State of Minnesota

HOUSE OF REPRESENTATIVES

NINETY-THIRD SESSION

H. F. No. 3495

02/12/2024 Authored by Fischer, Curran, Kiel, Hill and Frederick
The bill was read for the first time and referred to the Committee on Human Services Policy
04/02/2024 Adoption of Report: Amended and re-referred to the Committee on Health Finance and Policy

A bill for an act

relating to behavioral health; modifying provisions related to mental and behavioral health care, including service standards, adult and child mental health services grants, substance use disorder services, supportive housing, and provider certification and reimbursement; appropriating money; requiring reports; amending Minnesota Statutes 2022, sections 144.226, by adding a subdivision; 148F.025, subdivision 2; 245.462, subdivision 6; 245.4663, subdivision 2; 245G.01, by adding subdivisions; 245G.07, subdivisions 3, 3a; 245G.11, subdivision 7; 245I.02, subdivisions 17, 19; 245I.04, subdivision 6; 245I.10, subdivision 9; 245I.11, subdivision 1, by adding a subdivision; 245I.20, subdivision 4; 245I.23, subdivision 14; 256B.0622, subdivisions 2a, 3a, 7a, 7d; 256B.0623, subdivision 5; 256B.0624, subdivision 7; 256B.0625, subdivision 20; 256B.0757, subdivisions 4a, 4d, 5, by adding a subdivision; 256B.0943, subdivisions 3, 12; 256B.0947, subdivision 5; 256B.76, subdivision 6; 256I.04, subdivision 2f; Minnesota Statutes 2023 Supplement, sections 245.4889, subdivision 1; 245G.05, subdivision 1; 245G.06, subdivisions 1, 3, 3a, 4; 254B.04, subdivision 1a; 256.969, subdivision 2b; 256B.0622, subdivisions 7b, 8; 256B.0625, subdivision 5m; 256B.0941, subdivision 3; 256B.0947, subdivision 7; 256B.76, subdivision 1; 256B.761; 256D.01, subdivision 1a; 256I.05, subdivisions 1a, 11; Laws 2021, First Special Session chapter 7, article 17, section 12, as amended; Laws 2023, chapter 70, article 20, section 2, subdivision 29; proposing coding for new law in Minnesota Statutes, chapters 144; 253B; 256B; repealing Minnesota Statutes 2022, sections 256D.19, subdivisions 1, 2; 256D.20, subdivisions 1, 2, 3, 4; 256D.23, subdivisions 1, 2, 3; Minnesota Rules, part 2960.0620, subpart 3.

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

ARTICLE 1

MENTAL HEALTH UNIFORM SERVICE STANDARDS

Section 1. Minnesota Statutes 2022, section 245I.02, subdivision 17, is amended to read:

Subd. 17. **Functional assessment.** "Functional assessment" means the assessment of a client's current level of functioning relative to functioning that is appropriate for someone the client's age. ~~For a client five years of age or younger, a functional assessment is the~~

~~Early Childhood Service Intensity Instrument (ESCII). For a client six to 17 years of age, a functional assessment is the Child and Adolescent Service Intensity Instrument (CASII). For a client 18 years of age or older, a functional assessment is the functional assessment described in section 245I.10, subdivision 9.~~

Sec. 2. Minnesota Statutes 2022, section 245I.02, subdivision 19, is amended to read:

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

Sec. 3. Minnesota Statutes 2022, section 245I.04, subdivision 6, is amended to read:

Subd. 6. **Clinical trainee qualifications.** (a) A clinical trainee is a staff person who: (1) is enrolled in an accredited graduate program of study to prepare the staff person for independent licensure as a mental health professional and who is participating in a practicum or internship with the license holder through the individual's graduate program; ~~or~~ (2) has completed an accredited graduate program of study to prepare the staff person for independent licensure as a mental health professional and who is in compliance with the requirements of the applicable health-related licensing board, including requirements for supervised practice~~.~~; or (3) has completed an accredited graduate program of study to prepare the staff person for independent licensure as a mental health professional, has completed a practicum or internship and has not yet taken or received the results from the required test or is waiting for the final licensure decision.

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

Sec. 4. Minnesota Statutes 2022, section 245I.10, subdivision 9, is amended to read:

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

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

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

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

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

(i) the client's mental health symptoms;

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

(iii) the client's substance use;

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

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

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

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

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

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

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

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

~~(6)~~ (5) complete the client's functional assessment before the client's initial individual treatment plan unless a service specifies otherwise; and

~~(7)~~ (6) update the client's functional assessment with the client's current functioning whenever there is a significant change in the client's functioning or at least every ~~180~~ 365 days, unless a service specifies otherwise.

(b) A license holder may use any available, validated measurement tool, including but not limited to the Daily Living Activities-20, when completing the required elements of a functional assessment under this subdivision.

Sec. 5. Minnesota Statutes 2022, section 245I.11, subdivision 1, is amended to read:

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

(b) For purposes of this section, "observed self-administration" means the preparation and administration of a medication by a client to themselves under the direct supervision of a registered nurse or a staff member to whom a registered nurse delegates supervision duty. Observed self-administration does not include a client's use of a medication that they keep in their own possession while participating in a program.

Sec. 6. Minnesota Statutes 2022, section 245I.11, is amended by adding a subdivision to read:

Subd. 6. **Medication administration in children's day treatment settings.** (a) For a program providing children's day treatment services under section 256B.0943, the license holder must maintain policies and procedures that state whether the program will store medication and administer or allow observed self-administration.

(b) For a program providing children's day treatment services under section 256B.0943 that does not store medications but allows clients to use a medication that they keep in their own possession while participating in a program, the license holder must maintain documentation from a licensed prescriber regarding the safety of medications held by clients, including:

(1) an evaluation that the client is capable of holding and administering the medication safely;

(2) an evaluation of whether the medication is prone to diversion, misuse, or self-injury; and

(3) any conditions under which the license holder should no longer allow the client to maintain the medication in their own possession.

Sec. 7. Minnesota Statutes 2022, section 245I.20, subdivision 4, is amended to read:

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

(b) The treatment team must include:

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

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

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

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

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

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

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

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

Sec. 8. Minnesota Statutes 2022, section 245I.23, subdivision 14, is amended to read:

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

(b) A mental health professional or certified rehabilitation specialist must hold at least one team meeting each calendar week ~~and~~. The mental health professional or certified rehabilitation specialist must be physically present at the team meeting, except as permitted under paragraph (d). All treatment team members, including treatment team members who

work on a part-time or intermittent basis, must participate in a minimum of one team meeting during each calendar week when the treatment team member is working for the license holder. The license holder must document all weekly team meetings, including the names of meeting attendees, and indicate whether the meeting was conducted remotely under paragraph (d).

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

(d) A license holder may permit one weekly meeting to occur remotely and without physical presence due to illness or weather conditions. If the conditions that prevent physical presence persist for longer than one week, the license holder must request a variance to conduct additional meetings remotely.

ARTICLE 2
ADULT MENTAL HEALTH SERVICES

Section 1. Minnesota Statutes 2022, section 245.462, subdivision 6, is amended to read:

Subd. 6. **Community support services program.** "Community support services program" means services, other than inpatient or residential treatment services, provided or coordinated by an identified program and staff under the treatment supervision of a mental health professional designed to help adults with serious and persistent mental illness to function and remain in the community. A community support services program includes:

(1) client outreach,

(2) medication monitoring,

(3) assistance in independent living skills,

(4) development of employability and work-related opportunities,

(5) crisis assistance,

(6) psychosocial rehabilitation,

(7) help in applying for government benefits, and

(8) housing support services.

The community support services program must be coordinated with the case management services specified in section 245.4711. A program that meets the accreditation standards for Clubhouse International model programs meets the requirements of this subdivision.

Sec. 2. **[253B.042] ENGAGEMENT SERVICES PILOT GRANTS.**

Subdivision 1. **Creation.** The engagement services pilot grant program is established in the Department of Human Services, to provide grants to counties or certified community behavioral health centers to provide engagement services under section 253B.041. Engagement services provide culturally responsive, person-centered early interventions to prevent an individual from meeting the criteria for civil commitment and promote positive outcomes.

Subd. 2. **Allowable grant activities.** (a) Grantees must use grant money to:

(1) develop a system to respond to requests for engagement services;

(2) provide the following engagement services, taking into account an individual's preferences for treatment services and supports:

(i) assertive attempts to engage an individual in voluntary treatment for mental illness for at least 90 days;

(ii) efforts to engage an individual's existing support systems and interested persons, including but not limited to providing education on restricting means of harm and suicide prevention, when the provider determines that such engagement would be helpful; and

(iii) collaboration with the individual to meet the individual's immediate needs, including but not limited to housing access, food and income assistance, disability verification, medication management, and medical treatment;

(3) conduct outreach to families and providers; and

(4) evaluate the impact of engagement services on decreasing civil commitments, increasing engagement in treatment, decreasing police involvement with individuals exhibiting symptoms of serious mental illness, and other measures.

(b) Engagement services staff must have completed training on person-centered care. Staff may include but are not limited to mobile crisis providers under section 256B.0624,

certified peer specialists under section 256B.0615, community-based treatment programs staff, and homeless outreach workers.

Subd. 3. **Outcome evaluation.** The commissioner of management and budget must formally evaluate outcomes of grants awarded under this section, using an experimental or quasi-experimental design. The commissioner shall consult with the commissioner of management and budget to ensure that grants are administered to facilitate this evaluation. Grantees must collect and provide the information needed to the commissioner of human services to complete the evaluation. The commissioner must provide the information collected to the commissioner of management and budget to conduct the evaluation. The commissioner of management and budget may obtain additional relevant data to support the evaluation study pursuant to section 15.08.

Sec. 3. Minnesota Statutes 2022, section 256B.0622, subdivision 2a, is amended to read:

Subd. 2a. **Eligibility for assertive community treatment.** (a) An eligible client for assertive community treatment is an individual who meets the following criteria as assessed by an ACT team:

(1) is age 18 or older. Individuals ages 16 and 17 may be eligible upon approval by the commissioner;

(2) has a primary diagnosis of schizophrenia, schizoaffective disorder, major depressive disorder with psychotic features, other psychotic disorders, or bipolar disorder. Individuals with other psychiatric illnesses may qualify for assertive community treatment if they have a serious mental illness and meet the criteria outlined in clauses (3) and (4), but no more than ten percent of an ACT team's clients may be eligible based on this criteria. Individuals with a primary diagnosis of a substance use disorder, intellectual developmental disabilities, borderline personality disorder, antisocial personality disorder, traumatic brain injury, or an autism spectrum disorder are not eligible for assertive community treatment;

(3) has significant functional impairment as demonstrated by at least one of the following conditions:

(i) significant difficulty consistently performing the range of routine tasks required for basic adult functioning in the community or persistent difficulty performing daily living tasks without significant support or assistance;

(ii) significant difficulty maintaining employment at a self-sustaining level or significant difficulty consistently carrying out the head-of-household responsibilities; or

(iii) significant difficulty maintaining a safe living situation;

(4) has a need for continuous high-intensity services as evidenced by at least two of the following:

(i) two or more psychiatric hospitalizations or residential crisis stabilization services in the previous 12 months;

(ii) frequent utilization of mental health crisis services in the previous six months;

(iii) 30 or more consecutive days of psychiatric hospitalization in the previous 24 months;

(iv) intractable, persistent, or prolonged severe psychiatric symptoms;

(v) coexisting mental health and substance use disorders lasting at least six months;

(vi) recent history of involvement with the criminal justice system or demonstrated risk of future involvement;

(vii) significant difficulty meeting basic survival needs;

(viii) residing in substandard housing, experiencing homelessness, or facing imminent risk of homelessness;

(ix) significant impairment with social and interpersonal functioning such that basic needs are in jeopardy;

(x) coexisting mental health and physical health disorders lasting at least six months;

(xi) residing in an inpatient or supervised community residence but clinically assessed to be able to live in a more independent living situation if intensive services are provided;

(xii) requiring a residential placement if more intensive services are not available; or

(xiii) difficulty effectively using traditional office-based outpatient services;

(5) there are no indications that other available community-based services would be equally or more effective as evidenced by consistent and extensive efforts to treat the individual; 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 assertive community treatment is not provided.

(b) An individual meets the criteria for assertive community treatment under this section immediately following participation in a first episode of psychosis program if the individual:

(1) meets the eligibility requirements outlined in paragraph (a), clauses (1), (2), (5), and (6);

(2) is currently participating in a first episode of psychosis program under section 245.4905; and

(3) needs the level of intensity provided by an ACT team, in the opinion of the individual's first episode of psychosis program, in order to prevent crisis services, hospitalization, homelessness, and involvement with the criminal justice system.

Sec. 4. Minnesota Statutes 2022, section 256B.0622, subdivision 3a, is amended to read:

Subd. 3a. **Provider certification and contract requirements for assertive community treatment.** (a) The assertive community treatment provider must~~:~~

~~(1) have a contract with the host county to provide assertive community treatment services; and~~

~~(2)~~ have each ACT team be certified by the state following the certification process and procedures developed by the commissioner. The certification process determines whether the ACT team meets the standards for assertive community treatment under this section, the standards in chapter 245I as required in section 245I.011, subdivision 5, and minimum program fidelity standards as measured by a nationally recognized fidelity tool approved by the commissioner. Recertification must occur at least every three years.

(b) An ACT team certified under this subdivision must meet the following standards:

(1) have capacity to recruit, hire, manage, and train required ACT team members;

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

(3) ensure flexibility in service delivery to respond to the changing and intermittent care needs of a client as identified by the client and the individual treatment plan;

(4) keep all necessary records required by law;

(5) be an enrolled Medicaid provider; and

(6) establish and maintain a quality assurance plan to determine specific service outcomes and the client's satisfaction with services.

(c) The commissioner may intervene at any time and decertify an ACT team with cause. The commissioner shall establish a process for decertification of an ACT team and shall require corrective action, medical assistance repayment, or decertification of an ACT team that no longer meets the requirements in this section or that fails to meet the clinical quality

standards or administrative standards provided by the commissioner in the application and certification process. The decertification is subject to appeal to the state.

Sec. 5. Minnesota Statutes 2022, section 256B.0622, subdivision 7a, is amended to read:

Subd. 7a. **Assertive community treatment team staff requirements and roles.** (a) The required treatment staff qualifications and roles for an ACT team are:

(1) the team leader:

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

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

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

(iv) must be available to ~~provide~~ ensure that overall treatment supervision to the ACT team is available after regular business hours and on weekends and holidays~~. The team leader may delegate this duty to another~~ and is provided by a qualified member of the ACT team;

(2) the psychiatric care provider:

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

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

(iii) shall fulfill the following functions for assertive community treatment clients: provide assessment and treatment of clients' symptoms and response to medications, including side effects; provide brief therapy to clients; provide diagnostic and medication education

to clients, with medication decisions based on shared decision making; monitor clients' nonpsychiatric medical conditions and nonpsychiatric medications; and conduct home and community visits;

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

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

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

(3) the nursing staff:

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

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

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

(4) the co-occurring disorder specialist:

(i) shall be a full-time equivalent co-occurring disorder specialist who has received specific training on co-occurring disorders that is consistent with national evidence-based practices. The training must include practical knowledge of common substances and how they affect mental illnesses, the ability to assess substance use disorders and the client's stage of treatment, motivational interviewing, and skills necessary to provide counseling to

clients at all different stages of change and treatment. The co-occurring disorder specialist may also be an individual who is a licensed alcohol and drug counselor as described in section 148F.01, subdivision 5, or a counselor who otherwise meets the training, experience, and other requirements in section 245G.11, subdivision 5. No more than two co-occurring disorder specialists may occupy this role; and

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

(5) the vocational specialist:

(i) shall be a full-time vocational specialist who has at least one-year experience providing employment services or advanced education that involved field training in vocational services to individuals with mental illness. An individual who does not meet these qualifications may also serve as the vocational specialist upon completing a training plan approved by the commissioner;

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

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

(6) the mental health certified peer specialist:

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

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

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

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

(8) additional staff:

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

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

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

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

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

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

Sec. 6. Minnesota Statutes 2023 Supplement, section 256B.0622, subdivision 7b, is amended to read:

Subd. 7b. **Assertive community treatment program ~~size and opportunities~~ scores.** ~~(a)~~ Each ACT team ~~shall maintain an annual average caseload that does not exceed 100 clients. Staff-to-client ratios shall be based on team size as follows:~~ must demonstrate that the team attained a passing score according to the most recently issued Tool for Measurement of Assertive Community Treatment (TMACT).

~~(1) a small ACT team must:~~

~~(i) employ at least six but no more than seven full-time treatment team staff, excluding the program assistant and the psychiatric care provider;~~

~~(ii) serve an annual average maximum of no more than 50 clients;~~

~~(iii) ensure at least one full-time equivalent position for every eight clients served;~~

~~(iv) schedule ACT team staff on weekdays and on-call duty to provide crisis services and deliver services after hours when staff are not working;~~

~~(v) provide crisis services during business hours if the small ACT team does not have sufficient staff numbers to operate an after-hours on-call system. During all other hours, the ACT team may arrange for coverage for crisis assessment and intervention services through a reliable crisis-intervention provider as long as there is a mechanism by which the ACT team communicates routinely with the crisis-intervention provider and the on-call ACT team staff are available to see clients face-to-face when necessary or if requested by the crisis-intervention services provider;~~

~~(vi) adjust schedules and provide staff to carry out the needed service activities in the evenings or on weekend days or holidays, when necessary;~~

~~(vii) arrange for and provide psychiatric backup during all hours the psychiatric care provider is not regularly scheduled to work. If availability of the ACT team's psychiatric care provider during all hours is not feasible, alternative psychiatric prescriber backup must be arranged and a mechanism of timely communication and coordination established in writing; and~~

~~(viii) be composed of, at minimum, one full-time team leader, at least 16 hours each week per 50 clients of psychiatric provider time, or equivalent if fewer clients, one full-time equivalent nursing, one full-time co-occurring disorder specialist, one full-time equivalent mental health certified peer specialist, one full-time vocational specialist, one full-time program assistant, and at least one additional full-time ACT team member who has mental health professional, certified rehabilitation specialist, clinical trainee, or mental health practitioner status; and~~

~~(2) a midsize ACT team shall:~~

~~(i) be composed of, at minimum, one full-time team leader, at least 16 hours of psychiatry time for 51 clients, with an additional two hours for every six clients added to the team, 1.5 to two full-time equivalent nursing staff, one full-time co-occurring disorder specialist, one full-time equivalent mental health certified peer specialist, one full-time vocational specialist,~~

~~one full-time program assistant, and at least 1.5 to two additional full-time equivalent ACT members, with at least one dedicated full-time staff member with mental health professional status. Remaining team members may have mental health professional, certified rehabilitation specialist, clinical trainee, or mental health practitioner status;~~

~~(ii) employ seven or more treatment team full-time equivalents, excluding the program assistant and the psychiatric care provider;~~

~~(iii) serve an annual average maximum caseload of 51 to 74 clients;~~

~~(iv) ensure at least one full-time equivalent position for every nine clients served;~~

~~(v) schedule ACT team staff for a minimum of ten-hour shift coverage on weekdays and six- to eight-hour shift coverage on weekends and holidays. In addition to these minimum specifications, staff are regularly scheduled to provide the necessary services on a client-by-client basis in the evenings and on weekends and holidays;~~

~~(vi) schedule ACT team staff on-call duty to provide crisis services and deliver services when staff are not working;~~

~~(vii) have the authority to arrange for coverage for crisis assessment and intervention services through a reliable crisis-intervention provider as long as there is a mechanism by which the ACT team communicates routinely with the crisis-intervention provider and the on-call ACT team staff are available to see clients face-to-face when necessary or if requested by the crisis-intervention services provider; and~~

~~(viii) arrange for and provide psychiatric backup during all hours the psychiatric care provider is not regularly scheduled to work. If availability of the psychiatric care provider during all hours is not feasible, alternative psychiatric prescriber backup must be arranged and a mechanism of timely communication and coordination established in writing;~~

~~(3) a large ACT team must:~~

~~(i) be composed of, at minimum, one full-time team leader, at least 32 hours each week per 100 clients, or equivalent of psychiatry time, three full-time equivalent nursing staff, one full-time co-occurring disorder specialist, one full-time equivalent mental health certified peer specialist, one full-time vocational specialist, one full-time program assistant, and at least two additional full-time equivalent ACT team members, with at least one dedicated full-time staff member with mental health professional status. Remaining team members may have mental health professional or mental health practitioner status;~~

~~(ii) employ nine or more treatment team full-time equivalents, excluding the program assistant and psychiatric care provider;~~

~~(iii) serve an annual average maximum caseload of 75 to 100 clients;~~

~~(iv) ensure at least one full-time equivalent position for every nine individuals served;~~

~~(v) schedule staff to work two eight-hour shifts, with a minimum of two staff on the second shift providing services at least 12 hours per day weekdays. For weekends and holidays, the team must operate and schedule ACT team staff to work one eight-hour shift, with a minimum of two staff each weekend day and every holiday;~~

~~(vi) schedule ACT team staff on-call duty to provide crisis services and deliver services when staff are not working; and~~

~~(vii) arrange for and provide psychiatric backup during all hours the psychiatric care provider is not regularly scheduled to work. If availability of the ACT team psychiatric care provider during all hours is not feasible, alternative psychiatric backup must be arranged and a mechanism of timely communication and coordination established in writing.~~

~~(b) An ACT team of any size may have a staff-to-client ratio that is lower than the requirements described in paragraph (a) upon approval by the commissioner, but may not exceed a one-to-ten staff-to-client ratio.~~

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

Subd. 7d. **Assertive community treatment assessment and individual treatment plan.** (a) An initial assessment shall be completed the day of the client's admission to assertive community treatment by the ACT team leader or the psychiatric care provider, with participation by designated ACT team members and the client. The initial assessment must include obtaining or completing a standard diagnostic assessment according to section 245I.10, subdivision 6, and completing a 30-day individual treatment plan. The team leader, psychiatric care provider, or other mental health professional designated by the team leader or psychiatric care provider, must update the client's diagnostic assessment ~~at least annually~~ as required under section 245I.10, subdivision 2, paragraphs (f) and (g).

(b) A functional assessment must be completed according to section 245I.10, subdivision 9. Each part of the functional assessment areas shall be completed by each respective team specialist or an ACT team member with skill and knowledge in the area being assessed.

(c) Between 30 and 45 days after the client's admission to assertive community treatment, the entire ACT team must hold a comprehensive case conference, where all team members, including the psychiatric provider, present information discovered from the completed assessments and provide treatment recommendations. The conference must serve as the

basis for the first individual treatment plan, which must be written by the primary team member.

(d) The client's psychiatric care provider, primary team member, and individual treatment team members shall assume responsibility for preparing the written narrative of the results from the psychiatric and social functioning history timeline and the comprehensive assessment.

(e) The primary team member and individual treatment team members shall be assigned by the team leader in collaboration with the psychiatric care provider by the time of the first treatment planning meeting or 30 days after admission, whichever occurs first.

(f) Individual treatment plans must be developed through the following treatment planning process:

(1) The individual treatment plan shall be developed in collaboration with the client and the client's preferred natural supports, and guardian, if applicable and appropriate. The ACT team shall evaluate, together with each client, the client's needs, strengths, and preferences and develop the individual treatment plan collaboratively. The ACT team shall make every effort to ensure that the client and the client's family and natural supports, with the client's consent, are in attendance at the treatment planning meeting, are involved in ongoing meetings related to treatment, and have the necessary supports to fully participate. The client's participation in the development of the individual treatment plan shall be documented.

(2) The client and the ACT team shall work together to formulate and prioritize the issues, set goals, research approaches and interventions, and establish the plan. The plan is individually tailored so that the treatment, rehabilitation, and support approaches and interventions achieve optimum symptom reduction, help fulfill the personal needs and aspirations of the client, take into account the cultural beliefs and realities of the individual, and improve all the aspects of psychosocial functioning that are important to the client. The process supports strengths, rehabilitation, and recovery.

(3) Each client's individual treatment plan shall identify service needs, strengths and capacities, and barriers, and set specific and measurable short- and long-term goals for each service need. The individual treatment plan must clearly specify the approaches and interventions necessary for the client to achieve the individual goals, when the interventions shall happen, and identify which ACT team member shall carry out the approaches and interventions.

(4) The primary team member and the individual treatment team, together with the client and the client's family and natural supports with the client's consent, are responsible for

reviewing and rewriting the treatment goals and individual treatment plan whenever there is a major decision point in the client's course of treatment or at least every six months.

(5) The primary team member shall prepare a summary that thoroughly describes in writing the client's and the individual treatment team's evaluation of the client's progress and goal attainment, the effectiveness of the interventions, and the satisfaction with services since the last individual treatment plan. The client's most recent diagnostic assessment must be included with the treatment plan summary.

(6) The individual treatment plan and review must be approved or acknowledged by the client, the primary team member, the team leader, the psychiatric care provider, and all individual treatment team members. A copy of the approved individual treatment plan must be made available to the client.

Sec. 8. Minnesota Statutes 2023 Supplement, section 256B.0622, subdivision 8, is amended to read:

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

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

(c) The commissioner shall determine one rate for each provider that will bill medical assistance for residential services under this section and one rate for each assertive community treatment provider. If a single entity provides both services, one rate is established for the entity's residential services and another rate for the entity's nonresidential services under this section. A provider is not eligible for payment under this section without authorization from the commissioner. The commissioner shall develop rates using the following criteria:

(1) the provider's cost for services shall include direct services costs, other program costs, and other costs determined as follows:

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

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

(iii) physical plant costs calculated based on the percentage of space within the program that is entirely devoted to treatment and programming. This does not include administrative or residential space;

(iv) assertive community treatment physical plant costs must be reimbursed as part of the costs described in item (ii); ~~and~~

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

(vi) for assertive community treatment, intensive residential treatment services, and adult residential crisis stabilization services, estimated additional direct care staffing compensation costs, subject to review by the commissioner; and

(vii) for intensive residential treatment services and adult residential crisis stabilization services, estimated new capital costs, subject to review by the commissioner;

(2) actual cost is defined as costs which are allowable, allocable, and reasonable, and consistent with federal reimbursement requirements under Code of Federal Regulations, title 48, chapter 1, part 31, relating to for-profit entities, and Office of Management and Budget Circular Number A-122, relating to nonprofit entities;

(3) the number of service units;

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

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

(d) The rate for intensive residential treatment services and assertive community treatment must exclude the medical assistance room and board rate, as defined in section 256B.056, subdivision 5d, and services not covered under this section, such as partial hospitalization, home care, and inpatient services.

(e) Physician services that are not separately billed may be included in the rate to the extent that a psychiatrist, or other health care professional providing physician services within their scope of practice, is a member of the intensive residential treatment services treatment team. Physician services, whether billed separately or included in the rate, may be delivered by telehealth. For purposes of this paragraph, "telehealth" has the meaning given to "mental health telehealth" in section 256B.0625, subdivision 46, when telehealth is used to provide intensive residential treatment services.

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

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

(h) The rates for existing programs must be established prospectively based upon the expenditures and utilization over a prior 12-month period using the criteria established in paragraph (c). The rates for new programs must be established based upon estimated expenditures and estimated utilization using the criteria established in paragraph (c). For a rate that was set incorporating the provider's estimated direct care staffing compensation and new capital costs, the commissioner must reconcile the provider's rate with the provider's actual costs from the prior 12 months.

(i) Effective for the rate years beginning on and after January 1, 2024, rates for assertive community treatment, adult residential crisis stabilization services, and intensive residential treatment services must be annually adjusted for inflation using the Centers for Medicare and Medicaid Services Medicare Economic Index, as forecasted in the fourth quarter of the calendar year before the rate year. The inflation adjustment must be based on the 12-month period from the midpoint of the previous rate year to the midpoint of the rate year for which the rate is being determined.

(j) Entities who discontinue providing services must be subject to a settle-up process whereby actual costs and reimbursement for the previous 12 months are compared. In the event that the entity was paid more than the entity's actual costs plus any applicable performance-related funding due the provider, the excess payment must be reimbursed to the department. If a provider's revenue is less than actual allowed costs due to lower utilization than projected, the commissioner may reimburse the provider to recover its actual allowable costs. The resulting adjustments by the commissioner must be proportional to the percent of total units of service reimbursed by the commissioner and must reflect a difference of greater than five percent.

(k) A provider may request of the commissioner a review of any rate-setting decision made under this subdivision.

EFFECTIVE DATE. This section is effective January 1, 2025, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 9. Minnesota Statutes 2022, section 256B.0623, subdivision 5, is amended to read:

Subd. 5. **Qualifications of provider staff.** Adult rehabilitative mental health services must be provided by qualified individual provider staff of a certified provider entity. Individual provider staff must be qualified as:

(1) a mental health professional who is qualified according to section 245I.04, subdivision 2;

(2) a certified rehabilitation specialist who is qualified according to section 245I.04, subdivision 8;

(3) a clinical trainee who is qualified according to section 245I.04, subdivision 6;

(4) a mental health practitioner qualified according to section 245I.04, subdivision 4;

(5) a mental health certified peer specialist who is qualified according to section 245I.04, subdivision 10; ~~or~~

(6) a mental health rehabilitation worker who is qualified according to section 245I.04, subdivision 14~~.~~; or

(7) a licensed occupational therapist, as defined in section 148.6402, subdivision 14.

Sec. 10. Minnesota Statutes 2022, section 256B.0624, subdivision 7, is amended to read:

Subd. 7. **Crisis stabilization services.** (a) Crisis stabilization services must be provided by qualified staff of a crisis stabilization services provider entity and must meet the following standards:

(1) a crisis treatment plan must be developed that meets the criteria in subdivision 11;

(2) staff must be qualified as defined in subdivision 8;

(3) crisis stabilization services must be delivered according to the crisis treatment plan and include face-to-face contact with the recipient by qualified staff for further assessment, help with referrals, updating of the crisis treatment plan, skills training, and collaboration with other service providers in the community; and

(4) if a provider delivers crisis stabilization services while the recipient is absent, the provider must document the reason for delivering services while the recipient is absent.

(b) If crisis stabilization services are provided in a supervised, licensed residential setting that serves no more than four adult residents, and one or more individuals are present at the setting to receive residential crisis stabilization, the residential staff must include, for at least eight hours per day, at least one mental health professional, clinical trainee, certified rehabilitation specialist, or mental health practitioner. The commissioner shall establish a statewide per diem rate for crisis stabilization services provided under this paragraph to medical assistance enrollees. The rate for a provider shall not exceed the rate charged by that provider for the same service to other payers. Payment shall not be made to more than one entity for each individual for services provided under this paragraph on a given day. The commissioner shall set rates prospectively for the annual rate period. The commissioner shall require providers to submit annual cost reports on a uniform cost reporting form and shall use submitted cost reports to inform the rate-setting process. The commissioner shall recalculate the statewide per diem every year.

(c) For crisis stabilization services provided in a supervised, licensed residential setting that serves more than four adult residents, the commissioner must set prospective rates for the annual rate period using the same methodology described under section 256B.0622, subdivision 8, for intensive residential treatment services.

EFFECTIVE DATE. This section is effective January 1, 2025, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 11. Minnesota Statutes 2022, section 256B.0625, subdivision 20, is amended to read:

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

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

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

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

(2) at least a telephone contact or contact via secure electronic message, if preferred by the adult client, with the adult or the adult's legal representative and document a face-to-face contact either in person or by interactive video that meets the requirements of subdivision 20b with the adult or the adult's legal representative within the preceding two months.

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

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

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

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

document, in the recipient's file, the need for team case management and a description of the roles of the team members.

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

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

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

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

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

(2) programming the information systems.

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

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

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

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

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

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

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

Sec. 12. **REVISOR INSTRUCTION.**

The revisor of statutes, in consultation with the Office of Senate Counsel, Research and Fiscal Analysis; the House Research Department; and the commissioner of human services, shall prepare legislation for the 2025 legislative session to recodify Minnesota Statutes, section 256B.0622, to move provisions related to assertive community treatment and intensive residential treatment services into separate sections of statute. The revisor shall correct any cross-references made necessary by this recodification.

ARTICLE 3
CHILDREN'S MENTAL HEALTH SERVICES

Section 1. Minnesota Statutes 2023 Supplement, section 245.4889, subdivision 1, is amended to read:

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

(1) counties;

(2) Indian tribes;

(3) children's collaboratives under section 124D.23 or 245.493; or

(4) mental health service providers.

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

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

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

(3) respite care services for children with emotional disturbances or severe emotional disturbances who are at risk of ~~out-of-home placement or~~ residential treatment or hospitalization, who are already in out-of-home placement in family foster settings as defined in chapter 245A and at risk of change in out-of-home placement or placement in a residential facility or other higher level of care, who have utilized crisis services or emergency room services, or who have experienced a loss of in-home staffing support. Allowable activities and expenses for respite care services are defined under subdivision 4. A child is not required to have case management services to receive respite care services. Counties must work to provide access to regularly scheduled respite care;

(4) children's mental health crisis services;

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

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

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

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

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

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

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

(12) mental health first aid training;

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

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

(15) early childhood mental health consultation;

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

(17) psychiatric consultation for primary care practitioners; and

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

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

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

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

Sec. 2. Minnesota Statutes 2023 Supplement, section 256B.0941, subdivision 3, is amended to read:

Subd. 3. **Per diem rate.** (a) The commissioner must establish one per diem rate per provider for psychiatric residential treatment facility services for individuals 21 years of age or younger. The rate for a provider must not exceed the rate charged by that provider for the same service to other payers. Payment must not be made to more than one entity for each individual for services provided under this section on a given day. The commissioner must set rates prospectively for the annual rate period. The commissioner must require providers to submit annual cost reports on a uniform cost reporting form and must use submitted cost reports to inform the rate-setting process. The cost reporting must be done according to federal requirements for Medicare cost reports.

(b) The following are included in the rate:

(1) costs necessary for licensure and accreditation, meeting all staffing standards for participation, meeting all service standards for participation, meeting all requirements for active treatment, maintaining medical records, conducting utilization review, meeting inspection of care, and discharge planning. The direct services costs must be determined

using the actual cost of salaries, benefits, payroll taxes, and training of direct services staff and service-related transportation; ~~and~~

(2) payment for room and board provided by facilities meeting all accreditation and licensing requirements for participation~~.~~;

(3) estimated additional direct care staffing compensation costs, subject to review by the commissioner; and

(4) estimated new capital costs, subject to review by the commissioner.

(c) A facility may submit a claim for payment outside of the per diem for professional services arranged by and provided at the facility by an appropriately licensed professional who is enrolled as a provider with Minnesota health care programs. Arranged services may be billed by either the facility or the licensed professional. These services must be included in the individual plan of care and are subject to prior authorization.

(d) Medicaid must reimburse for concurrent services as approved by the commissioner to support continuity of care and successful discharge from the facility. "Concurrent services" means services provided by another entity or provider while the individual is admitted to a psychiatric residential treatment facility. Payment for concurrent services may be limited and these services are subject to prior authorization by the state's medical review agent. Concurrent services may include targeted case management, assertive community treatment, clinical care consultation, team consultation, and treatment planning.

(e) Payment rates under this subdivision must not include the costs of providing the following services:

(1) educational services;

(2) acute medical care or specialty services for other medical conditions;

(3) dental services; and

(4) pharmacy drug costs.

(f) For purposes of this section, "actual cost" means costs that are allowable, allocable, reasonable, and consistent with federal reimbursement requirements in Code of Federal Regulations, title 48, chapter 1, part 31, relating to for-profit entities, and the Office of Management and Budget Circular Number A-122, relating to nonprofit entities.

(g) The commissioner shall annually adjust psychiatric residential treatment facility services per diem rates to reflect the change in the Centers for Medicare and Medicaid Services Inpatient Psychiatric Facility Market Basket. The commissioner shall use the

indices as forecasted for the midpoint of the prior rate year to the midpoint of the current rate year.

(h) For a rate that was set incorporating the provider's estimated direct care staffing compensation and new capital costs under paragraph (b), the commissioner must reconcile the provider's rate with the provider's actual costs from the prior 12 months.

EFFECTIVE DATE. This section is effective January 1, 2025, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 3. Minnesota Statutes 2022, section 256B.0943, subdivision 3, is amended to read:

Subd. 3. **Determination of client eligibility.** (a) Based on a client's needs identified in a crisis assessment, a hospital's medical history and presentation examination, or a brief diagnostic assessment under section 245I.10, subdivision 5, a license holder may provide a client with any combination of psychotherapy sessions, group psychotherapy sessions, family psychotherapy sessions, and family psychoeducation sessions.

~~(a)~~ (b) A client's ongoing eligibility to receive children's therapeutic services and supports under this section shall be determined based on a standard diagnostic assessment by a mental health professional or a clinical trainee that is performed within one year before the initial start of service and updated as required under section 245I.10, subdivision 2. The standard diagnostic assessment must:

(1) determine whether a child under age 18 has a diagnosis of emotional disturbance or, if the person is between the ages of 18 and 21, whether the person has a mental illness;

(2) document children's therapeutic services and supports as medically necessary to address an identified disability, functional impairment, and the individual client's needs and goals; and

(3) be used in the development of the individual treatment plan.

~~(b)~~ (c) Notwithstanding paragraph ~~(a)~~ (b), a client may be determined to be eligible for up to five days of day treatment under this section based on a hospital's medical history and presentation examination of the client.

~~(c)~~ (d) Children's therapeutic services and supports include development and rehabilitative services that support a child's developmental treatment needs.

Sec. 4. Minnesota Statutes 2022, section 256B.0943, subdivision 12, is amended to read:

Subd. 12. **Excluded services.** The following services are not eligible for medical assistance payment as children's therapeutic services and supports:

(1) service components of children's therapeutic services and supports simultaneously provided by more than one provider entity unless prior authorization is obtained;

~~(2) treatment by multiple providers within the same agency at the same clock time;~~

~~(3)~~ (2) children's therapeutic services and supports provided in violation of medical assistance policy in Minnesota Rules, part 9505.0220;

~~(4)~~ (3) mental health behavioral aide services provided by a personal care assistant who is not qualified as a mental health behavioral aide and employed by a certified children's therapeutic services and supports provider entity;

~~(5)~~ (4) service components of CTSS that are the responsibility of a residential or program license holder, including foster care providers under the terms of a service agreement or administrative rules governing licensure; and

~~(6)~~ (5) adjunctive activities that may be offered by a provider entity but are not otherwise covered by medical assistance, including:

(i) 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, activities such as craft hours, leisure time, social hours, meal or snack time, trips to community activities, and tours;

(ii) a social or educational service that does not have or cannot reasonably be expected to have a therapeutic outcome related to the client's emotional disturbance;

(iii) prevention or education programs provided to the community; and

(iv) treatment for clients with primary diagnoses of alcohol or other drug abuse.

Sec. 5. Minnesota Statutes 2022, section 256B.0947, subdivision 5, is amended to read:

Subd. 5. **Standards for intensive nonresidential rehabilitative providers.** (a) Services must meet the standards in this section and chapter 245I as required in section 245I.011, subdivision 5.

(b) The treatment team must have specialized training in providing services to the specific age group of youth that the team serves. An individual treatment team must serve youth

who are: (1) at least eight years of age or older and under 16 years of age, or (2) at least 14 years of age or older and under 21 years of age.

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

(1) Based on professional qualifications and client needs, clinically qualified core team members are assigned on a rotating basis as the client's lead worker to coordinate a client's care. The core team must comprise at least four full-time equivalent direct care staff and must minimally include:

(i) a mental health professional who serves as team leader to provide administrative direction and treatment supervision to the team;

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

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

~~(iv)~~ (iii) a mental health certified peer specialist who is qualified according to section 245I.04, subdivision 10, and is also a former children's mental health consumer~~.~~; and

(iv) a co-occurring disorder specialist who meets the requirements under section 256B.0622, subdivision 7a, paragraph (a), clause (4), who will provide or facilitate the provision of co-occurring disorder treatment to clients.

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

(i) additional mental health professionals;

(ii) a vocational specialist;

(iii) an educational specialist with knowledge and experience working with youth regarding special education requirements and goals, special education plans, and coordination of educational activities with health care activities;

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

(v) a clinical trainee qualified according to section 245I.04, subdivision 6;

(vi) a mental health practitioner qualified according to section 245I.04, subdivision 4;

(vii) a case management service provider, as defined in section 245.4871, subdivision 4;

(viii) a housing access specialist; and

(ix) a family peer specialist as defined in subdivision 2, paragraph (j).

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

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

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

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

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

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

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

(d) The treatment supervisor shall be an active member of the treatment team and shall function as a practicing clinician at least on a part-time basis. The treatment team shall meet with the treatment supervisor at least weekly to discuss recipients' progress and make rapid adjustments to meet recipients' needs. The team meeting must include client-specific case reviews and general treatment discussions among team members. Client-specific case reviews and planning must be documented in the individual client's treatment record.

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

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

(g) Nonclinical staff shall have prompt access in person or by telephone to a mental health practitioner, clinical trainee, or mental health professional. The provider shall 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.

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

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

Sec. 6. Minnesota Statutes 2023 Supplement, section 256B.0947, subdivision 7, is amended to read:

Subd. 7. **Medical assistance payment and rate setting.** (a) Payment for services in this section must be based on one daily encounter rate per provider inclusive of the following services received by an eligible client in a given calendar day: all rehabilitative services, supports, and ancillary activities under this section, staff travel time to provide rehabilitative services under this section, and crisis response services under section 256B.0624.

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

(c) The commissioner shall establish regional cost-based rates for entities that will bill medical assistance for nonresidential intensive rehabilitative mental health services. In developing these rates, the commissioner shall consider:

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

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

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

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

(5) the costs of other services that will be separately reimbursed~~.~~<u>; and</u>

<u>(6) the estimated additional direct care staffing compensation costs for the next rate year as reported by entities providing the service, subject to review by the commissioner.</u>

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

(e) Effective for the rate years beginning on and after January 1, 2024, rates must be annually adjusted for inflation using the Centers for Medicare and Medicaid Services Medicare Economic Index, as forecasted in the fourth quarter of the calendar year before the rate year. The inflation adjustment must be based on the 12-month period from the midpoint of the previous rate year to the midpoint of the rate year for which the rate is being determined.

(f) For a rate that was set incorporating the provider's estimated direct care staffing compensation and new capital costs under paragraph (c), the commissioner must reconcile the provider's rate with the provider's actual costs from the prior 12 months.

EFFECTIVE DATE. This section is effective January 1, 2025, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 7. **DIRECTION TO COMMISSIONER OF HUMAN SERVICES; RESPITE CARE ACCESS.**

The commissioner of human services, in coordination with stakeholders, must develop proposals by December 31, 2025, to increase access to licensed respite foster care homes that take into consideration the new rule directing title IV-E agencies to adopt one set of licensing or approval standards for all relative or kinship foster family homes that is different from the licensing or approval standards used for nonrelative or nonkinship foster family homes, as provided by the Federal Register, volume 88, page 66700.

Sec. 8. **DIRECTION TO COMMISSIONER; MEDICAL ASSISTANCE CHILDREN'S RESIDENTIAL MENTAL HEALTH CRISIS STABILIZATION.**

(a) The commissioner of human services must consult with providers, advocates, Tribal Nations, counties, people with lived experience as or with a child in a mental health crisis, and other interested community members to develop a covered benefit under medical assistance to provide residential mental health crisis stabilization for children. The benefit must:

(1) consist of evidence-based promising practices or culturally responsive treatment services for children under the age of 21 experiencing a mental health crisis;

(2) embody an integrative care model that supports individuals experiencing a mental health crisis who may also be experiencing co-occurring conditions;

(3) qualify for federal financial participation; and

(4) include services that support children and families, including but not limited to:

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

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

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

(iv) supportive counseling and clinical services;

(v) skills training and positive support services, as identified in the child's individual crisis stabilization plan;

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

(vii) development of an individualized and culturally responsive crisis response action plan; and

(viii) assistance to access and store medication.

(b) When developing the new benefit, the commissioner must make recommendations for providers to be reimbursed for room and board.

(c) The commissioner must consult with or contract with rate-setting experts to develop a prospective data-based rate methodology for the children's residential mental health crisis stabilization benefit.

(d) No later than October 1, 2025, the commissioner must submit to the chairs and ranking minority members of the legislative committees with jurisdiction over human services policy and finance a report detailing for the children's residential mental health crisis stabilization benefit the proposed:

(1) eligibility, clinical and service requirements, provider standards, licensing requirements, and reimbursement rates;

(2) process for community engagement, community input, and crisis models studied in other states;

(3) deadline for the commissioner to submit a state plan amendment to the Centers for Medicare and Medicaid Services; and

(4) draft legislation with the statutory changes necessary to implement the benefit.

EFFECTIVE DATE. This section is effective July 1, 2024.

Sec. 9. **DIRECTION TO COMMISSIONER; CHILDREN'S RESIDENTIAL FACILITY RULEMAKING.**

(a) The commissioner of human services must use the expedited rulemaking process and comply with all requirements under Minnesota Statutes, section 14.389, to adopt the amendments required under this section.

(b) The commissioner of human services must amend Minnesota Rules, chapter 2960, to replace all instances of the term "clinical supervision" with the term "treatment supervision."

(c) The commissioner of human services must amend Minnesota Rules, part 2960.0020, to replace all instances of the term "clinical supervisor" with the term "treatment supervisor."

(d) The commissioner of human services must amend Minnesota Rules, part 2960.0020, to add the definition of "licensed prescriber" to mean an individual who is authorized to prescribe legend drugs under Minnesota Statutes, section 151.37.

(e) The commissioner of human services must amend Minnesota Rules, parts 2960.0020 to 2960.0710, to replace all instances of "physician" with "licensed prescriber."

(f) The commissioner of human services must amend Minnesota Rules, part 2960.0620, subpart 1, item B, to allow a license holder to meet requirements by obtaining a copy of the resident's medication management or evaluation treatment plan from the licensed prescriber.

(g) The commissioner of human services must amend Minnesota Rules, part 2960.0620, subpart 5, to:

(1) remove the requirement for the license holder to conduct a psychotropic medication review;

(2) require the license holder to document treatment coordination with the licensed prescriber; and

(3) strike items A to D, and remove the requirements for the license holder to consider and document items A to D at a quarterly review and provide the information in items A and D to the licensed prescriber for review.

(h) The commissioner of human services must amend Minnesota Rules, part 2960.0620, subpart 2, to strike all of the current language and insert the following language: "If a resident is prescribed a psychotropic medication, the license holder must monitor for side effects of the medication. Within 24 hours of admission, a registered nurse or licensed prescriber must assess the resident for and document any current side effects and document instructions for how frequently the license holder must monitor for side effects of the psychotropic medications the resident is taking. When a resident begins taking a new psychotropic medication or stops taking a psychotropic medication, the license holder must monitor for side effects according to the instructions of the registered nurse or licensed prescriber. The license holder must monitor for side effects using standardized checklists, rating scales, or other tools according to the instructions of the registered nurse or licensed prescriber. The license holder must provide the results of the checklist, rating scale, or other tool to the licensed prescriber for review."

(i) The commissioner of human services must amend Minnesota Rules, part 2960.0630, subpart 2, to allow license holders to use the ancillary meeting process under Minnesota Statutes, section 245I.23, subdivision 14, paragraph (c), if a staff member cannot participate in a weekly clinical supervision session.

(j) The commissioner of human services must amend Minnesota Rules, part 2960.0630, subpart 3, to strike item D.

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

Sec. 10. **REPEALER.**

Minnesota Rules, part 2960.0620, subpart 3, is repealed.

ARTICLE 4
SUBSTANCE USE DISORDER SERVICES

Section 1. **[144.2256] CERTIFIED BIRTH RECORD FOR PERSONS ELIGIBLE FOR MEDICAL ASSISTANCE.**

Subdivision 1. **Application; birth record.** A subject of a birth record who is eligible for medical assistance according to chapter 256B and who has been treated for a substance use disorder within the last 12 months may apply to the state registrar or a local issuance office for a certified birth record according to this section. The state registrar or local issuance office shall issue a certified birth record, or statement of no vital record found, to a subject of a birth record who submits:

(1) a completed application signed by the subject of the birth record;

(2) a statement of eligibility from an employee of a human services agency or treatment provider licensed under chapter 245G that receives public funding to provide services to people with substance use disorders. The statement must verify the subject of the birth record is eligible for medical assistance according to chapter 256B and has been treated for a substance use disorder in the last 12 months. The statement must comply with the requirements in subdivision 2; and

(3) identification in the form of:

(i) a document of identity listed in Minnesota Rules, part 4601.2600, subpart 8, or, at the discretion of the state registrar or local issuance office, Minnesota Rules, part 4601.2600, subpart 9;

(ii) a statement that complies with Minnesota Rules, part 4601.2600, subparts 6 and 7; or

(iii) a statement of identity provided by the employee of a human services agency or treatment provider that receives public funding to provide services to people with substance use disorders who verified eligibility. The statement must comply with Minnesota Rules, part 4601.2600, subpart 7.

Subd. 2. **Statement of eligibility.** A statement of eligibility must be from an employee of a human services agency or treatment provider that receives public funding to provide services to people with substance use disorders and must verify the subject of the birth record is eligible for medical assistance according to chapter 256B and has been treated for a substance use disorder within the last 12 months. The statement of eligibility must include:

(1) the employee's first name, middle name, if any, and last name; home or business address; telephone number, if any; and email address, if any;

(2) the name of the human services agency or treatment provider that receives public funding to provide services to people with substance use disorders that employs the person making the eligibility statement;

(3) the first name, middle name, if any, and last name of the subject of the birth record;

(4) a copy of the individual's employment identification or verification of employment linking the employee to the human services agency or treatment provider that provided treatment; and

(5) a statement specifying the relationship of the individual providing the eligibility statement to the subject of the birth record.

Subd. 3. **Data practices.** Data listed under subdivision 1, clauses (2) and (3), are private data on individuals.

Sec. 2. Minnesota Statutes 2022, section 144.226, is amended by adding a subdivision to read:

Subd. 9. **Birth record fees waived for persons treated for substance use disorders.** A subject of a birth record who is eligible for medical assistance according to chapter 256B and who has been treated for a substance use disorder within the last 12 months must not be charged any of the fees specified in this section for a certified birth record or statement of no vital record found under section 144.2256.

EFFECTIVE DATE. This section is effective January 1, 2024.

Sec. 3. Minnesota Statutes 2022, section 148F.025, subdivision 2, is amended to read:

Subd. 2. **Education requirements for licensure.** An applicant for licensure must submit evidence satisfactory to the board that the applicant has:

(1) received a bachelor's or master's degree from an accredited school or educational program; and

(2) received 18 semester credits or 270 clock hours of academic course work and 880 clock hours of supervised alcohol and drug counseling practicum from an accredited school or education program. The course work and practicum do not have to be part of the bachelor's degree earned under clause (1). The academic course work must be in the following areas:

(i) an overview of the transdisciplinary foundations of alcohol and drug counseling, including theories of chemical dependency, the continuum of care, and the process of change;

(ii) pharmacology of substance abuse disorders and the dynamics of addiction, including substance use disorder treatment with medications for opioid use disorder;

(iii) professional and ethical responsibilities;

(iv) multicultural aspects of chemical dependency;

(v) co-occurring disorders; and

(vi) the core functions defined in section 148F.01, subdivision 10.

Sec. 4. Minnesota Statutes 2022, section 245G.01, is amended by adding a subdivision to read:

Subd. 8a. **Clinical trainee.** "Clinical trainee" means a staff person who is qualified according to section 245I.04, subdivision 6, working under the supervision of a mental health professional.

Sec. 5. Minnesota Statutes 2022, section 245G.01, is amended by adding a subdivision to read:

Subd. 17a. **Mental health professional.** "Mental health professional" means a staff person who is qualified under section 245I.04, subdivision 2.

Sec. 6. Minnesota Statutes 2022, section 245G.01, is amended by adding a subdivision to read:

Subd. 17b. **Qualified professional.** "Qualified professional" means a licensed alcohol and drug counselor; mental health professional; registered nurse who has completed at least 12 hours of training in diagnosing and treating addiction, co-occurring disorders, or substance use disorder; or clinical trainee working under the supervision of a mental health professional.

Sec. 7. Minnesota Statutes 2023 Supplement, section 245G.05, subdivision 1, is amended to read:

Subdivision 1. **Comprehensive assessment.** A comprehensive assessment of the client's substance use disorder must be administered face-to-face by ~~an alcohol and drug counselor~~ a qualified professional within five calendar days from the day of service initiation for a residential program or by the end of the fifth day on which a treatment service is provided in a nonresidential program. The number of days to complete the comprehensive assessment excludes the day of service initiation. If the comprehensive assessment is not completed within the required time frame, the person-centered reason for the delay and the planned completion date must be documented in the client's file. The comprehensive assessment is complete upon a qualified ~~staff member's~~ professional's dated signature. If the client received a comprehensive assessment that authorized the treatment service, ~~an alcohol and drug counselor~~ a qualified professional may use the comprehensive assessment for requirements of this subdivision but must document a review of the comprehensive assessment and update the comprehensive assessment as clinically necessary to ensure compliance with this subdivision within applicable timelines. An alcohol and drug counselor must sign and date the comprehensive assessment review and update.

Sec. 8. Minnesota Statutes 2023 Supplement, section 245G.06, subdivision 1, is amended to read:

Subdivision 1. **General.** Each client must have a person-centered individual treatment plan developed by ~~an alcohol and drug counselor~~ a qualified professional within ten days from the day of service initiation for a residential program, by the end of the tenth day on which a treatment session has been provided from the day of service initiation for a client in a nonresidential program, not to exceed 30 days. Opioid treatment programs must complete the individual treatment plan within 21 days from the day of service initiation. The number of days to complete the individual treatment plan excludes the day of service initiation. The individual treatment plan must be signed by the client and the ~~alcohol and drug counselor~~ qualified professional and document the client's involvement in the development of the plan. The individual treatment plan is developed upon the qualified ~~staff member's~~ professional's dated signature. Treatment planning must include ongoing assessment of client needs. An individual treatment plan must be updated based on new information gathered about the client's condition, the client's level of participation, and on whether methods identified have the intended effect. A change to the plan must be signed by the client and the ~~alcohol and drug counselor~~ qualified professional. If the client chooses to have family or others involved in treatment services, the client's individual treatment plan must include how the family or others will be involved in the client's treatment. If a client is receiving treatment services or an assessment via telehealth and the ~~alcohol and drug counselor~~ qualified professional documents the reason the client's signature cannot be obtained, the ~~alcohol and drug counselor~~ qualified professional may document the client's verbal approval or electronic written approval of the treatment plan or change to the treatment plan in lieu of the client's signature.

Sec. 9. Minnesota Statutes 2023 Supplement, section 245G.06, subdivision 3, is amended to read:

Subd. 3. **Treatment plan review.** A treatment plan review must be completed by the ~~alcohol and drug counselor~~ qualified professional responsible for the client's treatment plan. The review must indicate the span of time covered by the review and must:

(1) document client goals addressed since the last treatment plan review and whether the identified methods continue to be effective;

(2) document monitoring of any physical and mental health problems and include toxicology results for alcohol and substance use, when available;

(3) document the participation of others involved in the individual's treatment planning, including when services are offered to the client's family or significant others;

(4) if changes to the treatment plan are determined to be necessary, document staff recommendations for changes in the methods identified in the treatment plan and whether the client agrees with the change;

(5) include a review and evaluation of the individual abuse prevention plan according to section 245A.65; and

(6) document any referrals made since the previous treatment plan review.

Sec. 10. Minnesota Statutes 2023 Supplement, section 245G.06, subdivision 3a, is amended to read:

Subd. 3a. **Frequency of treatment plan reviews.** (a) A license holder must ensure that the ~~alcohol and drug counselor~~ qualified professional responsible for a client's treatment plan completes and documents a treatment plan review that meets the requirements of subdivision 3 in each client's file, according to the frequencies required in this subdivision. All ASAM levels referred to in this chapter are those described in section 254B.19, subdivision 1.

(b) For a client receiving residential ASAM level 3.3 or 3.5 high-intensity services or residential hospital-based services, a treatment plan review must be completed once every 14 days.

(c) For a client receiving residential ASAM level 3.1 low-intensity services or any other residential level not listed in paragraph (b), a treatment plan review must be completed once every 30 days.

(d) For a client receiving nonresidential ASAM level 2.5 partial hospitalization services, a treatment plan review must be completed once every 14 days.

(e) For a client receiving nonresidential ASAM level 1.0 outpatient or 2.1 intensive outpatient services or any other nonresidential level not included in paragraph (d), a treatment plan review must be completed once every 30 days.

(f) For a client receiving nonresidential opioid treatment program services according to section 245G.22:

(1) a treatment plan review must be completed weekly for the ten weeks following completion of the treatment plan; and

(2) monthly thereafter.

Treatment plan reviews must be completed more frequently when clinical needs warrant.

(g) Notwithstanding paragraphs (e) and (f), clause (2), for a client in a nonresidential program with a treatment plan that clearly indicates less than five hours of skilled treatment services will be provided to the client each month, a treatment plan review must be completed once every 90 days. Treatment plan reviews must be completed more frequently when clinical needs warrant.

Sec. 11. Minnesota Statutes 2023 Supplement, section 245G.06, subdivision 4, is amended to read:

Subd. 4. **Service discharge summary.** (a) ~~An alcohol and drug counselor~~ A qualified professional must write a service discharge summary for each client. The service discharge summary must be completed within five days of the client's service termination. A copy of the client's service discharge summary must be provided to the client upon the client's request.

(b) The service discharge summary must be recorded in the six dimensions listed in section 254B.04, subdivision 4, and include the following information:

(1) the client's issues, strengths, and needs while participating in treatment, including services provided;

(2) the client's progress toward achieving each goal identified in the individual treatment plan;

(3) a risk rating and description for each of the ASAM six dimensions;

(4) the reasons for and circumstances of service termination. If a program discharges a client at staff request, the reason for discharge and the procedure followed for the decision to discharge must be documented and comply with the requirements in section 245G.14, subdivision 3, clause (3);

(5) the client's living arrangements at service termination;

(6) continuing care recommendations, including transitions between more or less intense services, or more frequent to less frequent services, and referrals made with specific attention to continuity of care for mental health, as needed; and

(7) service termination diagnosis.

Sec. 12. Minnesota Statutes 2022, section 245G.07, subdivision 3, is amended to read:

Subd. 3. ~~**Counselors**~~ **Qualified professionals.** All treatment services, except peer recovery support services and treatment coordination, must be provided by an alcohol and drug counselor qualified according to section 245G.11, subdivision 5, or any other qualified professional, as defined in section 245G.01, subdivision 17b, unless the individual providing the service is specifically qualified according to the accepted credential required to provide the service. The commissioner shall maintain a current list of professionals qualified to provide treatment services.

Sec. 13. Minnesota Statutes 2022, section 245G.07, subdivision 3a, is amended to read:

Subd. 3a. **Use of guest speakers.** (a) The license holder may allow a guest speaker to present information to clients as part of a treatment service provided by ~~an alcohol and drug counselor~~ a qualified professional, according to the requirements of this subdivision.

(b) ~~An alcohol and drug counselor~~ A qualified professional must visually observe and listen to the presentation of information by a guest speaker the entire time the guest speaker presents information to the clients. The ~~alcohol and drug counselor~~ qualified professional is responsible for all information the guest speaker presents to the clients.

(c) The presentation of information by a guest speaker constitutes a direct contact service, as defined in section 245C.02, subdivision 11.

(d) The license holder must provide the guest speaker with all training required for staff members. If the guest speaker provides direct contact services one day a month or less, the license holder must only provide the guest speaker with orientation training on the following subjects before the guest speaker provides direct contact services:

(1) mandatory reporting of maltreatment, as specified in sections 245A.65, 626.557, and 626.5572 and chapter 260E;

(2) applicable client confidentiality rules and regulations;

(3) ethical standards for client interactions; and

(4) emergency procedures.

Sec. 14. Minnesota Statutes 2022, section 245G.11, subdivision 7, is amended to read:

Subd. 7. **Treatment coordination provider qualifications.** (a) Treatment coordination must be provided by qualified staff. An individual is qualified to provide treatment

coordination if the individual meets the qualifications of an alcohol and drug counselor under subdivision 5 or if the individual:

(1) is skilled in the process of identifying and assessing a wide range of client needs;

(2) is knowledgeable about local community resources and how to use those resources for the benefit of the client;

(3) has successfully completed ~~30 hours of classroom instruction on treatment coordination for an individual with substance use disorder~~ specific training on substance use and co-occurring disorders that is consistent with national evidence-based practices; and

(4) ~~has either~~ meets one of the following criteria:

(i) has a bachelor's degree in one of the behavioral sciences or related fields and at least 1,000 hours of supervised experience working with individuals with substance use disorder; ~~or~~

(ii) is qualified as a mental health practitioner under section 245I.04, subdivision 4; or

~~(ii)~~ (iii) has a current certification as an alcohol and drug counselor, level I, by the Upper Midwest Indian Council on Addictive Disorders~~; and~~.

~~(5) has at least 2,000 hours of supervised experience working with individuals with substance use disorder.~~

(b) A treatment coordinator must receive at least one hour of supervision regarding individual service delivery from an alcohol and drug counselor, or a mental health professional who has substance use treatment and assessments within the scope of their practice, on a monthly basis.

Sec. 15. Minnesota Statutes 2023 Supplement, section 254B.04, subdivision 1a, is amended to read:

Subd. 1a. **Client eligibility.** (a) Persons eligible for benefits under Code of Federal Regulations, title 25, part 20, who meet the income standards of section 256B.056, subdivision 4, and are not enrolled in medical assistance, are entitled to behavioral health fund services. State money appropriated for this paragraph must be placed in a separate account established for this purpose.

(b) Persons with dependent children who are determined to be in need of substance use disorder treatment pursuant to an assessment under section 260E.20, subdivision 1, or in need of chemical dependency treatment pursuant to a case plan under section 260C.201,

subdivision 6, or 260C.212, shall be assisted by the local agency to access needed treatment services. Treatment services must be appropriate for the individual or family, which may include long-term care treatment or treatment in a facility that allows the dependent children to stay in the treatment facility. The county shall pay for out-of-home placement costs, if applicable.

(c) Notwithstanding paragraph (a), persons enrolled in medical assistance are eligible for room and board services under section 254B.05, subdivision 5, paragraph (b), clause (12).

(d) A client is eligible to have substance use disorder treatment paid for with funds from the behavioral health fund when the client:

(1) is eligible for MFIP as determined under chapter 256J;

(2) is eligible for medical assistance as determined under Minnesota Rules, parts 9505.0010 to 9505.0150;

(3) is eligible for general assistance, general assistance medical care, or work readiness as determined under Minnesota Rules, parts 9500.1200 to 9500.1318; or

(4) has income that is within current household size and income guidelines for entitled persons, as defined in this subdivision and subdivision 7.

(e) Clients who meet the financial eligibility requirement in paragraph (a) and who have a third-party payment source are eligible for the behavioral health fund if the third-party payment source pays less than 100 percent of the cost of treatment services for eligible clients.

(f) A client is ineligible to have substance use disorder treatment services paid for with behavioral health fund money if the client:

(1) has an income that exceeds current household size and income guidelines for entitled persons as defined in this subdivision and subdivision 7; or

(2) has an available third-party payment source that will pay the total cost of the client's treatment.

(g) A client who is disenrolled from a state prepaid health plan during a treatment episode is eligible for continued treatment service that is paid for by the behavioral health fund until the treatment episode is completed or the client is re-enrolled in a state prepaid health plan if the client:

(1) continues to be enrolled in MinnesotaCare, medical assistance, or general assistance medical care; or

(2) is eligible according to paragraphs (a) and (b) and is determined eligible by a local agency under section 254B.04.

(h) When a county commits a client under chapter 253B to a regional treatment center for substance use disorder services and the client is ineligible for the behavioral health fund, the county is responsible for the payment to the regional treatment center according to section 254B.05, subdivision 4.

(i) Notwithstanding paragraph (a), persons enrolled in MinnesotaCare are eligible for room and board services under section 254B.05, subdivision 1a, paragraph (e).

EFFECTIVE DATE. This section is effective January 1, 2025, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

ARTICLE 5
HOUSING SUPPORTS

Section 1. Minnesota Statutes 2023 Supplement, section 256D.01, subdivision 1a, is amended to read:

Subd. 1a. **Standards.** (a) A principal objective in providing general assistance is to provide for single adults, childless couples, or children as defined in section 256D.02, subdivision 2b, ineligible for federal programs who are unable to provide for themselves. The minimum standard of assistance determines the total amount of the general assistance grant without separate standards for shelter, utilities, or other needs.

(b) The standard of assistance for an assistance unit consisting of a recipient who is childless and unmarried or living apart from children and spouse and who does not live with a parent or parents or a legal custodian, or consisting of a childless couple, is $350 per month effective October 1, 2024, and must be adjusted by a percentage equal to the change in the consumer price index as of January 1 every year, beginning October 1, 2025.

(c) For an assistance unit consisting of a single adult who lives with a parent or parents, the general assistance standard of assistance is $350 per month effective October 1, ~~2023~~ 2024, and must be adjusted by a percentage equal to the change in the consumer price index as of January 1 every year, beginning October 1, 2025. Benefits received by a responsible relative of the assistance unit under the Supplemental Security Income program, a workers'

compensation program, the Minnesota supplemental aid program, or any other program based on the responsible relative's disability, and any benefits received by a responsible relative of the assistance unit under the Social Security retirement program, may not be counted in the determination of eligibility or benefit level for the assistance unit. Except as provided below, the assistance unit is ineligible for general assistance if the available resources or the countable income of the assistance unit and the parent or parents with whom the assistance unit lives are such that a family consisting of the assistance unit's parent or parents, the parent or parents' other family members and the assistance unit as the only or additional minor child would be financially ineligible for general assistance. For the purposes of calculating the countable income of the assistance unit's parent or parents, the calculation methods must follow the provisions under section 256P.06.

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

Sec. 2. Minnesota Statutes 2022, section 256I.04, subdivision 2f, is amended to read:

Subd. 2f. **Required services.** (a) In ~~licensed and registered~~ authorized settings under subdivision 2a, providers shall ensure that participants have at a minimum:

(1) food preparation and service for three nutritional meals a day on site;

(2) a bed, clothing storage, linen, bedding, laundering, and laundry supplies or service;

(3) housekeeping, including cleaning and lavatory supplies or service; and

(4) maintenance and operation of the building and grounds, including heat, water, garbage removal, electricity, telephone for the site, cooling, supplies, and parts and tools to repair and maintain equipment and facilities.

(b) In addition, when providers serve participants described in subdivision 1, paragraph (c), the providers are required to assist the participants in applying for continuing housing support payments before the end of the eligibility period.

Sec. 3. Minnesota Statutes 2023 Supplement, section 256I.05, subdivision 1a, is amended to read:

Subd. 1a. **Supplementary service rates.** (a) Subject to the provisions of section 256I.04, subdivision 3, the agency may negotiate a payment not to exceed $494.91 for other services necessary to provide room and board if the residence is licensed by or registered by the Department of Health, or licensed by the Department of Human Services to provide services in addition to room and board, and if the provider of services is not also concurrently receiving funding for services for a recipient in the residence under the following programs

or funding sources: (1) home and community-based waiver services under chapter 256S or section 256B.0913, 256B.092, or 256B.49; (2) personal care assistance under section 256B.0659; (3) community first services and supports under section 256B.85; or (4) services for adults with mental illness grants under section 245.73. If funding is available for other necessary services through a home and community-based waiver under chapter 256S, or section 256B.0913, 256B.092, or 256B.49; personal care assistance services under section 256B.0659; community first services and supports under section 256B.85; or services for adults with mental illness grants under section 245.73, then the housing support rate is limited to the rate set in subdivision 1. Unless otherwise provided in law, in no case may the supplementary service rate exceed $494.91. The registration and licensure requirement does not apply to establishments which are exempt from state licensure because they are located on Indian reservations and for which the tribe has prescribed health and safety requirements. Service payments under this section may be prohibited under rules to prevent the supplanting of federal funds with state funds.

~~(b) The commissioner is authorized to make cost-neutral transfers from the housing support fund for beds under this section to other funding programs administered by the department after consultation with the agency in which the affected beds are located. The commissioner may also make cost-neutral transfers from the housing support fund to agencies for beds permanently removed from the housing support census under a plan submitted by the agency and approved by the commissioner. The commissioner shall report the amount of any transfers under this provision annually to the legislature.~~

~~(c)~~ (b) Agencies must not negotiate supplementary service rates with providers of housing support that are licensed as board and lodging with special services and that do not encourage a policy of sobriety on their premises and make referrals to available community services for volunteer and employment opportunities for residents.

Sec. 4. Minnesota Statutes 2023 Supplement, section 256I.05, subdivision 11, is amended to read:

Subd. 11. **~~Transfer of emergency shelter funds~~ Cost-neutral transfers from the housing support fund.** (a) The commissioner is authorized to make cost-neutral transfers from the housing support fund for beds under this section to other funding programs administered by the department after consultation with the agency in which the affected beds are located.

(b) The commissioner may also make cost-neutral transfers from the housing support fund to agencies for beds removed from the housing support census under a plan submitted by the agency and approved by the commissioner.

~~(a)~~ (c) The commissioner shall make a cost-neutral transfer of funding from the housing support fund to the agency for emergency shelter beds removed from the housing support census under a ~~biennial~~ plan submitted by the agency and approved by the commissioner. Plans submitted under this paragraph must include anticipated and actual outcomes for persons experiencing homelessness in emergency shelters.

~~The plan~~ (d) Plans submitted under paragraph (b) or (c) must describe: (1) ~~anticipated and actual outcomes for persons experiencing homelessness in emergency shelters; (2)~~ improved efficiencies in administration; ~~(3)~~ (2) requirements for individual eligibility; and ~~(4)~~ (3) plans for quality assurance monitoring and quality assurance outcomes. The commissioner shall review ~~the~~ agency ~~plan~~ plans to monitor implementation and outcomes at least biennially, and more frequently if the commissioner deems necessary.

~~(b) The~~ (e) Funding under paragraph ~~(a)~~ (b), (c), or (d) may be used for the provision of room and board or supplemental services according to section 256I.03, subdivisions 14a and 14b. Providers must meet the requirements of section 256I.04, subdivisions 2a to 2f. Funding must be allocated annually, and the room and board portion of the allocation shall be adjusted according to the percentage change in the housing support room and board rate. ~~The room and board portion of the allocation shall be determined at the time of transfer.~~ The commissioner or agency may return beds to the housing support fund with 180 days' notice, including financial reconciliation.

Sec. 5. **REVISOR INSTRUCTION.**

The revisor of statutes shall renumber Minnesota Statutes, section 256D.21, as Minnesota Statutes, section 261.004.

Sec. 6. **REPEALER.**

Minnesota Statutes 2022, sections 256D.19, subdivisions 1 and 2; 256D.20, subdivisions 1, 2, 3, and 4; and 256D.23, subdivisions 1, 2, and 3, are repealed.

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

ARTICLE 6
MISCELLANEOUS

Section 1. **[144.88] MENTAL HEALTH AND SUBSTANCE USE DISORDER EDUCATION CENTER.**

Subdivision 1. **Establishment.** The Mental Health and Substance Use Disorder Education Center is established in the Department of Health. The purposes of the center are to increase the number of professionals, practitioners, and peers working in mental health and substance use disorder treatment; increase the diversity of professionals, practitioners, and peers working in mental health and substance use disorder treatment; and facilitate a culturally informed and responsive mental health and substance use disorder treatment workforce.

Subd. 2. **Activities.** The Mental Health and Substance Use Disorder Education Center must:

(1) analyze the geographic and demographic availability of licensed mental health and substance use disorder treatment professionals, identify gaps, and prioritize the need for additional licensed professionals by type, location, and demographics;

(2) create a program that exposes high school and college students to careers in the mental health and substance use disorder fields;

(3) create a website for individuals considering becoming a mental health provider that clearly labels the steps necessary to achieve licensure and certification in the various mental health fields and lists resources and links for more information;

(4) create a job board for organizations seeking employees to provide mental health and substance use disorder treatment, services, and supports;

(5) track the number of students at the undergraduate and graduate levels who are graduating from programs in Minnesota that could facilitate a career as a mental health or substance use disorder treatment practitioner or professional and work with Minnesota colleges and universities to support the students in obtaining licensure;

(6) identify barriers to mental health professional licensure and make recommendations to address the barriers;

(7) establish learning collaborative partnerships with mental health and substance use disorder treatment providers, schools, criminal justice agencies, and others;

(8) promote and expand loan forgiveness programs, funding for professionals to become supervisors, funding to pay for supervision, and funding for pathways to licensure;

(9) identify barriers to using loan forgiveness programs and develop recommendations to address the barriers;

(10) work to expand Medicaid graduate medical education to other mental health professionals;

(11) identify current sites for internships and practicums and assess the need for additional sites;

(12) develop training to increase the knowledge about mental health and substance use disorders for other health care professionals, including but not limited to community health workers, pediatricians, primary care physicians, physician assistants, and nurses; and

(13) support training for integrated mental health and primary care in rural areas.

Subd. 3. **Reports.** Beginning January 1, 2025, the commissioner of health shall submit an annual report to the chairs and ranking minority members of the legislative committees with jurisdiction over health finance and policy summarizing the center's activities and progress in addressing the mental health and substance use disorder treatment workforce shortage.

Sec. 2. Minnesota Statutes 2022, section 245.4663, subdivision 2, is amended to read:

Subd. 2. **Eligible providers.** In order to be eligible for a grant under this section, a mental health provider must:

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

(2) primarily serve underrepresented communities as defined in section 148E.010, subdivision 20~~.~~; or

(3) provide services to people in a city or township that is not within the seven-county metropolitan area as defined in section 473.121, subdivision 2, and is not the city of Duluth, Mankato, Moorhead, Rochester, or St. Cloud.

Sec. 3. Minnesota Statutes 2023 Supplement, section 256.969, subdivision 2b, is amended to read:

Subd. 2b. **Hospital payment rates.** (a) For discharges occurring on or after November 1, 2014, hospital inpatient services for hospitals located in Minnesota shall be paid according to the following:

(1) critical access hospitals as defined by Medicare shall be paid using a cost-based methodology;

(2) long-term hospitals as defined by Medicare shall be paid on a per diem methodology under subdivision 25;

(3) rehabilitation hospitals or units of hospitals that are recognized as rehabilitation distinct parts as defined by Medicare shall be paid according to the methodology under subdivision 12; and

(4) all other hospitals shall be paid on a diagnosis-related group (DRG) methodology.

(b) For the period beginning January 1, 2011, through October 31, 2014, rates shall not be rebased, except that a Minnesota long-term hospital shall be rebased effective January 1, 2011, based on its most recent Medicare cost report ending on or before September 1, 2008, with the provisions under subdivisions 9 and 23, based on the rates in effect on December 31, 2010. For rate setting periods after November 1, 2014, in which the base years are updated, a Minnesota long-term hospital's base year shall remain within the same period as other hospitals.

(c) Effective for discharges occurring on and after November 1, 2014, payment rates for hospital inpatient services provided by hospitals located in Minnesota or the local trade area, except for the hospitals paid under the methodologies described in paragraph (a), clauses (2) and (3), shall be rebased, incorporating cost and payment methodologies in a manner similar to Medicare. The base year or years for the rates effective November 1, 2014, shall be calendar year 2012. The rebasing under this paragraph shall be budget neutral, ensuring that the total aggregate payments under the rebased system are equal to the total aggregate payments that were made for the same number and types of services in the base year. Separate budget neutrality calculations shall be determined for payments made to critical access hospitals and payments made to hospitals paid under the DRG system. Only the rate increases or decreases under subdivision 3a or 3c that applied to the hospitals being rebased during the entire base period shall be incorporated into the budget neutrality calculation.

(d) For discharges occurring on or after November 1, 2014, through the next rebasing that occurs, the rebased rates under paragraph (c) that apply to hospitals under paragraph (a), clause (4), shall include adjustments to the projected rates that result in no greater than a five percent increase or decrease from the base year payments for any hospital. Any adjustments to the rates made by the commissioner under this paragraph and paragraph (e) shall maintain budget neutrality as described in paragraph (c).

(e) For discharges occurring on or after November 1, 2014, the commissioner may make additional adjustments to the rebased rates, and when evaluating whether additional adjustments should be made, the commissioner shall consider the impact of the rates on the following:

(1) pediatric services;

(2) behavioral health services;

(3) trauma services as defined by the National Uniform Billing Committee;

(4) transplant services;

(5) obstetric services, newborn services, and behavioral health services provided by hospitals outside the seven-county metropolitan area;

(6) outlier admissions;

(7) low-volume providers; and

(8) services provided by small rural hospitals that are not critical access hospitals.

(f) Hospital payment rates established under paragraph (c) must incorporate the following:

(1) for hospitals paid under the DRG methodology, the base year payment rate per admission is standardized by the applicable Medicare wage index and adjusted by the hospital's disproportionate population adjustment;

(2) for critical access hospitals, payment rates for discharges between November 1, 2014, and June 30, 2015, shall be set to the same rate of payment that applied for discharges on October 31, 2014;

(3) the cost and charge data used to establish hospital payment rates must only reflect inpatient services covered by medical assistance; and

(4) in determining hospital payment rates for discharges occurring on or after the rate year beginning January 1, 2011, through December 31, 2012, the hospital payment rate per discharge shall be based on the cost-finding methods and allowable costs of the Medicare

program in effect during the base year or years. In determining hospital payment rates for discharges in subsequent base years, the per discharge rates shall be based on the cost-finding methods and allowable costs of the Medicare program in effect during the base year or years.

(g) The commissioner shall validate the rates effective November 1, 2014, by applying the rates established under paragraph (c), and any adjustments made to the rates under paragraph (d) or (e), to hospital claims paid in calendar year 2013 to determine whether the total aggregate payments for the same number and types of services under the rebased rates are equal to the total aggregate payments made during calendar year 2013.

(h) Effective for discharges occurring on or after July 1, 2017, and every two years thereafter, payment rates under this section shall be rebased to reflect only those changes in hospital costs between the existing base year or years and the next base year or years. In any year that inpatient claims volume falls below the threshold required to ensure a statistically valid sample of claims, the commissioner may combine claims data from two consecutive years to serve as the base year. Years in which inpatient claims volume is reduced or altered due to a pandemic or other public health emergency shall not be used as a base year or part of a base year if the base year includes more than one year. Changes in costs between base years shall be measured using the lower of the hospital cost index defined in subdivision 1, paragraph (a), or the percentage change in the case mix adjusted cost per claim. The commissioner shall establish the base year for each rebasing period considering the most recent year or years for which filed Medicare cost reports are available, except that the base years for the rebasing effective July 1, 2023, are calendar years 2018 and 2019. The estimated change in the average payment per hospital discharge resulting from a scheduled rebasing must be calculated and made available to the legislature by January 15 of each year in which rebasing is scheduled to occur, and must include by hospital the differential in payment rates compared to the individual hospital's costs.

(i) Effective for discharges occurring on or after July 1, 2015, inpatient payment rates for critical access hospitals located in Minnesota or the local trade area shall be determined using a new cost-based methodology. The commissioner shall establish within the methodology tiers of payment designed to promote efficiency and cost-effectiveness. Payment rates for hospitals under this paragraph shall be set at a level that does not exceed the total cost for critical access hospitals as reflected in base year cost reports. Until the next rebasing that occurs, the new methodology shall result in no greater than a five percent decrease from the base year payments for any hospital, except a hospital that had payments that were greater than 100 percent of the hospital's costs in the base year shall have their

rate set equal to 100 percent of costs in the base year. The rates paid for discharges on and after July 1, 2016, covered under this paragraph shall be increased by the inflation factor in subdivision 1, paragraph (a). The new cost-based rate shall be the final rate and shall not be settled to actual incurred costs. Hospitals shall be assigned a payment tier based on the following criteria:

(1) hospitals that had payments at or below 80 percent of their costs in the base year shall have a rate set that equals 85 percent of their base year costs;

(2) hospitals that had payments that were above 80 percent, up to and including 90 percent of their costs in the base year shall have a rate set that equals 95 percent of their base year costs; and

(3) hospitals that had payments that were above 90 percent of their costs in the base year shall have a rate set that equals 100 percent of their base year costs.

(j) The commissioner may refine the payment tiers and criteria for critical access hospitals to coincide with the next rebasing under paragraph (h). The factors used to develop the new methodology may include, but are not limited to:

(1) the ratio between the hospital's costs for treating medical assistance patients and the hospital's charges to the medical assistance program;

(2) the ratio between the hospital's costs for treating medical assistance patients and the hospital's payments received from the medical assistance program for the care of medical assistance patients;

(3) the ratio between the hospital's charges to the medical assistance program and the hospital's payments received from the medical assistance program for the care of medical assistance patients;

(4) the statewide average increases in the ratios identified in clauses (1), (2), and (3);

(5) the proportion of that hospital's costs that are administrative and trends in administrative costs; and

(6) geographic location.

(k) Effective for discharges occurring on or after January 1, 2024, the rates paid to hospitals described in paragraph (a), clauses (2) to (4), must include a rate factor specific to each hospital that qualifies for a medical education and research cost distribution under section 62J.692, subdivision 4, paragraph (a).

(l) Effective for discharges occurring on or after January 1, 2025, the commissioner shall increase payments for inpatient mental health services provided by hospitals paid under the DRG methodology by increasing the adjustment for mental health services under paragraph (e).

(m) Effective for discharges occurring on or after January 1, 2025, the commissioner shall increase capitation payments made to managed care plans and county-based purchasing plans to reflect the rate increase provided under paragraph (l). Managed care and county-based purchasing plans must use the capitation rate increase provided under this paragraph to increase payment rates for inpatient mental health services provided by hospitals paid under the DRG methodology. The commissioner must monitor the effect of this rate increase on enrollee access to inpatient mental health services. If for any contract year federal approval is not received for this paragraph, the commissioner must adjust the capitation rates paid to managed care plans and county-based purchasing plans for that contract year to reflect the removal of this paragraph. Contracts between managed care plans and county-based purchasing plans and providers to whom this paragraph applies must allow recovery of payments from those providers if capitation rates are adjusted in accordance with this paragraph. Payment recoveries must not exceed the amount equal to any increase in rates that results from this paragraph.

Sec. 4. **[256B.0617] MENTAL HEALTH SERVICES PROVIDER CERTIFICATION.**

(a) The commissioner of human services shall establish an initial provider entity application and certification and recertification processes to determine whether a provider entity has administrative and clinical infrastructures that meet the certification requirements. This process shall apply to providers of the following services:

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

(2) children's intensive behavioral health services under section 256B.0946; and

(3) intensive nonresidential rehabilitative mental health services under section 256B.0947.

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

(c) The commissioner shall establish a process for decertification of a provider entity and shall require corrective action, medical assistance repayment, or decertification of a provider entity that no longer meets the requirements in this section or that fails to meet the

clinical quality standards or administrative standards provided by the commissioner in the application and certification process.

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

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

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

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

EFFECTIVE DATE. This section is effective July 1, 2024, and the commissioner of human services must implement all requirements of this section by September 1, 2024.

Sec. 5. Minnesota Statutes 2023 Supplement, section 256B.0625, subdivision 5m, is amended to read:

Subd. 5m. **Certified community behavioral health clinic services.** (a) Medical assistance covers services provided by a not-for-profit certified community behavioral health clinic (CCBHC) that meets the requirements of section 245.735, subdivision 3.

(b) The commissioner shall reimburse CCBHCs on a per-day basis for each day that an eligible service is delivered using the CCBHC daily bundled rate system for medical assistance payments as described in paragraph (c). The commissioner shall include a quality incentive payment in the CCBHC daily bundled rate system as described in paragraph (e). There is no county share for medical assistance services when reimbursed through the CCBHC daily bundled rate system.

(c) The commissioner shall ensure that the CCBHC daily bundled rate system for CCBHC payments under medical assistance meets the following requirements:

(1) the CCBHC daily bundled rate shall be a provider-specific rate calculated for each CCBHC, based on the daily cost of providing CCBHC services and the total annual allowable CCBHC costs divided by the total annual number of CCBHC visits. For calculating the payment rate, total annual visits include visits covered by medical assistance and visits not covered by medical assistance. Allowable costs include but are not limited to the salaries and benefits of medical assistance providers; the cost of CCBHC services provided under

section 245.735, subdivision 3, paragraph (a), clauses (6) and (7); and other costs such as insurance or supplies needed to provide CCBHC services;

(2) payment shall be limited to one payment per day per medical assistance enrollee when an eligible CCBHC service is provided. A CCBHC visit is eligible for reimbursement if at least one of the CCBHC services listed under section 245.735, subdivision 3, paragraph (a), clause (6), is furnished to a medical assistance enrollee by a health care practitioner or licensed agency employed by or under contract with a CCBHC;

(3) initial CCBHC daily bundled rates for newly certified CCBHCs under section 245.735, subdivision 3, shall be established by the commissioner using a provider-specific rate based on the newly certified CCBHC's audited historical cost report data adjusted for the expected cost of delivering CCBHC services. Estimates are subject to review by the commissioner and must include the expected cost of providing the full scope of CCBHC services and the expected number of visits for the rate period;

(4) the commissioner shall rebase CCBHC rates once every two years following the last rebasing and no less than 12 months following an initial rate or a rate change due to a change in the scope of services. For CCBHCs certified after September 31, 2020, and before January 1, 2021, the commissioner shall rebase rates according to this clause beginning for dates of service provided on January 1, 2024;

(5) the commissioner shall provide for a 60-day appeals process after notice of the results of the rebasing;

(6) an entity that receives a CCBHC daily bundled rate that overlaps with another federal Medicaid rate is not eligible for the CCBHC rate methodology;

(7) payments for CCBHC services to individuals enrolled in managed care shall be coordinated with the state's phase-out of CCBHC wrap payments. The commissioner shall complete the phase-out of CCBHC wrap payments within 60 days of the implementation of the CCBHC daily bundled rate system in the Medicaid Management Information System (MMIS), for CCBHCs reimbursed under this chapter, with a final settlement of payments due made payable to CCBHCs no later than 18 months thereafter;

(8) the CCBHC daily bundled rate for each CCBHC shall be updated by trending each provider-specific rate by the Medicare Economic Index for primary care services. This update shall occur each year in between rebasing periods determined by the commissioner in accordance with clause (4). CCBHCs must provide data on costs and visits to the state annually using the CCBHC cost report established by the commissioner; and

(9) a CCBHC may request a rate adjustment for changes in the CCBHC's scope of services when such changes are expected to result in an adjustment to the CCBHC payment rate by 2.5 percent or more. The CCBHC must provide the commissioner with information regarding the changes in the scope of services, including the estimated cost of providing the new or modified services and any projected increase or decrease in the number of visits resulting from the change. Estimated costs are subject to review by the commissioner. Rate adjustments for changes in scope shall occur no more than once per year in between rebasing periods per CCBHC and are effective on the date of the annual CCBHC rate update.

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

(e) The commissioner shall implement a quality incentive payment program for CCBHCs that meets the following requirements:

(1) a CCBHC shall receive a quality incentive payment upon meeting specific numeric thresholds for performance metrics established by the commissioner, in addition to payments for which the CCBHC is eligible under the CCBHC daily bundled rate system described in paragraph (c);

(2) a CCBHC must be certified and enrolled as a CCBHC for the entire measurement year to be eligible for incentive payments;

(3) each CCBHC shall receive written notice of the criteria that must be met in order to receive quality incentive payments at least 90 days prior to the measurement year; and

(4) a CCBHC must provide the commissioner with data needed to determine incentive payment eligibility within six months following the measurement year. The commissioner shall notify CCBHC providers of their performance on the required measures and the incentive payment amount within 12 months following the measurement year.

(f) All claims to managed care plans for CCBHC services as provided under this section shall be submitted directly to, and paid by, the commissioner on the dates specified no later than January 1 of the following calendar year, if:

(1) one or more managed care plans does not comply with the federal requirement for payment of clean claims to CCBHCs, as defined in Code of Federal Regulations, title 42, section 447.45(b), and the managed care plan does not resolve the payment issue within 30 days of noncompliance; and

(2) the total amount of clean claims not paid in accordance with federal requirements by one or more managed care plans is 50 percent of, or greater than, the total CCBHC claims eligible for payment by managed care plans.

If the conditions in this paragraph are met between January 1 and June 30 of a calendar year, claims shall be submitted to and paid by the commissioner beginning on January 1 of the following year. If the conditions in this paragraph are met between July 1 and December 31 of a calendar year, claims shall be submitted to and paid by the commissioner beginning on July 1 of the following year.

(g) Peer services provided by a CCBHC certified under section 245.735 are a covered service under medical assistance when a licensed mental health professional or alcohol and drug counselor determines that peer services are medically necessary. Eligibility under this subdivision for peer services provided by a CCBHC supersede eligibility standards under sections 256B.0615, 256B.0616, and 245G.07, subdivision 2, clause (8).

Sec. 6. Minnesota Statutes 2022, section 256B.0757, subdivision 4a, is amended to read:

Subd. 4a. **Behavioral health home services provider requirements.** A behavioral health home services provider must:

(1) be an enrolled Minnesota Health Care Programs provider;

(2) provide a medical assistance covered primary care or behavioral health service;

(3) utilize an electronic health record;

(4) utilize an electronic patient registry that contains data elements required by the commissioner;

(5) demonstrate the organization's capacity to administer screenings approved by the commissioner for substance use disorder or alcohol and tobacco use;

(6) demonstrate the organization's capacity to refer an individual to resources appropriate to the individual's screening results;

(7) have policies and procedures to track referrals to ensure that the referral met the individual's needs;

(8) conduct a brief needs assessment when an individual begins receiving behavioral health home services. The brief needs assessment must be completed with input from the individual and the individual's identified supports. The brief needs assessment must address the individual's immediate safety and transportation needs and potential barriers to participating in behavioral health home services;

(9) conduct a health wellness assessment within 60 days after intake that contains all required elements identified by the commissioner;

(10) conduct a health action plan that contains all required elements identified by the commissioner. The plan must be completed within 90 days after intake and must be updated at least once every six months, or more frequently if significant changes to an individual's needs or goals occur;

(11) agree to cooperate with and participate in the state's monitoring and evaluation of behavioral health home services; and

(12) obtain the individual's ~~written~~ consent to begin receiving behavioral health home services using a form approved by the commissioner.

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

Sec. 7. Minnesota Statutes 2022, section 256B.0757, subdivision 4d, is amended to read:

Subd. 4d. **Behavioral health home services delivery standards.** (a) A behavioral health home services provider must meet the following service delivery standards:

(1) establish and maintain processes to support the coordination of an individual's primary care, behavioral health, and dental care;

(2) maintain a team-based model of care, including regular coordination and communication between behavioral health home services team members;

(3) use evidence-based practices that recognize and are tailored to the medical, social, economic, behavioral health, functional impairment, cultural, and environmental factors affecting the individual's health and health care choices;

(4) use person-centered planning practices to ensure the individual's health action plan accurately reflects the individual's preferences, goals, resources, and optimal outcomes for the individual and the individual's identified supports;

(5) use the patient registry to identify individuals and population subgroups requiring specific levels or types of care and provide or refer the individual to needed treatment, intervention, or services;

(6) ~~utilize the Department of Human Services Partner Portal to~~ identify past and current treatment or services and identify potential gaps in care using a tool approved by the commissioner;

(7) deliver services consistent with the standards for frequency and face-to-face contact required by the commissioner;

(8) ensure that a diagnostic assessment is completed for each individual receiving behavioral health home services within six months of the start of behavioral health home services;

(9) deliver services in locations and settings that meet the needs of the individual;

(10) provide a central point of contact to ensure that individuals and the individual's identified supports can successfully navigate the array of services that impact the individual's health and well-being;

(11) have capacity to assess an individual's readiness for change and the individual's capacity to integrate new health care or community supports into the individual's life;

(12) offer or facilitate the provision of wellness and prevention education on evidenced-based curriculums specific to the prevention and management of common chronic conditions;

(13) help an individual set up and prepare for medical, behavioral health, social service, or community support appointments, including accompanying the individual to appointments as appropriate, and providing follow-up with the individual after these appointments;

(14) offer or facilitate the provision of health coaching related to chronic disease management and how to navigate complex systems of care to the individual, the individual's family, and identified supports;

(15) connect an individual, the individual's family, and identified supports to appropriate support services that help the individual overcome access or service barriers, increase self-sufficiency skills, and improve overall health;

(16) provide effective referrals and timely access to services; and

(17) establish a continuous quality improvement process for providing behavioral health home services.

(b) The behavioral health home services provider must also create a plan, in partnership with the individual and the individual's identified supports, to support the individual after discharge from a hospital, residential treatment program, or other setting. The plan must include protocols for:

(1) maintaining contact between the behavioral health home services team member, the individual, and the individual's identified supports during and after discharge;

(2) linking the individual to new resources as needed;

(3) reestablishing the individual's existing services and community and social supports; and

(4) following up with appropriate entities to transfer or obtain the individual's service records as necessary for continued care.

(c) If the individual is enrolled in a managed care plan, a behavioral health home services provider must:

(1) notify the behavioral health home services contact designated by the managed care plan within 30 days of when the individual begins behavioral health home services; and

(2) adhere to the managed care plan communication and coordination requirements described in the behavioral health home services manual.

(d) Before terminating behavioral health home services, the behavioral health home services provider must:

(1) provide a 60-day notice of termination of behavioral health home services to all individuals receiving behavioral health home services, the commissioner, and managed care plans, if applicable; and

(2) refer individuals receiving behavioral health home services to a new behavioral health home services provider.

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

Sec. 8. Minnesota Statutes 2022, section 256B.0757, subdivision 5, is amended to read:

Subd. 5. **Payments for health home services.** The commissioner shall make payments to each designated provider for the provision of health home services described in subdivision 3, other than behavioral health home services, to each eligible individual under subdivision 2 that selects the health home as a provider.

EFFECTIVE DATE. This section is effective January 1, 2025, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 9. Minnesota Statutes 2022, section 256B.0757, is amended by adding a subdivision to read:

Subd. 5a. **Payments for behavioral health home services.** (a) Notwithstanding subdivision 5, the commissioner shall determine and implement a single statewide reimbursement rate for behavioral health home services under this section. The rate must be no less than $408 per member per month. The commissioner must adjust the statewide reimbursement rate annually according to the change from the midpoint of the previous rate year to the midpoint of the rate year for which the rate is being determined using the Centers for Medicare and Medicaid Services Medicare Economic Index as forecasted in the fourth quarter of the calendar year before the rate year.

(b) The commissioner must review and update the behavioral health home service rate under paragraph (a) at least every four years. The updated rate must account for the average hours required for behavioral health home team members spent providing services and the Department of Labor prevailing wage for required behavioral health home team members. The updated rate must ensure that behavioral health home services rates are sufficient to allow providers to meet required certifications, training, and practice transformation standards, staff qualification requirements, and service delivery standards.

EFFECTIVE DATE. This section is effective January 1, 2025, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 10. Minnesota Statutes 2023 Supplement, section 256B.76, subdivision 1, is amended to read:

Subdivision 1. **Physician and professional services reimbursement.** ~~(a) Effective for services rendered on or after October 1, 1992, the commissioner shall make payments for physician services as follows:~~

~~(1) payment for level one Centers for Medicare and Medicaid Services' common procedural coding system codes titled "office and other outpatient services," "preventive medicine new and established patient," "delivery, antepartum, and postpartum care," "critical care," cesarean delivery and pharmacologic management provided to psychiatric patients,~~

~~and level three codes for enhanced services for prenatal high risk, shall be paid at the lower of (i) submitted charges, or (ii) 25 percent above the rate in effect on June 30, 1992;~~

~~(2) payments for all other services shall be paid at the lower of (i) submitted charges, or (ii) 15.4 percent above the rate in effect on June 30, 1992; and~~

~~(3) all physician rates shall be converted from the 50th percentile of 1982 to the 50th percentile of 1989, less the percent in aggregate necessary to equal the above increases except that payment rates for home health agency services shall be the rates in effect on September 30, 1992.~~

~~(b)~~ (a) Effective for services rendered on or after January 1, 2000, through December 31, 2024, payment rates for physician and professional services shall be increased by three percent over the rates in effect on December 31, 1999, except for home health agency and family planning agency services. The increases in this paragraph shall be implemented January 1, 2000, for managed care.

~~(c)~~ (b) Effective for services rendered on or after July 1, 2009, through December 31, 2024, payment rates for physician and professional services shall be reduced by five percent, except that for the period July 1, 2009, through June 30, 2010, payment rates shall be reduced by 6.5 percent for the medical assistance and general assistance medical care programs, over the rates in effect on June 30, 2009. This reduction and the reductions in paragraph (d) do not apply to office or other outpatient visits, preventive medicine visits and family planning visits billed by physicians, advanced practice registered nurses, or physician assistants in a family planning agency or in one of the following primary care practices: general practice, general internal medicine, general pediatrics, general geriatrics, and family medicine. This reduction and the reductions in paragraph (d) do not apply to federally qualified health centers, rural health centers, and Indian health services. Effective October 1, 2009, payments made to managed care plans and county-based purchasing plans under sections 256B.69, 256B.692, and 256L.12 shall reflect the payment reduction described in this paragraph.

~~(d)~~ (c) Effective for services rendered on or after July 1, 2010, through December 31, 2024, payment rates for physician and professional services shall be reduced an additional seven percent over the five percent reduction in rates described in paragraph (c). This additional reduction does not apply to physical therapy services, occupational therapy services, and speech pathology and related services provided on or after July 1, 2010. This additional reduction does not apply to physician services billed by a psychiatrist or an advanced practice registered nurse with a specialty in mental health. Effective October 1,

2010, payments made to managed care plans and county-based purchasing plans under sections 256B.69, 256B.692, and 256L.12 shall reflect the payment reduction described in this paragraph.

~~(e) Effective for services rendered on or after September 1, 2011, through June 30, 2013, payment rates for physician and professional services shall be reduced three percent from the rates in effect on August 31, 2011. This reduction does not apply to physical therapy services, occupational therapy services, and speech pathology and related services.~~

~~(f)~~ (d) Effective for services rendered on or after September 1, 2014, through December 31, 2024, payment rates for physician and professional services, including physical therapy, occupational therapy, speech pathology, and mental health services shall be increased by five percent from the rates in effect on August 31, 2014. In calculating this rate increase, the commissioner shall not include in the base rate for August 31, 2014, the rate increase provided under section 256B.76, subdivision 7. This increase does not apply to federally qualified health centers, rural health centers, and Indian health services. Payments made to managed care plans and county-based purchasing plans shall not be adjusted to reflect payments under this paragraph.

~~(g)~~ (e) Effective for services rendered on or after July 1, 2015, payment rates for physical therapy, occupational therapy, and speech pathology and related services provided by a hospital meeting the criteria specified in section 62Q.19, subdivision 1, paragraph (a), clause (4), shall be increased by 90 percent from the rates in effect on June 30, 2015. Payments made to managed care plans and county-based purchasing plans shall not be adjusted to reflect payments under this paragraph.

~~(h)~~ (f) Any ratables effective before July 1, 2015, do not apply to early intensive developmental and behavioral intervention (EIDBI) benefits described in section 256B.0949.

~~(i)~~ (g) The commissioner may reimburse physicians and other licensed professionals for costs incurred to pay the fee for testing newborns who are medical assistance enrollees for heritable and congenital disorders under section 144.125, subdivision 1, paragraph (c), when the sample is collected outside of an inpatient hospital or freestanding birth center and the cost is not recognized by another payment source.

Sec. 11. Minnesota Statutes 2022, section 256B.76, subdivision 6, is amended to read:

Subd. 6. **Medicare relative value units.** ~~Effective for services rendered on or after January 1, 2007, the commissioner shall make payments for physician and professional services based on the Medicare relative value units (RVU's). This change shall be budget~~

~~neutral and the cost of implementing RVU's will be incorporated in the established conversion factor~~ (a) Effective for physician and professional services included in the Medicare Physician Fee Schedule for mental health services, the commissioner shall make payments at rates equal to 100 percent of the corresponding rates in the Medicare Physician Fee Schedule. Payment rates set under this paragraph must use Medicare relative value units (RVUs) and conversion factors equal to those in the Medicare Physician Fee Schedule to implement the resource-based relative value scale.

(b) The commissioner shall revise fee-for-service payment methodologies under this section upon the issuance of a Medicare Physician Fee Schedule final rule by the Centers for Medicare and Medicaid Services to ensure the payment rates under this subdivision are equal to the corresponding rates in the final rule.

(c) All mental health services performed in a primary care or mental health care health professional shortage area, medically underserved area, or medically underserved population, as maintained and updated by the United States Department of Health and Human Services, are eligible for a ten percent bonus payment. Such services are eligible for a bonus based upon the performance of the service in a health professional shortage area if the provider maintains an office in a health professional shortage area.

(d) Effective for services rendered on or after January 1, 2025, the commissioner shall increase capitation payments made to managed care plans and county-based purchasing plans to reflect the rate increases provided under this subdivision. Managed care and county-based purchasing plans must use the capitation rate increase provided under this paragraph to increase payment rates to the providers corresponding to the rate increases. The commissioner must monitor the effect of this rate increase on enrollee access to services under this subdivision. If for any contract year federal approval is not received for this paragraph, the commissioner must adjust the capitation rates paid to managed care plans and county-based purchasing plans for that contract year to reflect the removal of this paragraph. Contracts between managed care plans and county-based purchasing plans and providers to whom this paragraph applies must allow recovery of payments from those providers if capitation rates are adjusted in accordance with this paragraph. Payment recoveries must not exceed the amount equal to any increase in rates that results from this paragraph.

Sec. 12. Minnesota Statutes 2023 Supplement, section 256B.761, is amended to read:

256B.761 REIMBURSEMENT FOR MENTAL HEALTH SERVICES.

(a) Effective for services rendered on or after July 1, 2001, payment for medication management provided to psychiatric patients, outpatient mental health services, day treatment services, home-based mental health services, and family community support services shall be paid at the lower of (1) submitted charges, or (2) 75.6 percent of the 50th percentile of 1999 charges.

(b) Effective July 1, 2001, the medical assistance rates for outpatient mental health services provided by an entity that operates: (1) a Medicare-certified comprehensive outpatient rehabilitation facility; and (2) a facility that was certified prior to January 1, 1993, with at least 33 percent of the clients receiving rehabilitation services in the most recent calendar year who are medical assistance recipients, will be increased by 38 percent, when those services are provided within the comprehensive outpatient rehabilitation facility and provided to residents of nursing facilities owned by the entity.

(c) In addition to rate increases otherwise provided, the commissioner may restructure coverage policy and rates to improve access to adult rehabilitative mental health services under section 256B.0623 and related mental health support services under section 256B.021, subdivision 4, paragraph (f), clause (2). For state fiscal years 2015 and 2016, the projected state share of increased costs due to this paragraph is transferred from adult mental health grants under sections 245.4661 and 256E.12. The transfer for fiscal year 2016 is a permanent base adjustment for subsequent fiscal years. Payments made to managed care plans and county-based purchasing plans under sections 256B.69, 256B.692, and 256L.12 shall reflect the rate changes described in this paragraph.

(d) Any ratables effective before July 1, 2015, do not apply to early intensive developmental and behavioral intervention (EIDBI) benefits described in section 256B.0949.

(e) Effective for services rendered on or after January 1, 2024, payment rates for behavioral health services included in the rate analysis required by Laws 2021, First Special Session chapter 7, article 17, section 18, except for adult day treatment services under section 256B.0671, subdivision 3; early intensive developmental and behavioral intervention services under section 256B.0949; and substance use disorder services under chapter 254B, must be increased by three percent from the rates in effect on December 31, 2023. Effective for services rendered on or after January 1, 2025, payment rates for behavioral health services included in the rate analysis required by Laws 2021, First Special Session chapter 7, article 17, section 18, except for adult day treatment services under section 256B.0671, subdivision

3; early intensive developmental behavioral intervention services under section 256B.0949; and substance use disorder services under chapter 254B, must be annually adjusted according to the change from the midpoint of the previous rate year to the midpoint of the rate year for which the rate is being determined using the Centers for Medicare and Medicaid Services Medicare Economic Index as forecasted in the fourth quarter of the calendar year before the rate year. For payments made in accordance with this paragraph, if and to the extent that the commissioner identifies that the state has received federal financial participation for behavioral health services in excess of the amount allowed under United States Code, title 42, section 447.321, the state shall repay the excess amount to the Centers for Medicare and Medicaid Services with state money and maintain the full payment rate under this paragraph. This paragraph does not apply to federally qualified health centers, rural health centers, Indian health services, certified community behavioral health clinics, cost-based rates, and rates that are negotiated with the county. This paragraph expires upon legislative implementation of the new rate methodology resulting from the rate analysis required by Laws 2021, First Special Session chapter 7, article 17, section 18.

(f) Effective January 1, 2024, the commissioner shall increase capitation payments made to managed care plans and county-based purchasing plans to reflect the behavioral health service rate increase provided in paragraph (e). Managed care and county-based purchasing plans must use the capitation rate increase provided under this paragraph to increase payment rates to behavioral health services providers. The commissioner must monitor the effect of this rate increase on enrollee access to behavioral health services. If for any contract year federal approval is not received for this paragraph, the commissioner must adjust the capitation rates paid to managed care plans and county-based purchasing plans for that contract year to reflect the removal of this provision. Contracts between managed care plans and county-based purchasing plans and providers to whom this paragraph applies must allow recovery of payments from those providers if capitation rates are adjusted in accordance with this paragraph. Payment recoveries must not exceed the amount equal to any increase in rates that results from this provision.

(g) Effective for mental health services under this section billed and coded under Healthcare Common Procedure Coding System H, S, and T codes, the payment rates shall be increased as necessary to align with the Medicare Physician Fee Schedule.

Sec. 13. **MENTAL HEALTH SERVICES FORMULA-BASED ALLOCATION.**

The commissioner of human services shall consult with the commissioner of management and budget, counties, Tribes, mental health providers, and advocacy organizations to develop

recommendations for moving from the children's and adult mental health grant funding structure to a formula-based allocation structure for mental health services. The recommendations must consider formula-based allocations for grants for respite care, school-linked behavioral health, mobile crisis teams, and first episode of psychosis programs.

ARTICLE 7
APPROPRIATIONS

Section 1. Laws 2021, First Special Session chapter 7, article 17, section 12, as amended by Laws 2022, chapter 98, article 15, section 13, Laws 2022, chapter 99, article 1, section 43, and Laws 2023, chapter 70, article 20, section 18, is amended to read:

Sec. 12. **ADULT AND CHILDREN'S MOBILE TRANSITION UNITS.**

(a) This act includes $1,572,000 in fiscal year 2022 and $0 in fiscal year 2023 for the commissioner of human services to create adult and children's mental health transition and support teams to facilitate transition back to the community or to the least restrictive level of care from inpatient psychiatric settings, emergency departments, inpatient hospitalization, juvenile detention facilities, residential treatment facilities, and child and adolescent behavioral health hospitals. Any unexpended amount in fiscal year 2022 is available through June 30, 2023. The general fund base included in this act for this purpose is $1,875,000 in fiscal year 2024 and ~~$0~~ $2,500,000 in fiscal year 2025.

(b) Beginning April 1, 2024, counties may fund and continue conducting activities funded under this section.

~~(c) This section expires March 31, 2024.~~

EFFECTIVE DATE. This section is effective retroactively from January 1, 2024.

Sec. 2. Laws 2023, chapter 70, article 20, section 2, subdivision 29, is amended to read:

Subd. 29. **Grant Programs; Adult Mental Health Grants**	132,327,000	121,270,000
(a) **Mobile crisis grants to Tribal Nations.** $1,000,000 in fiscal year 2024 and $1,000,000 in fiscal year 2025 are for mobile crisis grants under Minnesota Statutes section 245.4661, subdivision 9, paragraph (b), clause (15), to Tribal Nations.		

(b) **Mental health provider supervision grant program.** $1,500,000 in fiscal year 2024 and $1,500,000 in fiscal year 2025 are for the mental health provider supervision grant program under Minnesota Statutes, section 245.4663.

(c) **Minnesota State University, Mankato community behavioral health center.** $750,000 in fiscal year 2024 and $750,000 in fiscal year 2025 are for a grant to the Center for Rural Behavioral Health at Minnesota State University, Mankato to establish a community behavioral health center and training clinic. The community behavioral health center must provide comprehensive, culturally specific, trauma-informed, practice- and evidence-based, person- and family-centered mental health and substance use disorder treatment services in Blue Earth County and the surrounding region to individuals of all ages, regardless of an individual's ability to pay or place of residence. The community behavioral health center and training clinic must also provide training and workforce development opportunities to students enrolled in the university's training programs in the fields of social work, counseling and student personnel, alcohol and drug studies, psychology, and nursing. Upon request, the commissioner must make information regarding the use of this grant funding available to the chairs and ranking minority members of the legislative committees with jurisdiction over behavioral health. This is a onetime appropriation and is available until June 30, 2027.

(d) **White Earth Nation; adult mental health initiative.** $300,000 in fiscal year 2024 and $300,000 in fiscal year 2025 are for adult mental health initiative grants to the White Earth Nation. This is a onetime appropriation.

(e) **Mobile crisis grants.** $8,472,000 in fiscal year 2024 and ~~$8,380,000~~ $8,472,000 in fiscal year 2025 are for the mobile crisis grants under Minnesota Statutes, section 245.4661, subdivision 9, paragraph (b), clause (15). This ~~is a onetime~~ appropriation ~~and~~ is available until June 30, 2027. This funding is added to the base.

(f) **Base level adjustment.** The general fund base is $121,980,000 in fiscal year 2026 and $121,980,000 in fiscal year 2027.

Sec. 3. **APPROPRIATION; SOMALI MENTAL HEALTH PILOT PROJECT.**

(a) $900,000 in fiscal year 2024 and $900,000 in fiscal year 2025 are appropriated from the general fund to the commissioner of human services for a grant to the Intercultural Mutual Assistance Association for a pilot project in the city of Rochester to provide mental health education and support services to Somali students and mothers. The Intercultural Mutual Assistance Association shall partner with the Rochester Math and Science Academy and the Somali American Social Service Association to implement the pilot project.

(b) As part of the pilot project, the Intercultural Mutual Assistance Association and its partners shall:

(1) expand a dialectical behavioral therapy skills in schools pilot program for 20 or more additional students attending the Rochester Math and Science Academy and offer the program annually;

(2) develop and provide an educational program at the Rochester Math and Science Academy to build resiliency skills and improve students' social and emotional development; and

(3) establish a discussion group for mothers of students attending the Rochester Math and Science Academy to promote physical and emotional wellness.

(c) Grant funds may be used for pilot program development and implementation, staffing, training, and administrative costs.

(d) By January 15, 2025, the Intercultural Mutual Assistance Association must submit a report to the chairs and ranking minority members of the legislative committees with jurisdiction over mental health detailing the results of the pilot project. This is a onetime appropriation.

Sec. 4. **APPROPRIATION; ENGAGEMENT SERVICES PILOT GRANTS.**

$2,000,000 in fiscal year 2025 is appropriated from the general fund to the commissioner of human services for engagement services pilot grants under Minnesota Statutes, section 253B.042. This funding is added to the base.

Sec. 5. **APPROPRIATION; PROTECTED TRANSPORT START-UP GRANTS.**

$500,000 in fiscal year 2025 is appropriated from the general fund to the commissioner of human services to provide start-up grants to nonemergency medical transportation providers to configure vehicles to meet protected transport requirements. This funding is added to the base.

Sec. 6. **APPROPRIATION; RESPITE CARE SERVICES.**

(a) $5,000,000 in fiscal year 2025 is appropriated from the general fund to the commissioner of human services for respite care services under Minnesota Statutes, section 245.4889, subdivision 1, paragraph (b), clause (3).

(b) Of this appropriation, $1,000,000 in fiscal year 2025 is for grants to private child-placing agencies, as defined in Minnesota Rules, chapter 9545, to conduct recruitment and support licensing activities that are specific to increasing the availability of licensed foster homes to provide respite care services.

Sec. 7. **APPROPRIATION; IN-HOME CHILDREN'S MENTAL HEALTH INFRASTRUCTURE GRANTS.**

(a) $5,000,000 in fiscal year 2025 is appropriated from the general fund to the commissioner of human services for infrastructure grants to develop family-centered in-home mental health services that include children's intensive behavioral health services under Minnesota Statutes, section 256B.0946; intensive rehabilitative mental health services under Minnesota Statutes, section 256B.0947; services under Minnesota Statutes, section 256B.0943, that are provided in the home; and high-fidelity wrap around and collaborative

intensive bridging services eligible for grants under Minnesota Statutes, section 245.4889, subdivision 1, paragraph (b), clause (17).

(b) Grant funding may be used for start-up costs, including but not limited to initial hiring for specialized roles, staff training, technical assistance, and ancillary service costs required to establish and support the launch of these intensive mental health team models.

Sec. 8. **APPROPRIATION; CHILDREN'S RESIDENTIAL TREATMENT PROGRAMS.**

$2,500,000 in fiscal year 2025 is appropriated from the general fund to the commissioner of human services for a grant to an organization that provides children's residential treatment for mental health and substance use disorder to modify and sustain its children's residential treatment programs in Minnesota. Grant funds must be used to implement a planned consolidation of existing children's residential treatment programs and to create a specialized children's residential treatment program campus for children and youth with complex, high-acuity behavioral health treatment needs. This is a onetime appropriation.

256D.19 ABOLITION OF TOWNSHIP SYSTEM OF POOR RELIEF.

Subdivision 1. **Town system abolished.** The town system for caring for the poor in each of the counties in which it is in effect is hereby abolished. The local social services agency of each county shall administer general assistance under the provisions of Laws 1973, chapter 650, article 21.

Subd. 2. **Local social services agencies duty.** All local social services agencies affected by Laws 1973, chapter 650, article 21 are hereby authorized to take over for the county as of January 1, 1974, the ownership of all case records relating to the administration of poor relief.

256D.20 TRANSFER OF TOWN EMPLOYEES.

Subdivision 1. **Rules for merit system.** The term "merit system" as used herein shall mean the rules for a merit system of personnel administration for employees of local social services agencies adopted by the commissioner of human services in accordance with the provisions of section 393.07, including the merit system established for Hennepin County pursuant to Laws 1965, chapter 855, as amended, the federal Social Security article as amended, and merit system standards and regulations issued by the federal Social Security Board and the United States Children's Bureau.

Subd. 2. **Designation of employees.** All employees of any municipality or town who are engaged full time in poor relief work therein on January 1, 1974 shall be retained as employees of the county and placed under the jurisdiction of its local social services agency.

All transferred employees shall be blanketed into the merit system with comparable status, classification, longevity, and seniority, and subject to the administrative requirements of the local social services agency. Employees with permanent status under any civil service provision on January 1, 1974, shall be granted permanent status under the merit system at comparable classifications and in accordance with work assignments made under the authority of the local social services agency as provided by the merit system rules.

The determination of proper job allocation shall be the responsibility of the personnel officer or director as provided under merit system rules applicable to the county involved with the right of appeal of allocation to the Merit System Council or personnel board by any employee affected by this transfer.

All transferred employees shall receive salaries for the classification to which they are allocated in accordance with the schedule in effect for local social services agency employees and at a salary step which they normally would have received had they been employed by the local social services agency for the same period of service they had previously served under the civil service provisions of any municipality or town; provided, however, that no salary shall be reduced as a result of the transfer.

All accumulated sick leave of transferred employees in the amount of 60 days or less shall be transferred to the records of the local social services agency and such accumulated sick leave shall be the legal liability of the local social services agency. All accumulated sick leave in excess of 60 days shall be paid in cash to transferred employees by the municipality or town by which they were employed prior to their transfer, at the time of transfer. In lieu of the cash payment, the municipality or town shall, at the option of the employee concerned, allow a leave of absence with pay, prior to transfer, for all or part of the accumulated sick leave.

Subd. 3. **Merit system transfer.** Employees of municipalities and towns engaged in the work of administering poor relief who are not covered by civil service provisions shall be blanketed into the merit system subject to a qualifying examination. Employees with one year or more service shall be subject to a qualifying examination and those with less than one year's service shall be subject to an open competitive examination.

Subd. 4. **Disbursement of vacation time.** All vacation leave of employees referred to in subdivision 2, accumulated prior to their transfer to county employment shall be paid in cash to them by the municipality or town by which they were employed prior to their transfer, and at the time of their transfer. In lieu of the cash payment, the municipality or town shall, at the option of the employee concerned, allow a leave of absence with pay, prior to such transfer, for all or part of the accumulated vacation time.

256D.23 TEMPORARY COUNTY ASSISTANCE PROGRAM.

Subdivision 1. **Program established.** Minnesota residents who meet the income and resource standards of section 256D.01, subdivision 1a, but do not qualify for cash benefits under sections 256D.01 to 256D.21, may qualify for a county payment under this section.

Subd. 2. **Payment amount, duration, and method.** (a) A county may make a payment of up to $203 for a single individual and up to $260 for a married couple under the terms of this subdivision.

(b) Payments to an individual or married couple may only be made once in a calendar year. If the applicant qualifies for a payment as a result of an emergency, as defined by the county, the payment shall be made within ten working days of the date of application. If the applicant does not qualify under the county definition of emergency, the payment shall be made at the beginning of the second month following the month of application, and the applicant must receive the payment in person at the local agency office.

(c) Payments may be made in the form of cash or as vendor payments for rent and utilities. If vendor payments are made, they shall be equal to $203 for a single individual or $260 for a married couple, or the actual amount of rent and utilities, whichever is less.

(d) Each county must develop policies and procedures as necessary to implement this section.

(e) Payments under this section are not an entitlement. No county is required to make a payment in excess of the amount available to the county under subdivision 3.

Subd. 3. **State allocation to counties.** The commissioner shall allocate to each county on an annual basis the amount specifically appropriated for payments under this section. The allocation shall be based on each county's proportionate share of state fiscal year 1994 work readiness expenditures.

2960.0620 USE OF PSYCHOTROPIC MEDICATIONS.

Subp. 3. **Monitoring for tardive dyskinesia.** The license holder, under the direction of a medically licensed person, must monitor for tardive dyskinesia at least every three months if a resident is prescribed antipsychotic medication or amoxapine and must document the monitoring. A resident prescribed antipsychotic medication or amoxapine for more than 90 days must be checked for tardive dyskinesia at least 30 and 60 days after discontinuation of the antipsychotic medication or amoxapine. Monitoring must include use of a standardized rating scale and examination procedure. The license holder must provide the assessments to the physician for review if the results meet criteria that require physician review.