site crisis intervention services when needed. Team members must be experienced in mental health assessment, crisis intervention techniques, and clinical decision making under emergency conditions and have knowledge of local services and resources. The team must recommend and coordinate the team's services with appropriate local resources, including the county social services agency, mental health service providers, and local law enforcement, if necessary.

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Subd. 6. Initial screening and crisis assessment planning. (a) Before 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 245.4871, subdivision 14, and 245.4879, subdivisions 1 and 2. The screening must gather information, determine whether a crisis situation exists, identify the parties involved, and determine an appropriate response.

(b) If a crisis exists, a crisis assessment must be completed. A crisis assessment must evaluate 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.

(c) If the crisis assessment determines mobile crisis intervention services are needed, the intervention services must be provided promptly. As the opportunity presents itself 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 under 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 crisis treatment plan must be updated as needed to reflect current goals and services. The team must involve the client and the client's family in developing and implementing the plan.

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

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

Subd. 7. Crisis stabilization services. Crisis stabilization services must be provided by a mental health professional or a mental health practitioner, as defined in section 245.462, subdivision 17, who works under the clinical supervision of a mental health professional and for a crisis stabilization services provider entity and must meet the following standards:

(1) a crisis stabilization treatment plan must be developed which meets the criteria in subdivision 8;

(2) services must be delivered according to the treatment plan and include face-to-face contact with the recipient by qualified staff for further assessment, help with referrals, updating the crisis stabilization treatment plan, supportive counseling, skills training, and collaboration with other service providers in the community; and

(3) mental health practitioners must have completed at least 30 hours of training in crisis intervention and stabilization during the past two years.

Subd. 8. Treatment plan. (a) The individual crisis stabilization treatment plan must include, at a minimum:

(1) a list of problems identified in the assessment;

(2) a list of the recipient's strengths and resources;

(3) concrete, measurable short-term goals and tasks to be achieved, including time frames for achievement of the goals;

(4) specific objectives directed toward the achievement of each goal;

(5) documentation of the participants involved in the service planning;

(6) planned frequency and type of services initiated;

(7) a crisis response action plan if a crisis should occur; and

(8) clear progress notes on the outcome of goals.

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(b) The client, if clinically appropriate, must be a participant in the development of the crisis stabilization treatment plan. The client or the client's legal guardian must sign the service plan or documentation must be provided why this was not possible. A copy of the plan must be given to the client and the client's legal guardian. The plan should include services arranged, including specific providers where applicable.

(c) A treatment plan must be developed by a mental health professional or mental health practitioner under the clinical supervision of a mental health professional. A written plan must be completed within 24 hours of beginning services with the client.

Subd. 9. **Supervision.** (a) A mental health practitioner may provide crisis assessment and mobile crisis intervention services if the following clinical supervision requirements are met:

- (1) the mental health provider entity must accept full responsibility for the services provided;
- (2) the mental health professional of the provider entity, who is an employee or under contract with the provider entity, must be immediately available by telephone or in person for clinical supervision;
- (3) the mental health professional is consulted, in person or by telephone, during the first three hours when a mental health practitioner provides on-site service; and
- (4) the mental health professional must review and approve the tentative crisis assessment and crisis treatment plan, document the consultation, and sign the crisis assessment and treatment plan within the next business day.

(b) If the mobile crisis intervention services continue into a second calendar day, a mental health professional must contact the client face-to-face on the second day to provide services and update the crisis treatment plan. The on-site observation must be documented in the client's record and signed by the mental health professional.

Subd. 10. **Client record.** The provider must maintain a file for each client that complies with the requirements under section 256B.0943, subdivision 11, and contains the following information:

- (1) individual crisis treatment plans signed by the recipient, mental health professional, and mental health practitioner who developed the crisis treatment plan, or if the recipient refused to sign the plan, the date and reason stated by the recipient for not signing the plan;
- (2) signed release of information forms;
- (3) recipient health information and current medications;
- (4) emergency contacts for the recipient;
- (5) case records that document the date of service, place of service delivery, signature of the person providing the service, and the nature, extent, and units of service. Direct or telephone contact with the recipient's family or others should be documented;
- (6) required clinical supervision by mental health professionals;
- (7) summary of the recipient's case reviews by staff; and
- (8) any written information by the recipient that the recipient wants in the file.

Subd. 11. **Excluded services.** The following services are excluded from reimbursement under this section:

- (1) room and board services;
- (2) services delivered to a recipient while admitted to an inpatient hospital;
- (3) transportation services under children's mental health crisis response service;
- (4) services provided and billed by a provider who is not enrolled under medical assistance to provide children's mental health crisis response services;
- (5) crisis response services provided by a residential treatment center to clients in their facility;
- (6) services performed by volunteers;
- (7) direct billing of time spent "on call" when not delivering services to a recipient;
- (8) provider service time included in case management reimbursement;

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- (9) outreach services to potential recipients; and
- (10) a mental health service that is not medically necessary.

256B.0946 INTENSIVE TREATMENT IN FOSTER CARE.

Subd. 5. **Service authorization.** The commissioner will administer authorizations for services under this section in compliance with section 256B.0625, subdivision 25.

9505.0370 DEFINITIONS.

Subpart 1. **Scope.** For parts 9505.0370 to 9505.0372, the following terms have the meanings given them.

Subp. 2. **Adult day treatment.** "Adult day treatment" or "adult day treatment program" means a structured program of treatment and care.

Subp. 3. **Child.** "Child" means a person under 18 years of age.

Subp. 4. **Client.** "Client" means an eligible recipient who is determined to have or who is being assessed for a mental illness as specified in part 9505.0371.

Subp. 5. **Clinical summary.** "Clinical summary" means a written description of a clinician's formulation of the cause of the client's mental health symptoms, the client's prognosis, and the likely consequences of the symptoms; how the client meets the criteria for the diagnosis by describing the client's symptoms, the duration of symptoms, and functional impairment; an analysis of the client's other symptoms, strengths, relationships, life situations, cultural influences, and health concerns and their potential interaction with the diagnosis and formulation of the client's mental health condition; and alternative diagnoses that were considered and ruled out.

Subp. 6. **Clinical supervision.** "Clinical supervision" means the documented time a clinical supervisor and supervisee spend together to discuss the supervisee's work, to review individual client cases, and for the supervisee's professional development. It includes the documented oversight and supervision responsibility for planning, implementation, and evaluation of services for a client's mental health treatment.

Subp. 7. **Clinical supervisor.** "Clinical supervisor" means the mental health professional who is responsible for clinical supervision.

Subp. 8. **Cultural competence or culturally competent.** "Cultural competence" or "culturally competent" means the mental health provider's:

A. awareness of the provider's own cultural background, and the related assumptions, values, biases, and preferences that influence assessment and intervention processes;

B. ability and will to respond to the unique needs of an individual client that arise from the client's culture;

C. ability to utilize the client's culture as a resource and as a means to optimize mental health care; and

D. willingness to seek educational, consultative, and learning experiences to expand knowledge of and increase effectiveness with culturally diverse populations.

Subp. 9. **Cultural influences.** "Cultural influences" means historical, geographical, and familial factors that affect assessment and intervention processes. Cultural influences that are relevant to the client may include the client's:

A. racial or ethnic self-identification;

B. experience of cultural bias as a stressor;

C. immigration history and status;

D. level of acculturation;

E. time orientation;

F. social orientation;

G. verbal communication style;

H. locus of control;

I. spiritual beliefs; and

J. health beliefs and the endorsement of or engagement in culturally specific healing practices.

Subp. 10. **Culture.** "Culture" means the distinct ways of living and understanding the world that are used by a group of people and are transmitted from one generation to another or adopted by an individual.

Subp. 11. **Diagnostic assessment.** "Diagnostic assessment" means a written assessment that documents a clinical and functional face-to-face evaluation of the client's mental health, including the nature, severity and impact of behavioral difficulties, functional impairment, and subjective distress of the client, and identifies the client's strengths and resources.

Subp. 12. **Dialectical behavior therapy.** "Dialectical behavior therapy" means an evidence-based treatment approach provided in an intensive outpatient treatment program using a combination of individualized rehabilitative and psychotherapeutic interventions. A dialectical behavior therapy program is certified by the commissioner and involves the following service components: individual dialectical behavior therapy, group skills training, telephone coaching, and team consultation meetings.

Subp. 13. **Explanation of findings.** "Explanation of findings" means the explanation of a client's diagnostic assessment, psychological testing, treatment program, and consultation with culturally informed mental health consultants as required under parts 9520.0900 to 9520.0926, or other accumulated data and recommendations to the client, client's family, primary caregiver, or other responsible persons.

Subp. 14. **Family.** "Family" means a person who is identified by the client or the client's parent or guardian as being important to the client's mental health treatment. Family may include, but is not limited to, parents, children, spouse, committed partners, former spouses, persons related by blood or adoption, or persons who are presently residing together as a family unit.

Subp. 15. **Individual treatment plan.** "Individual treatment plan" means a written plan that outlines and defines the course of treatment. It delineates the goals, measurable objectives, target dates for achieving specific goals, main participants in treatment process, and recommended services that are based on the client's diagnostic assessment and other meaningful data that are needed to aid the client's recovery and enhance resiliency.

Subp. 16. **Medication management.** "Medication management" means a service that determines the need for or effectiveness of the medication prescribed for the treatment of a client's symptoms of a mental illness.

Subp. 17. **Mental health practitioner.** "Mental health practitioner" means a person who is qualified according to part 9505.0371, subpart 5, items B and C, and provides mental health services to a client with a mental illness under the clinical supervision of a mental health professional.

Subp. 18. **Mental health professional.** "Mental health professional" means a person who is enrolled to provide medical assistance services and is qualified according to part 9505.0371, subpart 5, item A.

Subp. 19. **Mental health telemedicine.** "Mental health telemedicine" has the meaning given in Minnesota Statutes, section 256B.0625, subdivision 46.

Subp. 20. **Mental illness.** "Mental illness" has the meaning given in Minnesota Statutes, section 245.462, subdivision 20. "Mental illness" includes "emotional disturbance" as defined in Minnesota Statutes, section 245.4871, subdivision 15.

Subp. 21. **Multidisciplinary staff.** "Multidisciplinary staff" means a group of individuals from diverse disciplines who come together to provide services to clients under part 9505.0372, subparts 8, 9, and 10.

Subp. 22. **Neuropsychological assessment.** "Neuropsychological assessment" means a specialized clinical assessment of the client's underlying cognitive abilities related to thinking, reasoning, and judgment that is conducted by a qualified neuropsychologist.

Subp. 23. **Neuropsychological testing.** "Neuropsychological testing" means administering standardized tests and measures designed to evaluate the client's ability to attend to, process, interpret, comprehend, communicate, learn and recall information; and use problem-solving and judgment.

Subp. 24. **Partial hospitalization program.** "Partial hospitalization program" means a provider's time-limited, structured program of psychotherapy and other therapeutic services, as defined in United States Code, title 42, chapter 7, subchapter XVIII, part E, section 1395x, (ff), that is provided in an outpatient hospital facility or community mental health center that meets Medicare requirements to provide partial hospitalization services.

Subp. 25. **Primary caregiver.** "Primary caregiver" means a person, other than the facility staff, who has primary legal responsibility for providing the client with food, clothing, shelter, direction, guidance, and nurturance.

Subp. 26. **Psychological testing.** "Psychological testing" means the use of tests or other psychometric instruments to determine the status of the recipient's mental, intellectual, and emotional functioning.

Subp. 27. **Psychotherapy.** "Psychotherapy" means treatment of a client with mental illness that applies the most appropriate psychological, psychiatric, psychosocial, or interpersonal method that conforms to prevailing community standards of professional practice to meet the mental health needs of the client.

Subp. 28. **Supervisee.** "Supervisee" means an individual who requires clinical supervision because the individual does not meet mental health professional standards in part 9505.0371, subpart 5, item A.

9505.0371 MEDICAL ASSISTANCE COVERAGE REQUIREMENTS FOR OUTPATIENT MENTAL HEALTH SERVICES.

Subpart 1. **Purpose.** This part describes the requirements that outpatient mental health services must meet to receive medical assistance reimbursement.

Subp. 2. **Client eligibility for mental health services.** The following requirements apply to mental health services:

A. The provider must use a diagnostic assessment as specified in part 9505.0372 to determine a client's eligibility for mental health services under this part, except:

(1) prior to completion of a client's initial diagnostic assessment, a client is eligible for:

(a) one explanation of findings;

(b) one psychological testing; and

(c) either one individual psychotherapy session, one family psychotherapy session, or one group psychotherapy session; and

(2) for a client who is not currently receiving mental health services covered by medical assistance, a crisis assessment as specified in Minnesota Statutes, section 256B.0624 or 256B.0944, conducted in the past 60 days may be used to allow up to ten sessions of mental health services within a 12-month period.

B. A brief diagnostic assessment must meet the requirements of part 9505.0372, subpart 1, item D, and:

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(1) may be used to allow up to ten sessions of mental health services as specified in part 9505.0372 within a 12-month period before a standard or extended diagnostic assessment is required when the client is:

(a) a new client; or

(b) an existing client who has had fewer than ten sessions of psychotherapy in the previous 12 months and is projected to need fewer than ten sessions of psychotherapy in the next 12 months, or who only needs medication management; and

(2) may be used for a subsequent annual assessment, if based upon the client's treatment history and the provider's clinical judgment, the client will need ten or fewer sessions of mental health services in the upcoming 12-month period; and

(3) must not be used for:

(a) a client or client's family who requires a language interpreter to participate in the assessment unless the client meets the requirements of subitem (1), unit (b), or (2); or

(b) more than ten sessions of mental health services in a 12-month period. If, after completion of ten sessions of mental health services, the mental health professional determines the need for additional sessions, a standard assessment or extended assessment must be completed.

C. For a child, a new standard or extended diagnostic assessment must be completed:

(1) when the child does not meet the criteria for a brief diagnostic assessment;

(2) at least annually following the initial diagnostic assessment, if:

(a) additional services are needed; and

(b) the child does not meet criteria for brief assessment;

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

(4) when the child's current mental health condition does not meet criteria of the child's current diagnosis.

D. For an adult, a new standard diagnostic assessment or extended diagnostic assessment must be completed:

(1) when the adult does not meet the criteria for a brief diagnostic assessment or an adult diagnostic assessment update;

(2) at least every three years following the initial diagnostic assessment for an adult who receives mental health services;

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

(4) when the adult's current mental health condition does not meet criteria of the current diagnosis.

E. An adult diagnostic assessment update must be completed at least annually unless a new standard or extended diagnostic assessment is performed. An adult diagnostic assessment update must include an update of the most recent standard or extended diagnostic assessment and any recent adult diagnostic assessment updates that have occurred since the last standard or extended diagnostic assessment.

Subp. 3. **Authorization for mental health services.** Mental health services under this part are subject to authorization criteria and standards published by the commissioner according to Minnesota Statutes, section 256B.0625, subdivision 25.

Subp. 4. Clinical supervision.

A. Clinical supervision must be based on each supervisee's written supervision plan and must:

- (1) promote professional knowledge, skills, and values development;
- (2) model ethical standards of practice;
- (3) promote cultural competency by:

(a) developing the supervisee's knowledge of cultural norms of behavior for individual clients and generally for the clients served by the supervisee regarding the client's cultural influences, age, class, gender, sexual orientation, literacy, and mental or physical disability;

(b) addressing how the supervisor's and supervisee's own cultures and privileges affect service delivery;

(c) developing the supervisee's ability to assess their own cultural competence and to identify when consultation or referral of the client to another provider is needed; and

(d) emphasizing the supervisee's commitment to maintaining cultural competence as an ongoing process;

(4) recognize that the client's family has knowledge about the client and will continue to play a role in the client's life and encourage participation among the client, client's family, and providers as treatment is planned and implemented; and

(5) monitor, evaluate, and document the supervisee's performance of assessment, treatment planning, and service delivery.

B. Clinical supervision must be conducted by a qualified supervisor using individual or group supervision. Individual or group face-to-face supervision may be conducted via electronic communications that utilize interactive telecommunications equipment that includes at a minimum audio and video equipment for two-way, real-time, interactive communication between the supervisor and supervisee, and meet the equipment and connection standards of part 9505.0370, subpart 19.

(1) Individual supervision means one or more designated clinical supervisors and one supervisee.

(2) Group supervision means one clinical supervisor and two to six supervisees in face-to-face supervision.

C. The supervision plan must be developed by the supervisor and the supervisee. The plan must be reviewed and updated at least annually. For new staff the plan must be completed and implemented within 30 days of the new staff person's employment. The supervision plan must include:

(1) the name and qualifications of the supervisee and the name of the agency in which the supervisee is being supervised;

(2) the name, licensure, and qualifications of the supervisor;

(3) the number of hours of individual and group supervision to be completed by the supervisee including whether supervision will be in person or by some other method approved by the commissioner;

(4) the policy and method that the supervisee must use to contact the clinical supervisor during service provision to a supervisee;

(5) procedures that the supervisee must use to respond to client emergencies;
and

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- (6) authorized scope of practices, including:
 - (a) description of the supervisee's service responsibilities;
 - (b) description of client population; and
 - (c) treatment methods and modalities.

D. Clinical supervision must be recorded in the supervisee's supervision record. The documentation must include:

- (1) date and duration of supervision;
- (2) identification of supervision type as individual or group supervision;
- (3) name of the clinical supervisor;
- (4) subsequent actions that the supervisee must take; and
- (5) date and signature of the clinical supervisor.

E. Clinical supervision pertinent to client treatment changes must be recorded by a case notation in the client record after supervision occurs.

Subp. 5. **Qualified providers.** Medical assistance covers mental health services according to part 9505.0372 when the services are provided by mental health professionals or mental health practitioners qualified under this subpart.

A. A mental health professional must be qualified in one of the following ways:

(1) in clinical social work, a person must be licensed as an independent clinical social worker by the Minnesota Board of Social Work under Minnesota Statutes, chapter 148D until August 1, 2011, and thereafter under Minnesota Statutes, chapter 148E;

(2) in psychology, a person licensed by the Minnesota Board of Psychology under Minnesota Statutes, sections 148.88 to 148.98, who has stated to the board competencies in the diagnosis and treatment of mental illness;

(3) in psychiatry, a physician licensed under Minnesota Statutes, chapter 147, who is certified by the American Board of Psychiatry and Neurology or is eligible for board certification;

(4) in marriage and family therapy, a person licensed as a marriage and family therapist by the Minnesota Board of Marriage and Family Therapy under Minnesota Statutes, sections 148B.29 to 148B.39, and defined in parts 5300.0100 to 5300.0350;

(5) in professional counseling, a person licensed as a professional clinical counselor by the Minnesota Board of Behavioral Health and Therapy under Minnesota Statutes, section 148B.5301;

(6) a tribally approved mental health care professional, who meets the standards in Minnesota Statutes, section 256B.02, subdivision 7, paragraphs (b) and (c), and who is serving a federally recognized Indian tribe; or

(7) in psychiatric nursing, a registered nurse who is licensed under Minnesota Statutes, sections 148.171 to 148.285, and meets one of the following criteria:

(a) is certified as a clinical nurse specialist;

(b) for children, is certified as a nurse practitioner in child or adolescent or family psychiatric and mental health nursing by a national nurse certification organization; or

(c) for adults, is certified as a nurse practitioner in adult or family psychiatric and mental health nursing by a national nurse certification organization.

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B. A mental health practitioner for a child client must have training working with children. A mental health practitioner for an adult client must have training working with adults. A mental health practitioner must be qualified in at least one of the following ways:

(1) holds a bachelor's degree in one of the behavioral sciences or related fields from an accredited college or university; and

(a) has at least 2,000 hours of supervised experience in the delivery of mental health services to clients with mental illness; or

(b) is fluent in the non-English language of the cultural group to which at least 50 percent of the practitioner's clients belong, completes 40 hours of training in the delivery of services to clients with mental illness, and receives clinical supervision from a mental health professional at least once a week until the requirements of 2,000 hours of supervised experience are met;

(2) has at least 6,000 hours of supervised experience in the delivery of mental health services to clients with mental illness. Hours worked as a mental health behavioral aide I or II under Minnesota Statutes, section 256B.0943, subdivision 7, may be included in the 6,000 hours of experience for child clients;

(3) is a graduate student in one of the mental health professional disciplines defined in item A and is formally assigned by an accredited college or university to an agency or facility for clinical training;

(4) holds a master's or other graduate degree in one of the mental health professional disciplines defined in item A from an accredited college or university; or

(5) is an individual who meets the standards in Minnesota Statutes, section 256B.02, subdivision 7, paragraphs (b) and (c), who is serving a federally recognized Indian tribe.

C. Medical assistance covers diagnostic assessment, explanation of findings, and psychotherapy performed by a mental health practitioner working as a clinical trainee when:

(1) the mental health practitioner is:

(a) complying with requirements for licensure or board certification as a mental health professional, as defined in item A, including supervised practice in the delivery of mental health services for the treatment of mental illness; or

(b) a student in a bona fide field placement or internship under a program leading to completion of the requirements for licensure as a mental health professional defined in item A; and

(2) the mental health practitioner's clinical supervision experience is helping the practitioner gain knowledge and skills necessary to practice effectively and independently. This may include supervision of:

(a) direct practice;

(b) treatment team collaboration;

(c) continued professional learning; and

(d) job management.

D. A clinical supervisor must:

(1) be a mental health professional licensed as specified in item A;

(2) hold a license without restrictions that has been in good standing for at least one year while having performed at least 1,000 hours of clinical practice;

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(3) be approved, certified, or in some other manner recognized as a qualified clinical supervisor by the person's professional licensing board, when this is a board requirement;

(4) be competent as demonstrated by experience and graduate-level training in the area of practice and the activities being supervised;

(5) not be the supervisee's blood or legal relative or cohabitant, or someone who has acted as the supervisee's therapist within the past two years;

(6) have experience and skills that are informed by advanced training, years of experience, and mastery of a range of competencies that demonstrate the following:

(a) capacity to provide services that incorporate best practice;

(b) ability to recognize and evaluate competencies in supervisees;

(c) ability to review assessments and treatment plans for accuracy and appropriateness;

(d) ability to give clear direction to mental health staff related to alternative strategies when a client is struggling with moving towards recovery; and

(e) ability to coach, teach, and practice skills with supervisees;

(7) accept full professional liability for a supervisee's direction of a client's mental health services;

(8) instruct a supervisee in the supervisee's work, and oversee the quality and outcome of the supervisee's work with clients;

(9) review, approve, and sign the diagnostic assessment, individual treatment plans, and treatment plan reviews of clients treated by a supervisee;

(10) review and approve the progress notes of clients treated by the supervisee according to the supervisee's supervision plan;

(11) apply evidence-based practices and research-informed models to treat clients;

(12) be employed by or under contract with the same agency as the supervisee;

(13) develop a clinical supervision plan for each supervisee;

(14) ensure that each supervisee receives the guidance and support needed to provide treatment services in areas where the supervisee practices;

(15) establish an evaluation process that identifies the performance and competence of each supervisee; and

(16) document clinical supervision of each supervisee and securely maintain the documentation record.

Subp. 6. **Release of information.** Providers who receive a request for client information and providers who request client information must:

A. comply with data practices and medical records standards in Minnesota Statutes, chapter 13, and Code of Federal Regulations, title 45, part 164; and

B. subject to the limitations in item A, promptly provide client information, including a written diagnostic assessment, to other providers who are treating the client to ensure that the client will get services without undue delay.

Subp. 7. **Individual treatment plan.** Except as provided in subpart 2, item A, subitem (1), a medical assistance payment is available only for services provided in accordance with the client's written individual treatment plan (ITP). The client must be involved in the development, review, and revision of the client's ITP. For all mental health services, except

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as provided in subpart 2, item A, subitem (1), and medication management, the ITP and subsequent revisions of the ITP must be signed by the client before treatment begins. The mental health professional or practitioner shall request the client, or other person authorized by statute to consent to mental health services for the client, to sign the client's ITP or revision of the ITP. In the case of a child, the child's parent, primary caregiver, or other person authorized by statute to consent to mental health services for the child shall be asked to sign the child's ITP and revisions of the ITP. If the client or authorized person refuses to sign the plan or a revision of the plan, the mental health professional or mental health practitioner shall note on the plan the refusal to sign the plan and the reason or reasons for the refusal. A client's individual treatment plan must be:

A. based on the client's current diagnostic assessment;

B. developed by identifying the client's service needs and considering relevant cultural influences to identify planned interventions that contain specific treatment goals and measurable objectives for the client; and

C. reviewed at least once every 90 days, and revised as necessary. Revisions to the initial individual treatment plan do not require a new diagnostic assessment unless the client's mental health status has changed markedly as provided in subpart 2.

Subp. 8. **Documentation.** To obtain medical assistance payment for an outpatient mental health service, a mental health professional or a mental health practitioner must promptly document:

A. in the client's mental health record:

(1) each occurrence of service to the client including the date, type of service, start and stop time, scope of the mental health service, name and title of the person who gave the service, and date of documentation; and

(2) all diagnostic assessments and other assessments, psychological test results, treatment plans, and treatment plan reviews;

B. the provider's contact with persons interested in the client such as representatives of the courts, corrections systems, or schools, or the client's other mental health providers, case manager, family, primary caregiver, legal representative, including the name and date of the contact or, if applicable, the reason the client's family, primary caregiver, or legal representative was not contacted; and

C. dates that treatment begins and ends and reason for the discontinuation of the mental health service.

Subp. 9. **Service coordination.** The provider must coordinate client services as authorized by the client as follows:

A. When a recipient receives mental health services from more than one mental health provider, each provider must coordinate mental health services they provide to the client with other mental health service providers to ensure services are provided in the most efficient manner to achieve maximum benefit for the client.

B. The mental health provider must coordinate mental health care with the client's physical health provider.

Subp. 10. **Telemedicine services.** Mental health services in part 9505.0372 covered as direct face-to-face services may be provided via two-way interactive video if it is medically appropriate to the client's condition and needs. The interactive video equipment and connection must comply with Medicare standards that are in effect at the time of service. The commissioner may specify parameters within which mental health services can be provided via telemedicine.

9505.0372 COVERED SERVICES.

Subpart 1. **Diagnostic assessment.** Medical assistance covers four types of diagnostic assessments when they are provided in accordance with the requirements in this subpart.

A. To be eligible for medical assistance payment, a diagnostic assessment must:

(1) identify a mental health diagnosis and recommended mental health services, which are the factual basis to develop the recipient's mental health services and treatment plan; or

(2) include a finding that the client does not meet the criteria for a mental health disorder.

B. A standard diagnostic assessment must include a face-to-face interview with the client and contain a written evaluation of a client by a mental health professional or practitioner working under clinical supervision as a clinical trainee according to part 9505.0371, subpart 5, item C. The standard diagnostic assessment must be done within the cultural context of the client and must include relevant information about:

(1) the client's current life situation, including the client's:

(a) age;

(b) current living situation, including household membership and housing status;

(c) basic needs status including economic status;

(d) education level and employment status;

(e) significant personal relationships, including the client's evaluation of relationship quality;

(f) strengths and resources, including the extent and quality of social networks;

(g) belief systems;

(h) contextual nonpersonal factors contributing to the client's presenting concerns;

(i) general physical health and relationship to client's culture; and

(j) current medications;

(2) the reason for the assessment, including the client's:

(a) perceptions of the client's condition;

(b) description of symptoms, including reason for referral;

(c) history of mental health treatment, including review of the client's records;

(d) important developmental incidents;

(e) maltreatment, trauma, or abuse issues;

(f) history of alcohol and drug usage and treatment;

(g) health history and family health history, including physical, chemical, and mental health history; and

(h) cultural influences and their impact on the client;

(3) the client's mental status examination;

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(4) the assessment of client's needs based on the client's baseline measurements, symptoms, behavior, skills, abilities, resources, vulnerabilities, and safety needs;

(5) the screenings used to determine the client's substance use, abuse, or dependency and other standardized screening instruments determined by the commissioner;

(6) assessment methods and use of standardized assessment tools by the provider as determined and periodically updated by the commissioner;

(7) the client's clinical summary, recommendations, and prioritization of needed mental health, ancillary or other services, client and family participation in assessment and service preferences, and referrals to services required by statute or rule; and

(8) the client data that is adequate to support the findings on all axes of the current edition of the Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association; and any differential diagnosis.

C. An extended diagnostic assessment must include a face-to-face interview with the client and contain a written evaluation of a client by a mental health professional or practitioner working under clinical supervision as a clinical trainee according to part 9505.0371, subpart 5, item C. The face-to-face interview is conducted over three or more assessment appointments because the client's complex needs necessitate significant additional assessment time. Complex needs are those caused by acuity of psychotic disorder; cognitive or neurocognitive impairment; need to consider past diagnoses and determine their current applicability; co-occurring substance abuse use disorder; or disruptive or changing environments, communication barriers, or cultural considerations as documented in the assessment. For child clients, the appointments may be conducted outside the diagnostician's office for face-to-face consultation and information gathering with family members, doctors, caregivers, teachers, and other providers, with or without the child present, and may involve directly observing the child in various settings that the child frequents such as home, school, or care settings. To complete the diagnostic assessment with adult clients, the appointments may be conducted outside of the diagnostician's office for face-to-face assessment with the adult client. The appointment may involve directly observing the adult client in various settings that the adult frequents, such as home, school, job, service settings, or community settings. The appointments may include face-to-face meetings with the adult client and the client's family members, doctors, caregivers, teachers, social support network members, recovery support resource representatives, and other providers for consultation and information gathering for the diagnostic assessment. The components of an extended diagnostic assessment include the following relevant information:

(1) for children under age 5:

(a) utilization of the DC:0-3R diagnostic system for young children;

(b) an early childhood mental status exam that assesses the client's developmental, social, and emotional functioning and style both within the family and with the examiner and includes:

- i. physical appearance including dysmorphic features;
- ii. reaction to new setting and people and adaptation during evaluation;
- iii. self-regulation, including sensory regulation, unusual behaviors, activity level, attention span, and frustration tolerance;
- iv. physical aspects, including motor function, muscle tone, coordination, tics, abnormal movements, and seizure activity;
- v. vocalization and speech production, including expressive and receptive language;

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- vi. thought, including fears, nightmares, dissociative states, and hallucinations;
 - vii. affect and mood, including modes of expression, range, responsiveness, duration, and intensity;
 - viii. play, including structure, content, symbolic functioning, and modulation of aggression;
 - ix. cognitive functioning; and
 - x. relatedness to parents, other caregivers, and examiner; and
- (c) other assessment tools as determined and periodically revised by the commissioner;
- (2) for children ages 5 to 18, completion of other assessment standards for children as determined and periodically revised by the commissioner; and
- (3) for adults, completion of other assessment standards for adults as determined and periodically revised by the commissioner.

D. A brief diagnostic assessment must include a face-to-face interview with the client and a written evaluation of the client by a mental health professional or practitioner working under clinical supervision as a clinical trainee according to part 9505.0371, subpart 5, item C. The professional or practitioner must gather initial background information using the components of a standard diagnostic assessment in item B, subitems (1), (2), unit (b), (3), and (5), and draw a provisional clinical hypothesis. The clinical hypothesis may be used to address the client's immediate needs or presenting problem. Treatment sessions conducted under authorization of a brief assessment may be used to gather additional information necessary to complete a standard diagnostic assessment or an extended diagnostic assessment.

E. Adult diagnostic assessment update includes a face-to-face interview with the client, and contains a written evaluation of the client by a mental health professional or practitioner working under clinical supervision as a clinical trainee according to part 9505.0371, subpart 5, item C, who reviews a standard or extended diagnostic assessment. The adult diagnostic assessment update must update the most recent assessment document in writing in the following areas:

- (1) review of the client's life situation, including an interview with the client about the client's current life situation, and a written update of those parts where significant new or changed information exists, and documentation where there has not been significant change;
- (2) review of the client's presenting problems, including an interview with the client about current presenting problems and a written update of those parts where there is significant new or changed information, and note parts where there has not been significant change;
- (3) screenings for substance use, abuse, or dependency and other screenings as determined by the commissioner;
- (4) the client's mental health status examination;
- (5) assessment of client's needs based on the client's baseline measurements, symptoms, behavior, skills, abilities, resources, vulnerabilities, and safety needs;
- (6) the client's clinical summary, recommendations, and prioritization of needed mental health, ancillary, or other services, client and family participation in assessment and service preferences, and referrals to services required by statute or rule; and
- (7) the client's diagnosis on all axes of the current edition of the Diagnostic and Statistical Manual and any differential diagnosis.

Subp. 2. **Neuropsychological assessment.** A neuropsychological assessment must include a face-to-face interview with the client, the interpretation of the test results, and preparation and completion of a report. A client is eligible for a neuropsychological assessment if at least one of the following criteria is met:

A. There is a known or strongly suspected brain disorder based on medical history or neurological evaluation such as a history of significant head trauma, brain tumor, stroke, seizure disorder, multiple sclerosis, neurodegenerative disorders, significant exposure to neurotoxins, central nervous system infections, metabolic or toxic encephalopathy, fetal alcohol syndrome, or congenital malformations of the brain; or

B. In the absence of a medically verified brain disorder based on medical history or neurological evaluation, there are cognitive or behavioral symptoms that suggest that the client has an organic condition that cannot be readily attributed to functional psychopathology, or suspected neuropsychological impairment in addition to functional psychopathology. Examples include:

- (1) poor memory or impaired problem solving;
- (2) change in mental status evidenced by lethargy, confusion, or disorientation;
- (3) deterioration in level of functioning;
- (4) marked behavioral or personality change;
- (5) in children or adolescents, significant delays in academic skill acquisition or poor attention relative to peers;
- (6) in children or adolescents, significant plateau in expected development of cognitive, social, emotional, or physical function, relative to peers; and
- (7) in children or adolescents, significant inability to develop expected knowledge, skills, or abilities as required to adapt to new or changing cognitive, social, emotional, or physical demands.

C. If neither criterion in item A nor B is fulfilled, neuropsychological evaluation is not indicated.

D. The neuropsychological assessment must be conducted by a neuropsychologist with competence in the area of neuropsychological assessment as stated to the Minnesota Board of Psychology who:

(1) was awarded a diploma by the American Board of Clinical Neuropsychology, the American Board of Professional Neuropsychology, or the American Board of Pediatric Neuropsychology;

(2) earned a doctoral degree in psychology from an accredited university training program:

(a) completed an internship, or its equivalent, in a clinically relevant area of professional psychology;

(b) completed the equivalent of two full-time years of experience and specialized training, at least one which is at the postdoctoral level, in the study and practices of clinical neuropsychology and related neurosciences supervised by a clinical neuropsychologist; and

(c) holds a current license to practice psychology independently in accordance with Minnesota Statutes, sections 148.88 to 148.98;

(3) is licensed or credentialed by another state's board of psychology examiners in the specialty of neuropsychology using requirements equivalent to requirements specified by one of the boards named in subitem (1); or

(4) was approved by the commissioner as an eligible provider of neuropsychological assessment prior to December 31, 2010.

Subp. 3. Neuropsychological testing.

A. Medical assistance covers neuropsychological testing when the client has either:

(1) a significant mental status change that is not a result of a metabolic disorder that has failed to respond to treatment;

(2) in children or adolescents, a significant plateau in expected development of cognitive, social, emotional, or physical function, relative to peers;

(3) in children or adolescents, significant inability to develop expected knowledge, skills, or abilities, as required to adapt to new or changing cognitive, social, physical, or emotional demands; or

(4) a significant behavioral change, memory loss, or suspected neuropsychological impairment in addition to functional psychopathology, or other organic brain injury or one of the following:

(a) traumatic brain injury;

(b) stroke;

(c) brain tumor;

(d) substance abuse or dependence;

(e) cerebral anoxic or hypoxic episode;

(f) central nervous system infection or other infectious disease;

(g) neoplasms or vascular injury of the central nervous system;

(h) neurodegenerative disorders;

(i) demyelinating disease;

(j) extrapyramidal disease;

(k) exposure to systemic or intrathecal agents or cranial radiation known to be associated with cerebral dysfunction;

(l) systemic medical conditions known to be associated with cerebral dysfunction, including renal disease, hepatic encephalopathy, cardiac anomaly, sickle cell disease, and related hematologic anomalies, and autoimmune disorders such as lupus, erythematosis, or celiac disease;

(m) congenital genetic or metabolic disorders known to be associated with cerebral dysfunction, such as phenylketonuria, craniofacial syndromes, or congenital hydrocephalus;

(n) severe or prolonged nutrition or malabsorption syndromes; or

(o) a condition presenting in a manner making it difficult for a clinician to distinguish between:

i. the neurocognitive effects of a neurogenic syndrome such as dementia or encephalopathy; and

ii. a major depressive disorder when adequate treatment for major depressive disorder has not resulted in improvement in neurocognitive function, or another disorder such as autism, selective mutism, anxiety disorder, or reactive attachment disorder.

B. Neuropsychological testing must be administered or clinically supervised by a neuropsychologist qualified as defined in subpart 2, item D.

C. Neuropsychological testing is not covered when performed:

- (1) primarily for educational purposes;
- (2) primarily for vocational counseling or training;
- (3) for personnel or employment testing;
- (4) as a routine battery of psychological tests given at inpatient admission or continued stay; or
- (5) for legal or forensic purposes.

Subp. 4. **Psychological testing.** Psychological testing must meet the following requirements:

A. The psychological testing must:

- (1) be administered or clinically supervised by a licensed psychologist with competence in the area of psychological testing as stated to the Minnesota Board of Psychology; and
- (2) be validated in a face-to-face interview between the client and a licensed psychologist or a mental health practitioner working as a clinical psychology trainee as required by part 9505.0371, subpart 5, item C, under the clinical supervision of a licensed psychologist according to part 9505.0371, subpart 5, item A, subitem (2).

B. The administration, scoring, and interpretation of the psychological tests must be done under the clinical supervision of a licensed psychologist when performed by a technician, psychometrist, or psychological assistant or as part of a computer-assisted psychological testing program.

C. The report resulting from the psychological testing must be:

- (1) signed by the psychologist conducting the face-to-face interview;
- (2) placed in the client's record; and
- (3) released to each person authorized by the client.

Subp. 5. **Explanations of findings.** To be eligible for medical assistance payment, the mental health professional providing the explanation of findings must obtain the authorization of the client or the client's representative to release the information as required in part 9505.0371, subpart 6. Explanation of findings is provided to the client, client's family, and caregivers, or to other providers to help them understand the results of the testing or diagnostic assessment, better understand the client's illness, and provide professional insight needed to carry out a plan of treatment. An explanation of findings is not paid separately when the results of psychological testing or a diagnostic assessment are explained to the client or the client's representative as part of the psychological testing or a diagnostic assessment.

Subp. 6. **Psychotherapy.** Medical assistance covers psychotherapy as conducted by a mental health professional or a mental health practitioner as defined in part 9505.0371, subpart 5, item C, as provided in this subpart.

A. Individual psychotherapy is psychotherapy designed for one client.

B. Family psychotherapy is designed for the client and one or more family members or the client's primary caregiver whose participation is necessary to accomplish the client's treatment goals. Family members or primary caregivers participating in a therapy session do not need to be eligible for medical assistance. For purposes of this subpart, the phrase "whose participation is necessary to accomplish the client's treatment goals" does not include shift or facility staff members at the client's residence. Medical assistance payment for family psychotherapy is limited to face-to-face sessions at which the client is present throughout the family psychotherapy session unless the mental health professional believes

the client's absence from the family psychotherapy session is necessary to carry out the client's individual treatment plan. If the client is excluded, the mental health professional must document the reason for and the length of time of the exclusion. The mental health professional must also document the reason or reasons why a member of the client's family is excluded.

C. Group psychotherapy is appropriate for individuals who because of the nature of their emotional, behavioral, or social dysfunctions can derive mutual benefit from treatment in a group setting. For a group of three to eight persons, one mental health professional or practitioner is required to conduct the group. For a group of nine to 12 persons, a team of at least two mental health professionals or two mental health practitioners or one mental health professional and one mental health practitioner is required to co-conduct the group. Medical assistance payment is limited to a group of no more than 12 persons.

D. A multiple-family group psychotherapy session is eligible for medical assistance payment if the psychotherapy session is designed for at least two but not more than five families. Multiple-family group psychotherapy is clearly directed toward meeting the identified treatment needs of each client as indicated in client's treatment plan. If the client is excluded, the mental health professional or practitioner must document the reason for and the length of the time of the exclusion. The mental health professional or practitioner must document the reasons why a member of the client's family is excluded.

Subp. 7. **Medication management.** The determination or evaluation of the effectiveness of a client's prescribed drug must be carried out by a physician or by an advanced practice registered nurse, as defined in Minnesota Statutes, sections 148.171 to 148.285, who is qualified in psychiatric nursing.

Subp. 8. **Adult day treatment.** Adult day treatment payment limitations include the following conditions.

A. Adult day treatment must consist of at least one hour of group psychotherapy, and must include group time focused on rehabilitative interventions, or other therapeutic services that are provided by a multidisciplinary staff. Adult day treatment is an intensive psychotherapeutic treatment. The services must stabilize the client's mental health status, and develop and improve the client's independent living and socialization skills. The goal of adult day treatment is to reduce or relieve the effects of mental illness so that an individual is able to benefit from a lower level of care and to enable the client to live and function more independently in the community. Day treatment services are not a part of inpatient or residential treatment services.

- B. To be eligible for medical assistance payment, a day treatment program must:
- (1) be reviewed by and approved by the commissioner;
 - (2) be provided to a group of clients by a multidisciplinary staff under the clinical supervision of a mental health professional;
 - (3) be available to the client at least two days a week for at least three consecutive hours per day. The day treatment may be longer than three hours per day, but medical assistance must not reimburse a provider for more than 15 hours per week;
 - (4) include group psychotherapy done by a mental health professional, or mental health practitioner qualified according to part 9505.0371, subpart 5, item C, and rehabilitative interventions done by a mental health professional or mental health practitioner daily;
 - (5) be included in the client's individual treatment plan as necessary and appropriate. The individual treatment plan must include attainable, measurable goals as they relate to services and must be completed before the first day treatment session. The vendor must review the recipient's progress and update the treatment plan at least every 30 days until the client is discharged and include an available discharge plan for the client in the treatment plan; and

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(6) document the interventions provided and the client's response daily.

C. To be eligible for adult day treatment, a recipient must:

(1) be 18 years of age or older;

(2) not be residing in a nursing facility, hospital, institute of mental disease, or regional treatment center, unless the recipient has an active discharge plan that indicates a move to an independent living arrangement within 180 days;

(3) have a diagnosis of mental illness as determined by a diagnostic assessment;

(4) have the capacity to engage in the rehabilitative nature, the structured setting, and the therapeutic parts of psychotherapy and skills activities of a day treatment program and demonstrate measurable improvements in the recipient's functioning related to the recipient's mental illness that would result from participating in the day treatment program;

(5) have at least three areas of functional impairment as determined by a functional assessment with the domains prescribed by Minnesota Statutes, section 245.462, subdivision 11a;

(6) have a level of care determination that supports the need for the level of intensity and duration of a day treatment program; and

(7) be determined to need day treatment by a mental health professional who must deem the day treatment services medically necessary.

D. The following services are not covered by medical assistance if they are provided by a day treatment program:

(1) a service that is primarily recreation-oriented or that is provided in a setting that is not medically supervised. This includes: sports activities, exercise groups, craft hours, leisure time, social hours, meal or snack time, trips to community activities, and tours;

(2) a social or educational service that does not have or cannot reasonably be expected to have a therapeutic outcome related to the client's mental illness;

(3) consultation with other providers or service agency staff about the care or progress of a client;

(4) prevention or education programs provided to the community;

(5) day treatment for recipients with primary diagnoses of alcohol or other drug abuse;

(6) day treatment provided in the client's home;

(7) psychotherapy for more than two hours daily; and

(8) participation in meal preparation and eating that is not part of a clinical treatment plan to address the client's eating disorder.

Subp. 9. **Partial hospitalization.** Partial hospitalization is a covered service when it is an appropriate alternative to inpatient hospitalization for a client who is experiencing an acute episode of mental illness that meets the criteria for an inpatient hospital admission as specified in part 9505.0520, subpart 1, and who has the family and community resources necessary and appropriate to support the client's residence in the community. Partial hospitalization consists of multiple intensive short-term therapeutic services provided by a multidisciplinary staff to treat the client's mental illness.

Subp. 10. **Dialectical behavior therapy (DBT).** Dialectical behavior therapy (DBT) treatment services must meet the following criteria:

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A. DBT must be provided according to this subpart and Minnesota Statutes, section 256B.0625, subdivision 5l.

B. DBT is an outpatient service that is determined to be medically necessary by either: (1) a mental health professional qualified according to part 9505.0371, subpart 5, or (2) a mental health practitioner working as a clinical trainee according to part 9505.0371, subpart 5, item C, who is under the clinical supervision of a mental health professional according to part 9505.0371, subpart 5, item D, with specialized skill in dialectical behavior therapy. The treatment recommendation must be based upon a comprehensive evaluation that includes a diagnostic assessment and functional assessment of the client, and review of the client's prior treatment history. Treatment services must be provided pursuant to the client's individual treatment plan and provided to a client who satisfies the criteria in item C.

C. To be eligible for DBT, a client must:

- (1) be 18 years of age or older;
- (2) have mental health needs that cannot be met with other available community-based services or that must be provided concurrently with other community-based services;
- (3) meet one of the following criteria:
 - (a) have a diagnosis of borderline personality disorder; or
 - (b) have multiple mental health diagnoses and exhibit behaviors characterized by impulsivity, intentional self-harm behavior, and be at significant risk of death, morbidity, disability, or severe dysfunction across multiple life areas;
- (4) understand and be cognitively capable of participating in DBT as an intensive therapy program and be able and willing to follow program policies and rules assuring safety of self and others; and
- (5) be at significant risk of one or more of the following if DBT is not provided:
 - (a) mental health crisis;
 - (b) requiring a more restrictive setting such as hospitalization;
 - (c) decompensation; or
 - (d) engaging in intentional self-harm behavior.

D. The treatment components of DBT are individual therapy and group skills as follows:

- (1) Individual DBT combines individualized rehabilitative and psychotherapeutic interventions to treat suicidal and other dysfunctional behaviors and reinforce the use of adaptive skillful behaviors. The therapist must:
 - (a) identify, prioritize, and sequence behavioral targets;
 - (b) treat behavioral targets;
 - (c) generalize DBT skills to the client's natural environment through telephone coaching outside of the treatment session;
 - (d) measure the client's progress toward DBT targets;
 - (e) help the client manage crisis and life-threatening behaviors; and
 - (f) help the client learn and apply effective behaviors when working with other treatment providers.

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(2) Individual DBT therapy is provided by a mental health professional or a mental health practitioner working as a clinical trainee, according to part 9505.0371, subpart 5, item C, under the supervision of a licensed mental health professional according to part 9505.0371, subpart 5, item D.

(3) Group DBT skills training combines individualized psychotherapeutic and psychiatric rehabilitative interventions conducted in a group format to reduce the client's suicidal and other dysfunctional coping behaviors and restore function by teaching the client adaptive skills in the following areas:

- (a) mindfulness;
- (b) interpersonal effectiveness;
- (c) emotional regulation; and
- (d) distress tolerance.

(4) Group DBT skills training is provided by two mental health professionals, or by a mental health professional cofacilitating with a mental health practitioner.

(5) The need for individual DBT skills training must be determined by a mental health professional or a mental health practitioner working as a clinical trainee, according to part 9505.0371, subpart 5, item C, under the supervision of a licensed mental health professional according to part 9505.0371, subpart 5, item D.

E. A program must be certified by the commissioner as a DBT provider. To qualify for certification, a provider must:

(1) hold current accreditation as a DBT program from a nationally recognized certification body approved by the commissioner or submit to the commissioner's inspection and provide evidence that the DBT program's policies, procedures, and practices will continuously meet the requirements of this subpart;

(2) be enrolled as a MHCP provider;

(3) collect and report client outcomes as specified by the commissioner; and

(4) have a manual that outlines the DBT program's policies, procedures, and practices which meet the requirements of this subpart.

F. The DBT treatment team must consist of persons who are trained in DBT treatment. The DBT treatment team may include persons from more than one agency. Professional and clinical affiliations with the DBT team must be delineated:

(1) A DBT team leader must:

(a) be a mental health professional employed by, affiliated with, or contracted by a DBT program certified by the commissioner;

(b) have appropriate competencies and working knowledge of the DBT principles and practices; and

(c) have knowledge of and ability to apply the principles and DBT practices that are consistent with evidence-based practices.

(2) DBT team members who provide individual DBT or group skills training must:

(a) be a mental health professional or be a mental health practitioner, who is employed by, affiliated with, or contracted with a DBT program certified by the commissioner;

(b) have or obtain appropriate competencies and working knowledge of DBT principles and practices within the first six months of becoming a part of the DBT program;

(c) have or obtain knowledge of and ability to apply the principles and practices of DBT consistently with evidence-based practices within the first six months of working at the DBT program;

(d) participate in DBT consultation team meetings; and

(e) require mental health practitioners to have ongoing clinical supervision by a mental health professional who has appropriate competencies and working knowledge of DBT principles and practices.

Subp. 11. **Noncovered services.** The mental health services in items A to J are not eligible for medical assistance payment under this part:

A. a mental health service that is not medically necessary;

B. a neuropsychological assessment carried out by a person other than a neuropsychologist who is qualified according to part 9505.0372, subpart 2, item D;

C. a service ordered by a court that is solely for legal purposes and not related to the recipient's diagnosis or treatment for mental illness;

D. services dealing with external, social, or environmental factors that do not directly address the recipient's physical or mental health;

E. a service that is only for a vocational purpose or an educational purpose that is not mental health related;

F. staff training that is not related to a client's individual treatment plan or plan of care;

G. child and adult protection services;

H. fund-raising activities;

I. community planning; and

J. client transportation.

9520.0010 STATUTORY AUTHORITY AND PURPOSE.

Parts 9520.0010 to 9520.0230 provide methods and procedures relating to the establishment and operation of area-wide, comprehensive, community-based mental health, developmental disability, and chemical dependency programs under state grant-in-aid as provided under Minnesota Statutes, sections 245.61 to 245.69. Minnesota Statutes, sections 245.61 to 245.69 are entitled The Community Mental Health Services Act. For purposes of these parts, "community mental health services" includes services to persons who have mental or emotional disorders or other psychiatric disabilities, developmental disabilities, and chemical dependency, including drug abuse and alcoholism.

9520.0020 BOARD DUTIES.

The community mental health board has the responsibility for ensuring the planning, development, implementation, coordination, and evaluation of the community comprehensive mental health program for the mentally ill/behaviorally disabled, developmentally disabled, and chemically dependent populations in the geographic area it serves. It also has the responsibility for ensuring delivery of services designated by statute.

9520.0030 DEFINITIONS.

Parts 9520.0040 and 9520.0050 also set forth definitions of community mental health centers and community mental health clinics.

9520.0040 COMMUNITY MENTAL HEALTH CENTER.

A community mental health center means an agency which includes all of the following:

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A. Established under the provision of Minnesota Statutes, sections 245.61 to 245.69.

B. Provides as a minimum the following services for individuals with mental or emotional disorders, developmental disabilities, alcoholism, drug abuse, and other psychiatric conditions. The extent of each service to be provided by the center shall be indicated in the program plan, which is to reflect the problems, needs, and resources of the community served:

(1) collaborative and cooperative services with public health and other groups for programs of prevention of mental illness, developmental disability, alcoholism, drug abuse, and other psychiatric disorders;

(2) informational and educational services to schools, courts, health and welfare agencies, both public and private;

(3) informational and educational services to the general public, lay, and professional groups;

(4) consultative services to schools, courts, and health and welfare agencies, both public and private;

(5) outpatient diagnostic and treatment services; and

(6) rehabilitative services, particularly for those who have received prior treatment in an inpatient facility.

C. Provides or contracts for detoxification, evaluation, and referral for chemical dependency services (Minnesota Statutes, section 254A.08).

D. Provides specific coordination for mentally ill/behaviorally disabled, developmental disability, and chemical dependency programs. (Minnesota Statutes, sections 254A.07 and 245.61).

E. Has a competent multidisciplinary mental health/developmental disability/chemical dependency professional team whose members meet the professional standards in their respective fields.

F. The professional mental health team is qualified by specific mental health training and experience and shall include as a minimum the services of each of the following:

(1) a licensed physician, who has completed an approved residency program in psychiatry; and

(2) a doctoral clinical, counseling, or health care psychologist, who is licensed under Minnesota Statutes, sections 148.88 to 148.98; and one or both of the following:

(3) a clinical social worker with a master's degree in social work from an accredited college or university; and/or

(4) a clinical psychiatric nurse with a master's degree from an accredited college or university and is registered under Minnesota Statutes, section 148.171. The master's degree shall be in psychiatric nursing or a related psychiatric nursing program such as public health nursing with mental health major, maternal and child health with mental health major, etc.

G. The multidisciplinary staff shall be sufficient in number to implement and operate the described program of the center. In addition to the above, this team should include other professionals, paraprofessionals, and disciplines, particularly in the preventive and rehabilitative components of the program, subject to review and approval of job descriptions and qualifications by the commissioner. If any of the minimum required professional staff are not immediately available, the commissioner may approve and make grants for the operation of the center, provided that the board and director can show evidence acceptable to the commissioner that they are making sincere, reasonable, and ongoing efforts

to acquire such staff and show evidence of how the specialized functions of the required professionals are being met. The services being rendered by employed personnel shall be consistent with their professional discipline.

9520.0050 COMMUNITY MENTAL HEALTH CLINIC.

Subpart 1. **Definitions.** A community mental health clinic is an agency which devotes, as its major service, at least two-thirds of its resources for outpatient mental health diagnosis, treatment, and consultation by a multidisciplinary professional mental health team. The multidisciplinary professional mental health team is qualified by special mental health training and experience and shall include as a minimum the services of each of the following:

A. a licensed physician, who has completed an approved residency program in psychiatry; and

B. a doctoral clinical, or counseling or health care psychologist who is licensed under Minnesota Statutes, sections 148.88 to 148.98; and one or both of the following:

C. a clinical social worker with a master's degree in social work from an accredited college or university; and/or

D. a clinical psychiatric nurse with a master's degree from an accredited college or university and is registered under Minnesota Statutes, section 148.171. The master's degree shall be in psychiatric nursing or a related psychiatric nursing program such as public health with a mental health major, maternal and child health with a mental health major.

Subp. 2. **Other members of multidisciplinary team.** The multidisciplinary team shall be sufficient in number to implement and operate the described program of the clinic. In addition to the above, this team should include other professionals, paraprofessionals and disciplines, particularly in the preventive and rehabilitative components of the program, subject to review and approval of job descriptions and qualifications by the commissioner.

Subp. 3. **Efforts to acquire staff.** If any of the minimum required professional staff are not immediately available, the commissioner may approve and make grants for the operation of the clinic, provided that the board and director can show evidence acceptable to the commissioner that they are making sincere, reasonable, and ongoing efforts to acquire such staff and evidence of how the specialized functions of the required professional positions are being met. The services being rendered by employed personnel shall be consistent with their professional discipline.

9520.0060 ANNUAL PLAN AND BUDGET.

On or before the date designated by the commissioner, each year the chair of the community mental health board or director of the community mental health program, provided for in Minnesota Statutes, section 245.62, shall submit an annual plan identifying program priorities in accordance with state grant-in-aid guidelines, and a budget on prescribed report forms for the next state fiscal year, together with the recommendations of the community mental health board, to the commissioner of human services for approval as provided under Minnesota Statutes, section 245.63.

9520.0070 FISCAL AFFILIATES.

Other providers of community mental health services may affiliate with the community mental health center and may be approved and eligible for state grant-in-aid funds. The state funding for other community mental health services shall be contingent upon appropriate inclusion in the center's community mental health plan for the continuum of community mental health services and conformity with the state's appropriate disability plan for mental health, developmental disability, or chemical dependency. Fiscal affiliates (funded contracting agencies) providing specialized services under contract must meet all rules and standards that apply to the services they are providing.

9520.0080 OTHER REQUIRED REPORTS.

The program director of the community mental health program shall provide the commissioner of human services with such reports of program activities as the commissioner may require.

9520.0090 FUNDING.

All state community mental health funding shall go directly to the community mental health board or to a human service board established pursuant to Laws of Minnesota 1975, chapter 402, which itself provides or contracts with another agency to provide the community mental health program. Such programs must meet the standards and rules for community mental health programs as enunciated in parts 9520.0010 to 9520.0230 in accordance with Laws of Minnesota 1975, chapter 402.

9520.0100 OPERATION OF OTHER PROGRAMS.

When the governing authority of the community mental health program operates other programs, services, or activities, only the community mental health center program shall be subject to these parts.

9520.0110 APPLICATIONS AND AGREEMENTS BY LOCAL COUNTIES.

New applications for state assistance or applications for renewal of support must be accompanied by an agreement executed by designated signatories on behalf of the participating counties that specifies the involved counties, the amount and source of local funds in each case, and the period of support. The local funds to be used to match state grant-in-aid must be assured in writing on Department of Human Services forms by the local funding authority(ies).

9520.0120 USE OF MATCHING FUNDS.

Funds utilized by the director as authorized by the community mental health board to match a state grant-in-aid must be available to that director for expenditures for the same general purpose as the state grant-in-aid funds.

9520.0130 QUARTERLY REPORTS.

The director of the community mental health program shall, within 20 days after the end of the quarter, submit quarterly prescribed reports to the commissioner of human services (controller's office), containing all receipts, expenditures, and cash balance, subject to an annual audit by the commissioner or his/her designee.

9520.0140 PAYMENTS.

Payments on approved grants will be made subsequent to the department's receipt of the program's quarterly reporting forms, unless the commissioner of human services has determined that funds allocated to a program are not needed for that program. Payments shall be in an amount of at least equal to the quarterly allocation minus any unexpended balance from the previous quarter providing this payment does not exceed the program grant award. In the event the program does not report within the prescribed time, the department will withhold the process of the program's payment until the next quarterly cycle.

9520.0150 FEES.

No fees shall be charged until the director with approval of the community mental health board has established fee schedules for the services rendered and they have been submitted to the commissioner of human services at least two months prior to the effective date thereof and have been approved by him/her. All fees shall conform to the approved schedules, which are accessible to the public.

9520.0160 SUPPLEMENTAL AWARDS.

The commissioner of human services may make supplemental awards to the community mental health boards.

9520.0170 WITHDRAWAL OF FUNDS.

The commissioner of human services may withdraw funds from any program that is not administered in accordance with its approved plan and budget. Written notice of such intended action will be provided to the director and community mental health board. Opportunity for hearing before the commissioner or his/her designee shall be provided.

9520.0180 BUDGET TRANSFERS.

Community mental health boards may make budget transfers within specified limits during any fiscal year without prior approval of the department. The specified limit which can be transferred in any fiscal year between program activity budgets shall be up to ten percent or up to \$5,000 whichever is less. Transfers within an activity can be made into or out of line items with a specified limit of up to ten percent or up to \$5,000 whichever is less. No line item can be increased or decreased by more than \$5,000 or ten percent in a fiscal year without prior approval of the commissioner. Transfers above the specified limits can be made with prior approval from the commissioner. All transfers within and into program budget activities and/or line items must have prior approval by the community mental health board and this approval must be reflected in the minutes of its meeting, it must be reported to the commissioner with the reasons therefor, including a statement of how the transfer will affect program objectives.

9520.0190 BUDGET ADJUSTMENTS.

Budget adjustments made necessary by funding limitations shall be made by the commissioner and provided in writing to the director and board of the community mental health center.

9520.0200 CENTER DIRECTOR.

Every community mental health board receiving state funds for a community mental health program shall have a center director, who is the full-time qualified professional staff member who serves as the executive officer. To be considered qualified, the individual must have professional training to at least the level of graduate degree in his/her clinical and/or administrative discipline, which is relevant to MH-DD-CD and a minimum of two years experience in community mental health programs. The center director is responsible for the planning/design, development, coordination, and evaluation of a comprehensive, area-wide program and for the overall administration of services operated by the board.

The center director shall be appointed by the community mental health board and shall be approved by the commissioner of human services.

9520.0210 DEADLINE FOR APPROVAL OR DENIAL OF REQUEST FOR APPROVAL STATUS.

The commissioner shall approve or deny, in whole or in part, an application for state financial assistance within 90 days of receipt of the grant-in-aid application or by the beginning of the state fiscal year, whichever is the later.

9520.0230 ADVISORY COMMITTEE.

Subpart 1. **Purpose.** To assist the community mental health board in meeting its responsibilities as described in Minnesota Statutes, section 245.68 and to provide opportunity for broad community representation necessary for effective comprehensive mental health, developmental disability, and chemical dependency program planning, each community

mental health board shall appoint a separate advisory committee in at least the three disability areas of mental health, developmental disability, and chemical dependency.

Subp. 2. **Membership.** The advisory committees shall consist of residents of the geographic area served who are interested and knowledgeable in the area governed by such committee.

Subp. 3. **Nominations for membership.** Nominations for appointments as members of the advisory committees are to be made to the community mental health board from agencies, organizations, groups, and individuals within the area served by the community mental health center. Appointments to the advisory committees are made by the community mental health board.

Subp. 4. **Board member on committee.** One community mental health board member shall serve on each advisory committee.

Subp. 5. **Nonprovider members.** Each advisory committee shall have at least one-half of its membership composed of individuals who are not providers of services to the three disability groups.

Subp. 6. **Representative membership.** Membership of each advisory committee shall generally reflect the population distribution of the service delivery area of the community mental health center.

Subp. 7. **Chairperson appointed.** The community mental health board shall appoint a chairperson for each advisory committee. The chairperson shall not be a community mental health board member nor a staff member. The power to appoint the chairperson may be delegated by the community mental health board to the individual advisory committee.

Subp. 8. **Committee responsibility to board.** Each advisory committee shall be directly responsible to the community mental health board. Direct communication shall be effected and maintained through contact between the chairperson of the particular advisory committee, or his/her designee, and the chairperson of the community mental health board, or his/her designee.

Subp. 9. **Staff.** Staff shall be assigned by the director to serve the staffing needs of each advisory committee.

Subp. 10. **Study groups and task forces.** Each advisory committee may appoint study groups and task forces upon consultation with the community mental health board. It is strongly recommended that specific attention be given to the aging and children and youth populations.

Subp. 11. **Quarterly meetings required.** Each advisory committee shall meet at least quarterly.

Subp. 12. **Annual report required.** Each advisory committee must make a formal written and oral report on its work to the community mental health board at least annually.

Subp. 13. **Minutes.** Each advisory committee shall submit copies of minutes of their meetings to the community mental health board and to the Department of Human Services (respective disability group program divisions).

Subp. 14. **Duties of advisory committee.** The advisory committees shall be charged by the community mental health board with assisting in the identification of the community's needs for mentally ill/behaviorally disabled, developmental disability, and chemical dependency programs. The advisory committee also assists the community mental health board in determining priorities for the community programs. Based on the priorities, each advisory committee shall recommend to the community mental health board ways in which the limited available community resources (work force, facilities, and finances) can be put to maximum and optimal use.

Subp. 15. **Recommendations.** The advisory committee recommendations made to the community mental health board shall be included as a separate section in the grant-in-aid request submitted to the Department of Human Services by the community mental health board.

Subp. 16. **Assessment of programs.** The advisory committees shall assist the community mental health board in assessing the programs carried on by the community mental health board, and make recommendations regarding the reordering of priorities and modifying of programs where necessary.

9520.0750 PURPOSE.

Parts 9520.0750 to 9520.0870 establish standards for approval of mental health centers and mental health clinics for purposes of insurance and subscriber contract reimbursement under Minnesota Statutes, section 62A.152.

9520.0760 DEFINITIONS.

Subpart 1. **Scope.** As used in parts 9520.0760 to 9520.0870, the following terms have the meanings given them.

Subp. 2. **Application.** "Application" means the formal statement by a center to the commissioner, on the forms created for this purpose, requesting recognition as meeting the requirements of Minnesota Statutes, section 245.69, subdivision 2, and parts 9520.0760 to 9520.0870.

Subp. 3. **Approval.** "Approval" means the determination by the commissioner that the applicant center has met the minimum standards of Minnesota Statutes, section 245.69, subdivision 2, and parts 9520.0760 to 9520.0870, and is therefore eligible to claim reimbursement for outpatient clinical services under the terms of Minnesota Statutes, section 62A.152. Approval of a center under these parts does not mean approval of a multidisciplinary staff person of such center to claim reimbursement from medical assistance or other third-party payors when practicing privately. Approval of a center under these parts does not mean approval of such center to claim reimbursement from medical assistance.

Subp. 4. **Case review.** "Case review" means a consultation process thoroughly examining a client's condition and treatment. It includes review of the client's reason for seeking treatment, diagnosis and assessment, and the individual treatment plan; review of the appropriateness, duration, and outcome of treatment provided; and treatment recommendations.

Subp. 5. **Center.** "Center" means a public or private health and human services facility which provides clinical services in the treatment of mental illness. It is an abbreviated term used in place of "mental health center" or "mental health clinic" throughout parts 9520.0750 to 9520.0870.

Subp. 6. **Client.** "Client" means a person accepted by the center to receive clinical services in the diagnosis and treatment of mental illness.

Subp. 7. **Clinical services.** "Clinical services" means services provided to a client to diagnose, describe, predict, and explain that client's status relative to a disabling condition or problem, and where necessary, to treat the client to reduce impairment due to that condition. Clinical services also include individual treatment planning, case review, record keeping required for treatment, peer review, and supervision.

Subp. 8. **Commissioner.** "Commissioner" means the commissioner of the Minnesota Department of Human Services or a designated representative.

Subp. 9. **Competent.** "Competent" means having sufficient knowledge of and proficiency in a specific mental illness assessment or treatment service, technique, method, or procedure, documented by experience, education, training, and certification, to be able to provide it to a client with little or no supervision.

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Subp. 10. **Consultation.** "Consultation" means the process of deliberating or conferring between multidisciplinary staff regarding a client and the client's treatment.

Subp. 11. **Deferral.** "Deferral" means the determination by the commissioner that the applicant center does not meet the minimum standards of Minnesota Statutes, section 245.69, subdivision 2, and parts 9520.0760 to 9520.0870 and is not approved, but is granted a period of time to comply with these standards and receive a second review without reapplication.

Subp. 12. **Department.** "Department" means the Minnesota Department of Human Services.

Subp. 13. **Disapproval or withdrawal of approval.** "Disapproval" or "withdrawal of approval" means a determination by the commissioner that the applicant center does not meet the minimum standards of Minnesota Statutes, section 245.69, subdivision 2, and parts 9520.0760 to 9520.0870.

Subp. 14. **Discipline.** "Discipline" means a branch of professional knowledge or skill acquired through a specific course of study and training and usually documented by a specific educational degree or certification of proficiency. Examples of the mental health disciplines include but are not limited to psychiatry, psychology, clinical social work, and psychiatric nursing.

Subp. 15. **Documentation.** "Documentation" means the automatically or manually produced and maintained evidence that can be read by person or machine, and that will attest to the compliance with requirements of Minnesota Statutes, section 245.69, subdivision 2, and parts 9520.0760 to 9520.0870.

Subp. 16. **Individual treatment plan.** "Individual treatment plan" means a written plan of intervention and treatment developed on the basis of assessment results for a specific client, and updated as necessary. The plan specifies the goals and objectives in measurable terms, states the treatment strategy, and identifies responsibilities of multidisciplinary staff.

Subp. 17. **Mental health practitioner.** "Mental health practitioner" means a staff person providing clinical services in the treatment of mental illness who is qualified in at least one of the following ways:

A. by having a bachelor's degree in one of the behavioral sciences or related fields from an accredited college or university and 2,000 hours of supervised experience in the delivery of clinical services in the treatment of mental illness;

B. by having 6,000 hours of supervised experience in the delivery of clinical services in the treatment of mental illness;

C. by being a graduate student in one of the behavioral sciences or related fields formally assigned to the center for clinical training by an accredited college or university; or

D. by having a master's or other graduate degree in one of the behavioral sciences or related fields from an accredited college or university.

Documentation of compliance with part 9520.0800, subpart 4, item B is required for designation of work as supervised experience in the delivery of clinical services. Documentation of the accreditation of a college or university shall be a listing in Accredited Institutions of Postsecondary Education Programs, Candidates for the year the degree was issued. The master's degree in behavioral sciences or related fields shall include a minimum of 28 semester hours of graduate course credit in mental health theory and supervised clinical training, as documented by an official transcript.

Subp. 18. **Mental health professional.** "Mental health professional" has the meaning given in Minnesota Statutes, section 245.462, subdivision 18.

Subp. 19. **Mental illness.** "Mental illness" means a condition which results in an inability to interpret the environment realistically and in impaired functioning in primary

aspects of daily living such as personal relations, living arrangements, work, and recreation, and which is listed in the clinical manual of the International Classification of Diseases (ICD-9-CM), Ninth Revision (1980), code range 290.0-302.99 or 306.0-316, or the corresponding code in the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM-III), Third Edition (1980), Axes I, II or III. These publications are available from the State Law Library.

Subp. 20. **Multidisciplinary staff.** "Multidisciplinary staff" means the mental health professionals and mental health practitioners employed by or under contract to the center to provide outpatient clinical services in the treatment of mental illness.

Subp. 21. **Serious violations of policies and procedures.** "Serious violations of policies and procedures" means a violation which threatens the health, safety, or rights of clients or center staff; the repeated nonadherence to center policies and procedures; and the nonadherence to center policies and procedures which result in noncompliance with Minnesota Statutes, section 245.69, subdivision 2 and parts 9520.0760 to 9520.0870.

Subp. 22. **Treatment strategy.** "Treatment strategy" means the particular form of service delivery or intervention which specifically addresses the client's characteristics and mental illness, and describes the process for achievement of individual treatment plan goals.

9520.0770 ORGANIZATIONAL STRUCTURE OF CENTER.

Subpart 1. **Basic unit.** The center or the facility of which it is a unit shall be legally constituted as a partnership, corporation, or government agency. The center shall be either the entire facility or a clearly identified unit within the facility which is administratively and clinically separate from the rest of the facility. All business shall be conducted in the name of the center or facility, except medical assistance billing by individually enrolled providers when the center is not enrolled.

Subp. 2. **Purpose, services.** The center shall document that the prevention, diagnosis, and treatment of mental illness are the main purposes of the center. If the center is a unit within a facility, the rest of the facility shall not provide clinical services in the outpatient treatment of mental illness. The facility may provide services other than clinical services in the treatment of mental illness, including medical services, chemical dependency services, social services, training, and education. The provision of these additional services is not reviewed in granting approval to the center under parts 9520.0760 to 9520.0870.

Subp. 3. **Governing body.** The center shall have a governing body. The governing body shall provide written documentation of its source of authority. The governing body shall be legally responsible for the implementation of the standards set forth in Minnesota Statutes, section 245.69, subdivision 2, and parts 9520.0760 to 9520.0870 through the establishment of written policy and procedures.

Subp. 4. **Chart or statement of organization.** The center shall have an organizational chart or statement which specifies the relationships among the governing body, any administrative and support staff, mental health professional staff, and mental health practitioner staff; their respective areas of responsibility; the lines of authority involved; the formal liaison between administrative and clinical staff; and the relationship of the center to the rest of the facility and any additional services provided.

9520.0780 SECONDARY LOCATIONS.

Subpart 1. **Main and satellite offices.** The center shall notify the commissioner of all center locations. If there is more than one center location, the center shall designate one as the main office and all secondary locations as satellite offices. The main office as a unit and the center as a whole shall be in compliance with part 9520.0810. The main office shall function as the center records and documentation storage area and house most administrative functions for the center. Each satellite office shall:

- A. be included as a part of the legally constituted entity;

- B. adhere to the same clinical and administrative policies and procedures as the main office;
- C. operate under the authority of the center's governing body;
- D. store all center records and the client records of terminated clients at the main office;
- E. ensure that a mental health professional is at the satellite office and competent to supervise and intervene in the clinical services provided there, whenever the satellite office is open;
- F. ensure that its multidisciplinary staff have access to and interact with main center staff for consultation, supervision, and peer review; and
- G. ensure that clients have access to all clinical services provided in the treatment of mental illness and the multidisciplinary staff of the center.

Subp. 2. **Noncompliance.** If the commissioner determines that a secondary location is not in compliance with subpart 1, it is not a satellite office. Outpatient clinical services in the treatment of mental illness delivered by the center or facility of which it is a unit shall cease at that location, or the application shall be disapproved.

9520.0790 MINIMUM TREATMENT STANDARDS.

Subpart 1. **Multidisciplinary approach.** The center shall document that services are provided in a multidisciplinary manner. That documentation shall include evidence that staff interact in providing clinical services, that the services provided to a client involve all needed disciplines represented on the center staff, and that staff participate in case review and consultation procedures as described in subpart 6.

Subp. 2. **Intake and case assignment.** The center shall establish an intake or admission procedure which outlines the intake process, including the determination of the appropriateness of accepting a person as a client by reviewing the client's condition and need for treatment, the clinical services offered by the center, and other available resources. The center shall document that case assignment for assessment, diagnosis, and treatment is made to a multidisciplinary staff person who is competent in the service, in the recommended treatment strategy and in treating the individual client characteristics. Responsibility for each case shall remain with a mental health professional.

Subp. 3. **Assessment and diagnostic process.** The center shall establish an assessment and diagnostic process that determines the client's condition and need for clinical services. The assessment of each client shall include clinical consideration of the client's general physical, medical, developmental, family, social, psychiatric, and psychological history and current condition. The diagnostic statement shall include the diagnosis based on the codes in the International Classification of Diseases or the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders and refer to the pertinent assessment data. The diagnosis shall be by or under the supervision of and signed by a psychiatrist or licensed psychologist. The diagnostic assessment, as defined by Minnesota Statutes, sections 245.462, subdivision 9, for adults, and 245.4871, subdivision 11, for children, must be provided by a licensed mental health professional in accordance with Minnesota Statutes, section 245.467, subdivision 2.

Subp. 4. **Treatment planning.** The individual treatment plan, based upon a diagnostic assessment of mental illness, shall be jointly developed by the client and the mental health professional. This planning procedure shall ensure that the client has been informed in the following areas: assessment of the client condition; treatment alternatives; possible outcomes and side effects of treatment; treatment recommendations; approximate length, cost, and hoped-for outcome of treatment; the client's rights and responsibilities in implementation of the individual treatment plan; staff rights and responsibilities in the treatment process; the Government Data Practices Act; and procedures for reporting grievances and alleged violation of client rights. If the client is considering chemotherapy, hospitalization, or other

medical treatment, the appropriate medical staff person shall inform the client of the treatment alternatives, the effects of the medical procedures, and possible side effects. Clinical services shall be appropriate to the condition, age, sex, socioeconomic, and ethnic background of the client, and provided in the least restrictive manner. Clinical services shall be provided according to the individual treatment plan and existing professional codes of ethics.

Subp. 5. **Client record.** The center shall maintain a client record for each client. The record must document the assessment process, the development and updating of the treatment plan, the treatment provided and observed client behaviors and response to treatment, and serve as data for the review and evaluation of the treatment provided to a client. The record shall include:

- A. a statement of the client's reason for seeking treatment;
- B. a record of the assessment process and assessment data;
- C. the initial diagnosis based upon the assessment data;
- D. the individual treatment plan;
- E. a record of all medication prescribed or administered by multidisciplinary staff;
- F. documentation of services received by the client, including consultation and progress notes;
- G. when necessary, the client's authorization to release private information, and client information obtained from outside sources;
- H. at the closing of the case, a statement of the reason for termination, current client condition, and the treatment outcome; and
- I. correspondence and other necessary information.

Subp. 6. **Consultation; case review.** The center shall establish standards for case review and encourage the ongoing consultation among multidisciplinary staff. The multidisciplinary staff shall attend staff meetings at least twice monthly for a minimum of four hours per month, or a minimum of two hours per month if the multidisciplinary staff person provides clinical services in the treatment of mental illness less than 15 hours per week. The purpose of these meetings shall be case review and consultation. Written minutes of the meeting shall be maintained at the center for at least three years after the meeting.

Subp. 7. **Referrals.** If the necessary treatment or the treatment desired by the client is not available at the center, the center shall facilitate appropriate referrals. The multidisciplinary staff person shall discuss with the client the reason for the referral, potential treatment resources, and what the process will involve. The staff person shall assist in the process to ensure continuity of the planned treatment.

Subp. 8. **Emergency service.** The center shall ensure that clinical services to treat mental illness are available to clients on an emergency basis.

Subp. 9. **Access to hospital.** The center shall document that it has access to hospital admission for psychiatric inpatient care, and shall provide that access when needed by a client. This requirement for access does not require direct hospital admission privileges on the part of qualified multidisciplinary staff.

9520.0800 MINIMUM QUALITY ASSURANCE STANDARDS.

Subpart 1. **Policies and procedures.** The center shall develop written policies and procedures and shall document the implementation of these policies and procedures for each treatment standard and each quality assurance standard in subparts 2 to 7. The policies shall be approved by the governing body. The procedures shall indicate what actions or accomplishments are to be performed, who is responsible for each action, and any documentation or required forms. Multidisciplinary staff shall have access to a copy of the policies and procedures at all times.

Subp. 2. **Peer review.** The center shall have a multidisciplinary peer review system to assess the manner in which multidisciplinary staff provide clinical services in the treatment of mental illness. Peer review shall include the examination of clinical services to determine if the treatment provided was effective, necessary, and sufficient and of client records to determine if the recorded information is necessary and sufficient. The system shall ensure review of a randomly selected sample of five percent or six cases, whichever is less, of the annual caseload of each mental health professional by other mental health professional staff. Peer review findings shall be discussed with staff involved in the case and followed up by any necessary corrective action. Peer review records shall be maintained at the center.

Subp. 3. **Internal utilization review.** The center shall have a system of internal utilization review to examine the quality and efficiency of resource usage and clinical service delivery. The center shall develop and carry out a review procedure consistent with its size and organization which includes collection or review of information, analysis or interpretation of information, and application of findings to center operations. The review procedure shall minimally include, within any three year period of time, review of the appropriateness of intake, the provision of certain patterns of services, and the duration of treatment. Criteria may be established for treatment length and the provision of services for certain client conditions. Utilization review records shall be maintained, with an annual report to the governing body for applicability of findings to center operations.

Subp. 4. **Staff supervision.** Staff supervision:

A. The center shall have a clinical evaluation and supervision procedure which identifies each multidisciplinary staff person's areas of competence and documents that each multidisciplinary staff person receives the guidance and support needed to provide clinical services for the treatment of mental illness in the areas they are permitted to practice.

B. A mental health professional shall be responsible for the supervision of the mental health practitioner, including approval of the individual treatment plan and bimonthly case review of every client receiving clinical services from the practitioner. This supervision shall include a minimum of one hour of face-to-face, client-specific supervisory contact for each 40 hours of clinical services in the treatment of mental illness provided by the practitioner.

Subp. 5. **Continuing education.** The center shall require that each multidisciplinary staff person attend a minimum of 36 clock hours every two years of academic or practical course work and training. This education shall augment job-related knowledge, understanding, and skills to update or enhance staff competencies in the delivery of clinical services to treat mental illness. Continued licensure as a mental health professional may be substituted for the continuing education requirement of this subpart.

Subp. 6. **Violations of standards.** The center shall have procedures for the reporting and investigating of alleged unethical, illegal, or grossly negligent acts, and of the serious violation of written policies and procedures. The center shall document that the reported behaviors have been reviewed and that responsible disciplinary or corrective action has been taken if the behavior was substantiated. The procedures shall address both client and staff reporting of complaints or grievances regarding center procedures, staff, and services. Clients and staff shall be informed they may file the complaint with the department if it was not resolved to mutual satisfaction. The center shall have procedures for the reporting of suspected abuse or neglect of clients, in accordance with Minnesota Statutes, sections 611A.32, subdivision 5; 626.556; and 626.557.

Subp. 7. **Data classification.** Client information compiled by the center, including client records and minutes of case review and consultation meetings, shall be protected as private data under the Minnesota Government Data Practices Act.

9520.0810 MINIMUM STAFFING STANDARDS.

Subpart 1. **Required staff.** Required staff:

A. The multidisciplinary staff of a center shall consist of at least four mental health professionals. At least two of the mental health professionals shall each be employed or under contract for a minimum of 35 hours a week by the center. Those two mental health professionals shall be of different disciplines.

B. The mental health professional staff shall include a psychiatrist and a licensed psychologist.

C. The mental health professional employed or under contract to the center to meet the requirement of item B shall be at the main office of the center and providing clinical services in the treatment of mental illness at least eight hours every two weeks.

Subp. 2. **Additional staff; staffing balance.** Additional mental health professional staff may be employed by or under contract to the center provided that no single mental health discipline or combination of allied fields shall comprise more than 60 percent of the full-time equivalent mental health professional staff. This provision does not apply to a center with fewer than six full-time equivalent mental health professional staff. Mental health practitioners may also be employed by or under contract to a center to provide clinical services for the treatment of mental illness in their documented area of competence. Mental health practitioners shall not comprise more than 25 percent of the full-time equivalent multidisciplinary staff. In determination of full-time equivalence, only time spent in clinical services for the treatment of mental illness shall be considered.

Subp. 3. **Multidisciplinary staff records.** The center shall maintain records sufficient to document that the center has determined and verified the clinical service qualifications of each multidisciplinary staff person, and sufficient to document each multidisciplinary staff person's terms of employment.

Subp. 4. **Credentialed occupations.** The center shall adhere to the qualifications and standards specified by rule for any human service occupation credentialed under Minnesota Statutes, section 214.13 and employed by or under contract to the center.

9520.0820 APPLICATION PROCEDURES.

Subpart 1. **Form.** A facility seeking approval as a center for insurance reimbursement of its outpatient clinical services in treatment of mental illness must make formal application to the commissioner for such approval. The application form for this purpose may be obtained from the Mental Illness Program Division of the department. The application form shall require only information which is required by statute or rule, and shall require the applicant center to explain and provide documentation of compliance with the minimum standards in Minnesota Statutes, section 245.69, subdivision 2, and parts 9520.0760 to 9520.0870.

Subp. 2. **Fee.** Each application shall be accompanied by payment of the nonrefundable application fee. The fee shall be established and adjusted in accordance with Minnesota Statutes, section 16A.128 to cover the costs to the department in implementing Minnesota Statutes, section 245.69, subdivision 2, and parts 9520.0760 to 9520.0870.

Subp. 3. **Completed application.** The application is considered complete on the date the application fee and all information required in the application form are received by the department.

Subp. 4. **Coordinator.** The center shall designate in the application a mental health professional as the coordinator for issues surrounding compliance with parts 9520.0760 to 9520.0870.

9520.0830 REVIEW OF APPLICANT CENTERS.

Subpart 1. **Site visit.** The formal review shall begin after the completed application has been received, and shall include an examination of the written application and a visit to the center. The applicant center shall be offered a choice of site visit dates, with at least one date falling within 60 days of the date on which the department receives the complete application. The site visit shall include interviews with multidisciplinary staff and examination

of a random sample of client records, consultation minutes, quality assurance reports, and multidisciplinary staff records.

Subp. 2. **Documentation.** If implementation of a procedure is too recent to be reliably documented, a written statement of the planned implementation shall be accepted as documentation on the initial application. The evidence of licensure or accreditation through another regulating body shall be accepted as documentation of a specific procedure when the required minimum standard of that body is the same or higher than a specific provision of parts 9520.0760 to 9520.0870.

9520.0840 DECISION ON APPLICATION.

Subpart 1. **Written report.** Upon completion of the site visit, a report shall be written. The report shall include a statement of findings, a recommendation to approve, defer, or disapprove the application, and the reasons for the recommendation.

Subp. 2. **Written notice to center.** The applicant center shall be sent written notice of approval, deferral, or disapproval within 30 days of the completion of the site visit. If the decision is a deferral or a disapproval, the notice shall indicate the specific areas of noncompliance.

Subp. 3. **Noncompliance with statutes and rules.** An application shall be disapproved or deferred if it is the initial application of a center, when the applicant center is not in compliance with Minnesota Statutes, section 245.69, subdivision 2, and parts 9520.0760 to 9520.0870.

Subp. 4. **Deferral of application.** If an application is deferred, the length of deferral shall not exceed 180 days. If the areas of noncompliance stated in the deferral notice are not satisfactorily corrected by the end of the deferral period, the application shall be disapproved. The applicant center shall allow the commissioner to inspect the center at any time during the deferral period, whether or not the site visit has been announced in advance. A site visit shall occur only during normal working hours of the center and shall not disrupt the normal functioning of the center. At any time during the deferral period, the applicant center may submit documentation indicating correction of noncompliance. The application shall then be approved or disapproved. At any time during the deferral period, the applicant center may submit a written request to the commissioner to change the application status to disapproval. The request shall be complied with within 14 days of receiving this written request. The applicant center is not an approved center for purposes of Minnesota Statutes, section 62A.152 during a deferral period.

Subp. 5. **Effective date of decision.** The effective date of a decision is the date the commissioner signs a letter notifying the applicant center of that decision.

9520.0850 APPEALS.

If an application is disapproved or approval is withdrawn, a contested case hearing and judicial review as provided in Minnesota Statutes, sections 14.48 to 14.69, may be requested by the center within 30 days of the commissioner's decision.

9520.0860 POSTAPPROVAL REQUIREMENTS.

Subpart 1. **Duration of approval.** Initial approval of an application is valid for 12 months from the effective date, subsequent approvals for 24 months, except when approval is withdrawn according to the criteria in subpart 4.

Subp. 2. **Reapplication.** The center shall contact the department for reapplication forms, and submit the completed application at least 90 days prior to the expected expiration date. If an approved center has met the conditions of Minnesota Statutes, section 245.69, subdivision 2, and parts 9520.0760 to 9520.0870, including reapplication when required, its status as an approved center shall remain in effect pending department processing of the reapplication.

Subp. 3. **Restrictions.** The approval is issued only for the center named in the application and is not transferable or assignable to another center. The approval is issued only for the center location named in the application and is not transferable or assignable to another location. If the commissioner is notified in writing at least 30 days in advance of a change in center location and can determine that compliance with all provisions of Minnesota Statutes, section 245.69, subdivision 2, and parts 9520.0760 to 9520.0870 are maintained, the commissioner shall continue the approval of the center at the new location.

Subp. 4. **Noncompliance.** Changes in center organization, staffing, treatment, or quality assurance procedures that affect the ability of the center to comply with the minimum standards of Minnesota Statutes, section 245.69, subdivision 2, and parts 9520.0760 to 9520.0870 shall be reported in writing by the center to the commissioner within 15 days of occurrence. Review of the change shall be conducted by the commissioner. A center with changes resulting in noncompliance in minimum standards shall receive written notice and may have up to 180 days to correct the areas of noncompliance before losing approval status. Interim procedures to resolve the noncompliance on a temporary basis shall be developed and submitted in writing to the commissioner for approval within 30 days of the commissioner's determination of the noncompliance. Nonreporting within 15 days of occurrence of a change that results in noncompliance, failure to develop an approved interim procedure within 30 days of the determination of the noncompliance, or nonresolution of the noncompliance within 180 days shall result in the immediate withdrawal of approval status.

Serious violation of policies or procedures, professional association or board sanctioning or loss of licensure for unethical practices, or the conviction of violating a state or federal statute shall be reported in writing by the center to the commissioner within ten days of the substantiation of such behavior. Review of this report and the action taken by the center shall be conducted by the commissioner. Approval shall be withdrawn immediately unless the commissioner determines that: the center acted with all proper haste and thoroughness in investigating the behavior, the center acted with all proper haste and thoroughness in taking appropriate disciplinary and corrective action, and that no member of the governing body was a party to the behavior. Failure to report such behavior within ten days of its substantiation shall result in immediate withdrawal of approval.

Subp. 5. **Compliance reports.** The center may be required to submit written information to the department during the approval period to document that the center has maintained compliance with the rule and center procedures. The center shall allow the commissioner to inspect the center at any time during the approval period, whether or not the site visit has been announced in advance. A site visit shall occur only during normal working hours of the center and shall not disrupt the normal functioning of the center.

9520.0870 VARIANCES.

Subpart 1. **When allowed.** The standards and procedures established by parts 9520.0760 to 9520.0860 may be varied by the commissioner. Standards and procedures established by statute shall not be varied.

Subp. 2. **Request procedure.** A request for a variance must be submitted in writing to the commissioner, accompanying or following the submission of a completed application for approval under Minnesota Statutes, section 245.69, subdivision 2, and parts 9520.0760 to 9520.0870. The request shall state:

- A. the standard or procedure to be varied;
- B. the specific reasons why the standard or procedure cannot be or should not be complied with; and
- C. the equivalent standard or procedure the center will establish to achieve the intent of the standard or procedure to be varied.

APPENDIX
Repealed Minnesota Rules: DIVH1495-1

Subp. 3. **Decision procedure.** Upon receiving the variance request, the commissioner shall consult with a panel of experts in the mental health disciplines regarding the request. Criteria for granting a variance shall be the commissioner's determination that subpart 2, items A to C are met. Hardship shall not be a sufficient reason to grant a variance. No variance shall be granted that would threaten the health, safety, or rights of clients. Variances granted by the commissioner shall specify in writing the alternative standards or procedures to be implemented and any specific conditions or limitations imposed on the variance by the commissioner. Variances denied by the commissioner shall specify in writing the reason for the denial.

Subp. 4. **Notification.** The commissioner shall send the center a written notice granting or not granting the variance within 90 days of receiving the written variance request. This notice shall not be construed as approval or disapproval of the center under Minnesota Statutes, section 245.69, subdivision 2, and parts 9520.0760 to 9520.0870.