ARTICLE 7

MENTAL HEALTH UNIFORM SERVICE STANDARDS

Section 1. Minnesota Statutes 2018, section 62A.152, subdivision 3, is amended to read:

Subd. 3. **Provider discrimination prohibited.** All group policies and group subscriber contracts that provide benefits for mental or nervous disorder treatments in a hospital must provide direct reimbursement for those services if performed by a mental health professional~~, as defined in sections 245.462, subdivision 18, clauses (1) to (5); and 245.4871, subdivision 27, clauses (1) to (5),~~ qualified according to section 245I.16, subdivision 2, to the extent that the services and treatment are within the scope of mental health professional licensure.

This subdivision is intended to provide payment of benefits for mental or nervous disorder treatments performed by a licensed mental health professional in a hospital and is not intended to change or add benefits for those services provided in policies or contracts to which this subdivision applies.

Sec. 2. Minnesota Statutes 2018, section 62A.3094, subdivision 1, is amended to read:

Subdivision 1. **Definitions.** (a) For purposes of this section, the terms defined in paragraphs (b) to (d) have the meanings given.

(b) "Autism spectrum disorders" means the conditions as determined by criteria set forth in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association.

(c) "Medically necessary care" means health care services appropriate, in terms of type, frequency, level, setting, and duration, to the enrollee's condition, and diagnostic testing and preventative services. Medically necessary care must be consistent with generally accepted practice parameters as determined by physicians and licensed psychologists who typically manage patients who have autism spectrum disorders.

(d) "Mental health professional" means a mental health professional as ~~defined in section 245.4871, subdivision 27~~ described in section 245I.16, subdivision 2, clause (1), (2), (3), (4), or (6), who has training and expertise in autism spectrum disorder and child development.

Sec. 3. Minnesota Statutes 2018, section 148B.5301, subdivision 2, is amended to read:

Subd. 2. **Supervision.** (a) To qualify as a LPCC, an applicant must have completed 4,000 hours of post-master's degree supervised professional practice in the delivery of clinical services in the diagnosis and treatment of mental illnesses and disorders in both children and adults. The supervised practice shall be conducted according to the requirements in paragraphs (b) to (e).

(b) The supervision must have been received under a contract that defines clinical practice and supervision from a mental health professional ~~as defined in section 245.462, subdivision 18, clauses (1) to (6), or 245.4871, subdivision 27, clauses (1) to (6),~~ qualified according

to section 245I.16, subdivision 2, or by a board-approved supervisor, who has at least two years of postlicensure experience in the delivery of clinical services in the diagnosis and treatment of mental illnesses and disorders. All supervisors must meet the supervisor requirements in Minnesota Rules, part 2150.5010.

(c) The supervision must be obtained at the rate of two hours of supervision per 40 hours of professional practice. The supervision must be evenly distributed over the course of the supervised professional practice. At least 75 percent of the required supervision hours must be received in person. The remaining 25 percent of the required hours may be received by telephone or by audio or audiovisual electronic device. At least 50 percent of the required hours of supervision must be received on an individual basis. The remaining 50 percent may be received in a group setting.

(d) The supervised practice must include at least 1,800 hours of clinical client contact.

(e) The supervised practice must be clinical practice. Supervision includes the observation by the supervisor of the successful application of professional counseling knowledge, skills, and values in the differential diagnosis and treatment of psychosocial function, disability, or impairment, including addictions and emotional, mental, and behavioral disorders.

Sec. 4. Minnesota Statutes 2018, section 148E.0555, subdivision 6, is amended to read:

Subd. 6. **Qualifications during grandfathering for licensure as LICSW.** (a) To be licensed as a licensed independent clinical social worker, an applicant for licensure under this section must provide evidence satisfactory to the board that the individual has:

(1) completed a graduate degree in social work from a program accredited by the Council on Social Work Education, the Canadian Association of Schools of Social Work, or a similar accrediting body designated by the board; or

(2) completed a graduate degree and is a mental health professional according to section ~~245.462, subdivision 18, clauses (1) to (6)~~ 245I.16, subdivision 2.

(b) To be licensed as a licensed independent clinical social worker, an applicant for licensure under this section must provide evidence satisfactory to the board that the individual has:

(1) practiced clinical social work as defined in section 148E.010, subdivision 6, including both diagnosis and treatment, and has met the supervised practice requirements specified in sections 148E.100 to 148E.125, excluding the 1,800 hours of direct clinical client contact specified in section 148E.115, subdivision 1, except that supervised practice hours obtained prior to August 1, 2011, must meet the requirements in Minnesota Statutes 2010, sections 148D.100 to 148D.125;

(2) submitted a completed, signed application and the license fee in section 148E.180;

(3) for applications submitted electronically, provided an attestation as specified by the board;

(4) submitted the criminal background check fee and a form provided by the board authorizing a criminal background check;

(5) paid the license fee in section 148E.180; and

(6) not engaged in conduct that was or would be in violation of the standards of practice specified in Minnesota Statutes 2010, sections 148D.195 to 148D.240, and sections 148E.195 to 148E.240. If the applicant has engaged in conduct that was or would be in violation of the standards of practice, the board may take action according to sections 148E.255 to 148E.270.

(c) An application which is not completed, signed, and accompanied by the correct license fee must be returned to the applicant, along with any fee submitted, and is void.

(d) By submitting an application for licensure, an applicant authorizes the board to investigate any information provided or requested in the application. The board may request that the applicant provide additional information, verification, or documentation.

(e) Within one year of the time the board receives an application for licensure, the applicant must meet all the requirements and provide all of the information requested by the board.

Sec. 5. Minnesota Statutes 2018, section 148E.120, subdivision 2, is amended to read:

Subd. 2. **Alternate supervisors.** (a) The board may approve an alternate supervisor as determined in this subdivision. The board shall approve up to 25 percent of the required supervision hours by a licensed mental health professional who is competent and qualified to provide supervision according to the mental health professional's respective licensing board, as established by section ~~245.462, subdivision 18, clauses (1) to (6), or 245.4871, subdivision 27, clauses (1) to (6)~~ 245I.16, subdivision 2.

(b) The board shall approve up to 100 percent of the required supervision hours by an alternate supervisor if the board determines that:

(1) there are five or fewer supervisors in the county where the licensee practices social work who meet the applicable licensure requirements in subdivision 1;

(2) the supervisor is an unlicensed social worker who is employed in, and provides the supervision in, a setting exempt from licensure by section 148E.065, and who has qualifications equivalent to the applicable requirements specified in sections 148E.100 to 148E.115;

(3) the supervisor is a social worker engaged in authorized social work practice in Iowa, Manitoba, North Dakota, Ontario, South Dakota, or Wisconsin, and has the qualifications equivalent to the applicable requirements in sections 148E.100 to 148E.115; or

(4) the applicant or licensee is engaged in nonclinical authorized social work practice outside of Minnesota and the supervisor meets the qualifications equivalent to the applicable

requirements in sections 148E.100 to 148E.115, or the supervisor is an equivalent mental health professional, as determined by the board, who is credentialed by a state, territorial, provincial, or foreign licensing agency; or

(5) the applicant or licensee is engaged in clinical authorized social work practice outside of Minnesota and the supervisor meets qualifications equivalent to the applicable requirements in section 148E.115, or the supervisor is an equivalent mental health professional as determined by the board, who is credentialed by a state, territorial, provincial, or foreign licensing agency.

(c) In order for the board to consider an alternate supervisor under this section, the licensee must:

(1) request in the supervision plan and verification submitted according to section 148E.125 that an alternate supervisor conduct the supervision; and

(2) describe the proposed supervision and the name and qualifications of the proposed alternate supervisor. The board may audit the information provided to determine compliance with the requirements of this section.

Sec. 6. Minnesota Statutes 2018, section 148F.11, subdivision 1, is amended to read:

Subdivision 1. **Other professionals.** (a) Nothing in this chapter prevents members of other professions or occupations from performing functions for which they are qualified or licensed. This exception includes, but is not limited to: licensed physicians; registered nurses; licensed practical nurses; licensed psychologists and licensed psychological practitioners; members of the clergy provided such services are provided within the scope of regular ministries; American Indian medicine men and women; licensed attorneys; probation officers; licensed marriage and family therapists; licensed social workers; social workers employed by city, county, or state agencies; licensed professional counselors; licensed professional clinical counselors; licensed school counselors; registered occupational therapists or occupational therapy assistants; Upper Midwest Indian Council on Addictive Disorders (UMICAD) certified counselors when providing services to Native American people; city, county, or state employees when providing assessments or case management under Minnesota Rules, chapter 9530; and individuals defined in section 256B.0623, subdivision 5, clauses (1) ~~and (2)~~ to (4), providing integrated dual diagnosis treatment in adult mental health rehabilitative programs certified by the Department of Human Services under section 256B.0622 or 256B.0623.

(b) Nothing in this chapter prohibits technicians and resident managers in programs licensed by the Department of Human Services from discharging their duties as provided in Minnesota Rules, chapter 9530.

(c) Any person who is exempt from licensure under this section must not use a title incorporating the words "alcohol and drug counselor" or "licensed alcohol and drug counselor" or otherwise hold himself or herself out to the public by any title or description stating or implying that he or she is engaged in the practice of alcohol and drug counseling,

or that he or she is licensed to engage in the practice of alcohol and drug counseling, unless that person is also licensed as an alcohol and drug counselor. Persons engaged in the practice of alcohol and drug counseling are not exempt from the board's jurisdiction solely by the use of one of the titles in paragraph (a).

Sec. 7. Minnesota Statutes 2018, 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 ~~clinical~~ 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.

Sec. 8. Minnesota Statutes 2018, section 245.462, subdivision 8, is amended to read:

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

~~services are distinguished from day care by their structured therapeutic program of psychotherapy services. The commissioner may limit medical assistance reimbursement for day treatment to 15 hours per week per person~~ the treatment services described under section 256B.0625, subdivision 23.

Sec. 9. Minnesota Statutes 2018, section 245.462, subdivision 9, is amended to read:

Subd. 9. **Diagnostic assessment.** ~~(a)~~ "Diagnostic assessment" ~~has the meaning given in Minnesota Rules, part 9505.0370, subpart 11, and is delivered as provided in Minnesota Rules, part 9505.0372, subpart 1, items A, B, C, and E. Diagnostic assessment includes a standard, extended, or brief diagnostic assessment, or an adult update~~ means the assessment described under section 256B.0671, subdivisions 2 to 4.

~~(b) A brief diagnostic assessment must include a face-to-face interview with the client and a written evaluation of the client by a mental health professional or a clinical trainee, as provided in Minnesota Rules, part 9505.0371, subpart 5, item C. The professional or clinical trainee must gather initial components of a standard diagnostic assessment, including the client's:~~

~~(1) age;~~

~~(2) description of symptoms, including reason for referral;~~

~~(3) history of mental health treatment;~~

~~(4) cultural influences and their impact on the client; and~~

~~(5) mental status examination.~~

~~(c) On the basis of the initial components, the professional or clinical trainee must draw a provisional clinical hypothesis. The clinical hypothesis may be used to address the client's immediate needs or presenting problem.~~

~~(d) Treatment sessions conducted under authorization of a brief assessment may be used to gather additional information necessary to complete a standard diagnostic assessment or an extended diagnostic assessment.~~

~~(e) Notwithstanding Minnesota Rules, part 9505.0371, subpart 2, item A, subitem (1), unit (b), prior to completion of a client's initial diagnostic assessment, a client is eligible for psychological testing as part of the diagnostic process.~~

~~(f) Notwithstanding Minnesota Rules, part 9505.0371, subpart 2, item A, subitem (1), unit (c), prior to completion of a client's initial diagnostic assessment, but in conjunction with the diagnostic assessment process, a client is eligible for up to three individual or family psychotherapy sessions or family psychoeducation sessions or a combination of the above sessions not to exceed three sessions.~~

~~(g) Notwithstanding Minnesota Rules, part 9505.0371, subpart 2, item B, subitem (3), unit (a), a brief diagnostic assessment may be used for a client's family who requires a language interpreter to participate in the assessment.~~

Sec. 10. Minnesota Statutes 2018, section 245.462, subdivision 14, is amended to read:

Subd. 14. **Individual treatment plan.** "Individual treatment plan" means ~~a written plan of intervention, treatment, and services for an adult with mental illness that is developed by a service provider under the clinical supervision of a mental health professional on the basis of a diagnostic assessment. The plan identifies goals and objectives of treatment, treatment strategy, a schedule for accomplishing treatment goals and objectives, and the individual responsible for providing treatment to the adult with mental illness~~ the individual treatment plan described under section 256B.0671, subdivisions 5 and 6.

Sec. 11. Minnesota Statutes 2018, section 245.462, subdivision 17, is amended to read:

Subd. 17. **Mental health practitioner.** ~~(a)~~ "Mental health practitioner" means a person ~~providing services to adults with mental illness or children with emotional disturbance who is qualified in at least one of the ways described in paragraphs (b) to (g). A mental health practitioner for a child client must have training working with children. A mental health practitioner for an adult client must have training working with adults~~ qualified according to section 245I.16, subdivision 4.

~~(b) For purposes of this subdivision, a practitioner is qualified through relevant coursework if the practitioner completes at least 30 semester hours or 45 quarter hours in behavioral sciences or related fields and:~~

~~(1) has at least 2,000 hours of supervised experience in the delivery of services to adults or children with:~~

~~(i) mental illness, substance use disorder, or emotional disturbance; or~~

~~(ii) traumatic brain injury or developmental disabilities and completes training on mental illness, recovery from mental illness, mental health de-escalation techniques, co-occurring mental illness and substance abuse, and psychotropic medications and side effects;~~

~~(2) is fluent in the non-English language of the ethnic group to which at least 50 percent of the practitioner's clients belong, completes 40 hours of training in the delivery of services to adults with mental illness or children with emotional disturbance, and receives clinical supervision from a mental health professional at least once a week until the requirement of 2,000 hours of supervised experience is met;~~

~~(3) is working in a day treatment program under section 245.4712, subdivision 2; or~~

~~(4) has completed a practicum or internship that (i) requires direct interaction with adults or children served, and (ii) is focused on behavioral sciences or related fields.~~

~~(c) For purposes of this subdivision, a practitioner is qualified through work experience if the person:~~

~~(1) has at least 4,000 hours of supervised experience in the delivery of services to adults or children with:~~

~~(i) mental illness, substance use disorder, or emotional disturbance; or~~

~~(ii) traumatic brain injury or developmental disabilities and completes training on mental illness, recovery from mental illness, mental health de-escalation techniques, co-occurring mental illness and substance abuse, and psychotropic medications and side effects; or~~

~~(2) has at least 2,000 hours of supervised experience in the delivery of services to adults or children with:~~

~~(i) mental illness, emotional disturbance, or substance use disorder, and receives clinical supervision as required by applicable statutes and rules from a mental health professional at least once a week until the requirement of 4,000 hours of supervised experience is met; or~~

~~(ii) traumatic brain injury or developmental disabilities; completes training on mental illness, recovery from mental illness, mental health de-escalation techniques, co-occurring mental illness and substance abuse, and psychotropic medications and side effects; and receives clinical supervision as required by applicable statutes and rules at least once a week from a mental health professional until the requirement of 4,000 hours of supervised experience is met.~~

~~(d) For purposes of this subdivision, a practitioner is qualified through a graduate student internship if the practitioner is a graduate student in behavioral sciences or related fields and is formally assigned by an accredited college or university to an agency or facility for clinical training.~~

~~(e) For purposes of this subdivision, a practitioner is qualified by a bachelor's or master's degree if the practitioner:~~

~~(1) holds a master's or other graduate degree in behavioral sciences or related fields; or~~

~~(2) holds a bachelor's degree in behavioral sciences or related fields and completes a practicum or internship that (i) requires direct interaction with adults or children served, and (ii) is focused on behavioral sciences or related fields.~~

~~(f) For purposes of this subdivision, a practitioner is qualified as a vendor of medical care if the practitioner meets the definition of vendor of medical care in section 256B.02, subdivision 7, paragraphs (b) and (c), and is serving a federally recognized tribe.~~

~~(g) For purposes of medical assistance coverage of diagnostic assessments, explanations of findings, and psychotherapy under section 256B.0625, subdivision 65, a mental health practitioner working as a clinical trainee means that the practitioner's clinical supervision~~

~~experience is helping the practitioner gain knowledge and skills necessary to practice effectively and independently. This may include supervision of direct practice, treatment team collaboration, continued professional learning, and job management. The practitioner must also:~~

~~(1) comply with requirements for licensure or board certification as a mental health professional, according to the qualifications under Minnesota Rules, part 9505.0371, subpart 5, item A, including supervised practice in the delivery of mental health services for the treatment of mental illness; or~~

~~(2) be a student in a bona fide field placement or internship under a program leading to completion of the requirements for licensure as a mental health professional according to the qualifications under Minnesota Rules, part 9505.0371, subpart 5, item A.~~

~~(h) For purposes of this subdivision, "behavioral sciences or related fields" has the meaning given in section 256B.0623, subdivision 5, paragraph (d).~~

~~(i) Notwithstanding the licensing requirements established by a health-related licensing board, as defined in section 214.01, subdivision 2, this subdivision supersedes any other statute or rule.~~

Sec. 12. Minnesota Statutes 2018, section 245.462, subdivision 18, is amended to read:

Subd. 18. **Mental health professional.** "Mental health professional" means a person ~~providing clinical services in the treatment of mental illness who is qualified in at least one of the following ways:~~ qualified according to section 245I.16, subdivision 2.

~~(1) in psychiatric nursing: a registered nurse who is licensed under sections 148.171 to 148.285; and:~~

~~(i) who is certified as a clinical specialist or as a nurse practitioner in adult or family psychiatric and mental health nursing by a national nurse certification organization; or~~

~~(ii) who has a master's degree in nursing or one of the behavioral sciences or related fields from an accredited college or university or its equivalent, with at least 4,000 hours of post-master's supervised experience in the delivery of clinical services in the treatment of mental illness;~~

~~(2) in clinical social work: a person licensed as an independent clinical social worker under chapter 148D, or a person with a master's degree in social work from an accredited college or university, with at least 4,000 hours of post-master's supervised experience in the delivery of clinical services in the treatment of mental illness;~~

~~(3) in psychology: an individual licensed by the Board of Psychology under sections 148.88 to 148.98 who has stated to the Board of Psychology competencies in the diagnosis and treatment of mental illness;~~

~~(4) in psychiatry: a physician licensed under chapter 147 and certified by the American Board of Psychiatry and Neurology or eligible for board certification in psychiatry, or an osteopathic physician licensed under chapter 147 and certified by the American Osteopathic Board of Neurology and Psychiatry or eligible for board certification in psychiatry;~~

~~(5) in marriage and family therapy: the mental health professional must be a marriage and family therapist licensed under sections 148B.29 to 148B.39 with at least two years of post-master's supervised experience in the delivery of clinical services in the treatment of mental illness;~~

~~(6) in licensed professional clinical counseling, the mental health professional shall be a licensed professional clinical counselor under section 148B.5301 with at least 4,000 hours of post-master's supervised experience in the delivery of clinical services in the treatment of mental illness; or~~

~~(7) in allied fields: a person with a master's degree from an accredited college or university in one of the behavioral sciences or related fields, with at least 4,000 hours of post-master's supervised experience in the delivery of clinical services in the treatment of mental illness.~~

Sec. 13. Minnesota Statutes 2018, section 245.462, subdivision 21, is amended to read:

Subd. 21. **Outpatient services.** "Outpatient services" means mental health services, excluding day treatment and community support services programs, provided by or under the ~~clinical~~ treatment supervision of a mental health professional to adults with mental illness who live outside a hospital. Outpatient services include clinical activities such as individual, group, and family therapy; individual treatment planning; diagnostic assessments; medication management; and psychological testing.

Sec. 14. Minnesota Statutes 2018, section 245.462, subdivision 23, is amended to read:

Subd. 23. **Residential treatment.** "Residential treatment" means a 24-hour-a-day program under the ~~clinical~~ treatment supervision of a mental health professional, in a community residential setting other than an acute care hospital or regional treatment center inpatient unit, that must be licensed as a residential treatment program for adults with mental illness under Minnesota Rules, parts 9520.0500 to 9520.0670, or other rules adopted by the commissioner.

Sec. 15. Minnesota Statutes 2018, section 245.462, is amended by adding a subdivision to read:

Subd. 27. **Treatment supervision.** "Treatment supervision" means the treatment supervision described under section 245I.18.

Sec. 16. Minnesota Statutes 2018, section 245.467, subdivision 2, is amended to read:

Subd. 2. **Diagnostic assessment.** ~~All providers of residential, acute care hospital inpatient, and regional treatment centers must complete a diagnostic assessment for each of their clients within five days of admission. Providers of day treatment services must complete a~~

~~diagnostic assessment within five days after the adult's second visit or within 30 days after intake, whichever occurs first. In cases where a diagnostic assessment is available and has been completed within three years preceding admission, only an adult diagnostic assessment update is necessary. An "adult diagnostic assessment update" means a written summary by a mental health professional of the adult's current mental health status and service needs and includes a face-to-face interview with the adult. If the adult's mental health status has changed markedly since the adult's most recent diagnostic assessment, a new diagnostic assessment is required. Compliance with the provisions of this subdivision does not ensure eligibility for medical assistance reimbursement under chapter 256B.~~ Providers of services governed by this section shall complete a diagnostic assessment according to the standards of section 256B.0671, including for services to a person not eligible for medical assistance.

Sec. 17. Minnesota Statutes 2018, section 245.467, subdivision 3, is amended to read:

Subd. 3. **Individual treatment plans.** ~~All providers of outpatient services, day treatment services, residential treatment, acute care hospital inpatient treatment, and all regional treatment centers must develop an individual treatment plan for each of their adult clients. The individual treatment plan must be based on a diagnostic assessment. To the extent possible, the adult client shall be involved in all phases of developing and implementing the individual treatment plan. Providers of residential treatment and acute care hospital inpatient treatment, and all regional treatment centers must develop the individual treatment plan within ten days of client intake and must review the individual treatment plan every 90 days after intake. Providers of day treatment services must develop the individual treatment plan before the completion of five working days in which service is provided or within 30 days after the diagnostic assessment is completed or obtained, whichever occurs first. Providers of outpatient services must develop the individual treatment plan within 30 days after the diagnostic assessment is completed or obtained or by the end of the second session of an outpatient service, not including the session in which the diagnostic assessment was provided, whichever occurs first. Outpatient and day treatment services providers must review the individual treatment plan every 90 days after intake.~~ Providers of services governed by this section shall complete an individual treatment plan according to the standards of section 256B.0671, subdivisions 5 and 6, including for services to a person not eligible for medical assistance.

Sec. 18. Minnesota Statutes 2018, section 245.469, subdivision 1, is amended to read:

Subdivision 1. **Availability of emergency services.** ~~By July 1, 1988,~~ County boards must provide or contract for enough emergency services within the county to meet the needs of adults in the county who are experiencing an emotional crisis or mental illness. Clients may be required to pay a fee according to section 245.481. Emergency service providers shall not delay the timely provision of emergency service because of delays in determining this fee or because of the unwillingness or inability of the client to pay the fee. Emergency services must include assessment, crisis intervention, and appropriate case disposition. A tribal authority that accepts crisis grant funding has the same responsibilities as county boards within the tribal authority's designated service area. Emergency services must:

(1) promote the safety and emotional stability of adults with mental illness or emotional crises;

(2) minimize further deterioration of adults with mental illness or emotional crises;

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

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

(5) provide support, psychoeducation, and referrals to family members, friends, service providers, or other third parties on behalf of a recipient in need of emergency services.

Sec. 19. Minnesota Statutes 2018, section 245.469, subdivision 2, is amended to read:

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

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

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

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

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

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

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

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

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

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

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

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

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

Sec. 20. Minnesota Statutes 2018, section 245.470, subdivision 1, is amended to read:

Subdivision 1. **Availability of outpatient services.** (a) County boards must provide or contract for enough outpatient services within the county to meet the needs of adults with mental illness residing in the county. Services may be provided directly by the county through county-operated mental health centers or mental health clinics approved by the commissioner under section 245.69, subdivision 2; by contract with privately operated mental health centers or mental health clinics approved by the commissioner under section 245.69, subdivision 2; by contract with hospital mental health outpatient programs certified by the Joint Commission on Accreditation of Hospital Organizations; or by contract with a licensed mental health professional ~~as defined in section 245.462, subdivision 18, clauses (1) to (6)~~. Clients may be required to pay a fee according to section 245.481. Outpatient services include:

(1) conducting diagnostic assessments;

(2) conducting psychological testing;

(3) developing or modifying individual treatment plans;

(4) making referrals and recommending placements as appropriate;

(5) treating an adult's mental health needs through therapy;

(6) prescribing and managing medication and evaluating the effectiveness of prescribed medication; and

(7) preventing placement in settings that are more intensive, costly, or restrictive than necessary and appropriate to meet client needs.

(b) County boards may request a waiver allowing outpatient services to be provided in a nearby trade area if it is determined that the client can best be served outside the county.

Sec. 21. Minnesota Statutes 2018, section 245.4712, subdivision 2, is amended to read:

Subd. 2. **Day treatment services provided.** (a) Day treatment services must be developed as a part of the community support services available to adults with serious and persistent mental illness residing in the county. Adults may be required to pay a fee according to section 245.481. Day treatment services must be designed to:

(1) provide a structured environment for treatment;

(2) provide support for residing in the community;

(3) prevent placement in settings that are more intensive, costly, or restrictive than necessary and appropriate to meet client need;

(4) coordinate with or be offered in conjunction with a local education agency's special education program; and

(5) operate on a continuous basis throughout the year.

(b) For purposes of complying with medical assistance requirements, an adult day treatment program must comply with the method of ~~clinical~~ treatment supervision specified in ~~Minnesota Rules, part 9505.0371, subpart 4~~ section 245I.18. ~~The clinical supervision must be performed by a qualified supervisor who satisfies the requirements of Minnesota Rules, part 9505.0371, subpart 5.~~

A day treatment program must demonstrate compliance with this ~~clinical~~ treatment supervision requirement by the commissioner's review and approval of the program according to ~~Minnesota Rules, part 9505.0372, subpart 8~~ section 256B.0625, subdivision 23.

(c) County boards may request a waiver from including day treatment services if they can document that:

(1) an alternative plan of care exists through the county's community support services for clients who would otherwise need day treatment services;

(2) day treatment, if included, would be duplicative of other components of the community support services; and

(3) county demographics and geography make the provision of day treatment services cost ineffective and infeasible.

Sec. 22. Minnesota Statutes 2018, section 245.472, subdivision 2, is amended to read:

Subd. 2. **Specific requirements.** Providers of residential services must be licensed under applicable rules adopted by the commissioner and must ~~be clinically supervised~~ provide treatment supervision by a mental health professional. ~~Persons employed in facilities licensed under Minnesota Rules, parts 9520.0500 to 9520.0670, in the capacity of program director as of July 1, 1987, in accordance with Minnesota Rules, parts 9520.0500 to 9520.0670, may be allowed to continue providing clinical supervision within a facility, provided they continue~~

~~to be employed as a program director in a facility licensed under Minnesota Rules, parts 9520.0500 to 9520.0670.~~

Sec. 23. Minnesota Statutes 2018, section 245.4863, is amended to read:

245.4863 INTEGRATED CO-OCCURRING DISORDER TREATMENT.

(a) The commissioner shall require individuals who perform chemical dependency assessments to screen clients for co-occurring mental health disorders, and staff who perform mental health diagnostic assessments to screen for co-occurring substance use disorders. Screening tools must be approved by the commissioner. If a client screens positive for a co-occurring mental health or substance use disorder, the individual performing the screening must document what actions will be taken in response to the results and whether further assessments must be performed.

(b) Notwithstanding paragraph (a), screening is not required when:

(1) the presence of co-occurring disorders was documented for the client in the past 12 months;

(2) the client is currently receiving co-occurring disorders treatment;

(3) the client is being referred for co-occurring disorders treatment; or

(4) a mental health professional, as ~~defined in Minnesota Rules, part 9505.0370, subpart 18~~ provided by section 245I.16, subdivision 2, who is competent to perform diagnostic assessments of co-occurring disorders is performing a diagnostic assessment that meets the requirements in Minnesota Rules, part 9533.0090, subpart 5, to identify whether the client may have co-occurring mental health and chemical dependency disorders. If an individual is identified to have co-occurring mental health and substance use disorders, the assessing mental health professional must document what actions will be taken to address the client's co-occurring disorders.

(c) The commissioner shall adopt rules as necessary to implement this section. The commissioner shall ensure that the rules are effective on July 1, 2013, thereby establishing a certification process for integrated dual disorder treatment providers and a system through which individuals receive integrated dual diagnosis treatment if assessed as having both a substance use disorder and either a serious mental illness or emotional disturbance.

(d) The commissioner shall apply for any federal waivers necessary to secure, to the extent allowed by law, federal financial participation for the provision of integrated dual diagnosis treatment to persons with co-occurring disorders.

Sec. 24. Minnesota Statutes 2018, section 245.4871, subdivision 9a, is amended to read:

Subd. 9a. **Crisis ~~assistance~~ planning.** "Crisis ~~assistance~~ planning" means ~~assistance to the child, the child's family, and all providers of services to the child to: recognize factors precipitating a mental health crisis, identify behaviors related to the crisis, and be informed of available resources to resolve the crisis. Crisis assistance requires the development of a~~

~~plan which addresses prevention and intervention strategies to be used in a potential crisis. Other interventions include: (1) arranging for admission to acute care hospital inpatient treatment; (2) crisis placement; (3) community resources for follow-up; and (4) emotional support to the family during crisis. Crisis assistance does not include services designed to secure the safety of a child who is at risk of abuse or neglect or necessary emergency services.~~ the development of a written plan to assist a child's family in preventing and addressing a potential crisis and is distinct from the immediate provision of mental health mobile crisis intervention services as defined in section 256B.0944. The plan must address prevention, de-escalation, and intervention strategies to be used in a crisis. The plan identifies factors that might precipitate a crisis, behaviors or symptoms related to the emergence of a crisis, and the resources available to resolve a crisis. The plan must include planning for the following potential needs: (1) acute care; (2) crisis placement; (3) community resources for follow-up; and (4) emotional support to the family during crisis. Crisis planning excludes services designed to secure the safety of a child who is at risk of abuse or neglect or necessary emergency services.

Sec. 25. Minnesota Statutes 2018, section 245.4871, subdivision 10, is amended to read:

Subd. 10. **Day treatment services.** "Day treatment," "day treatment services," or "day treatment program" means a structured program of treatment and care provided to a child in:

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

(2) a community mental health center under section 245.62;

(3) an entity that is under contract with the county board to operate a program that meets the requirements of section 245.4884, subdivision 2, and Minnesota Rules, parts 9505.0170 to 9505.0475; ~~or~~

(4) an entity that operates a program that meets the requirements of section 245.4884, subdivision 2, and Minnesota Rules, parts 9505.0170 to 9505.0475, that is under contract with an entity that is under contract with a county board~~.~~; or

(5) an entity that operates a program certified under section 256B.0943.

Day treatment consists of group psychotherapy and other intensive therapeutic services that are provided for a minimum two-hour time block by a multidisciplinary staff under the clinical supervision of a mental health professional. Day treatment may include education and consultation provided to families and other individuals as an extension of the treatment process. The services are aimed at stabilizing the child's mental health status, and developing and improving the child's daily independent living and socialization skills. Day treatment services are distinguished from day care by their structured therapeutic program of psychotherapy services. Day treatment services are not a part of inpatient hospital or residential treatment services.

A day treatment service must be available to a child up to 15 hours a week throughout the year and must be coordinated with, integrated with, or part of an education program offered by the child's school.

Sec. 26. Minnesota Statutes 2018, section 245.4871, subdivision 11a, is amended to read:

Subd. 11a. **Diagnostic assessment.** ~~(a)~~ "Diagnostic assessment" ~~has the meaning given in Minnesota Rules, part 9505.0370, subpart 11, and is delivered as provided in Minnesota Rules, part 9505.0372, subpart 1, items A, B, C, and E. Diagnostic assessment includes a standard, extended, or brief diagnostic assessment, or an adult update.~~ means the assessment described under section 256B.0671, subdivisions 2 to 4.

~~(b) A brief diagnostic assessment must include a face-to-face interview with the client and a written evaluation of the client by a mental health professional or a clinical trainee, as provided in Minnesota Rules, part 9505.0371, subpart 5, item C. The professional or clinical trainee must gather initial components of a standard diagnostic assessment, including the client's:~~

~~(1) age;~~

~~(2) description of symptoms, including reason for referral;~~

~~(3) history of mental health treatment;~~

~~(4) cultural influences and their impact on the client; and~~

~~(5) mental status examination.~~

~~(c) On the basis of the brief components, the professional or clinical trainee must draw a provisional clinical hypothesis. The clinical hypothesis may be used to address the client's immediate needs or presenting problem.~~

~~(d) Treatment sessions conducted under authorization of a brief assessment may be used to gather additional information necessary to complete a standard diagnostic assessment or an extended diagnostic assessment.~~

~~(e) Notwithstanding Minnesota Rules, part 9505.0371, subpart 2, item A, subitem (1), unit (b), prior to completion of a client's initial diagnostic assessment, a client is eligible for psychological testing as part of the diagnostic process.~~

~~(f) Notwithstanding Minnesota Rules, part 9505.0371, subpart 2, item A, subitem (1), unit (c), prior to completion of a client's initial diagnostic assessment, but in conjunction with the diagnostic assessment process, a client is eligible for up to three individual or family psychotherapy sessions or family psychoeducation sessions or a combination of the above sessions not to exceed three sessions.~~

Sec. 27. Minnesota Statutes 2018, section 245.4871, subdivision 17, is amended to read:

Subd. 17. **Family community support services.** "Family community support services" means services provided under the ~~clinical~~ treatment supervision of a mental health professional and designed to help each child with severe emotional disturbance to function and remain with the child's family in the community. Family community support services do not include acute care hospital inpatient treatment, residential treatment services, or regional treatment center services. Family community support services include:

(1) client outreach to each child with severe emotional disturbance and the child's family;

(2) medication monitoring where necessary;

(3) assistance in developing independent living skills;

(4) assistance in developing parenting skills necessary to address the needs of the child with severe emotional disturbance;

(5) assistance with leisure and recreational activities;

(6) crisis assistance, including crisis placement and respite care;

(7) professional home-based family treatment;

(8) foster care with therapeutic supports;

(9) day treatment;

(10) assistance in locating respite care and special needs day care; and

(11) assistance in obtaining potential financial resources, including those benefits listed in section 245.4884, subdivision 5.

Sec. 28. Minnesota Statutes 2018, section 245.4871, subdivision 21, is amended to read:

Subd. 21. **Individual treatment plan.** "Individual treatment plan" means ~~a written plan of intervention, treatment, and services for a child with an emotional disturbance that is developed by a service provider under the clinical supervision of a mental health professional on the basis of a diagnostic assessment. An individual treatment plan for a child must be developed in conjunction with the family unless clinically inappropriate. The plan identifies goals and objectives of treatment, treatment strategy, a schedule for accomplishing treatment goals and objectives, and the individuals responsible for providing treatment to the child with an emotional disturbance~~ the individual treatment plan described under section 256B.0671, subdivisions 5 and 6.

Sec. 29. Minnesota Statutes 2018, section 245.4871, subdivision 26, is amended to read:

Subd. 26. **Mental health practitioner.** "Mental health practitioner" ~~has the meaning given in~~ means a person qualified according to section ~~245.462, subdivision 17~~ 245I.16, subdivision 4.

Sec. 30. Minnesota Statutes 2018, section 245.4871, subdivision 27, is amended to read:

Subd. 27. **Mental health professional.** "Mental health professional" means a person ~~providing clinical services in the diagnosis and treatment of children's emotional disorders. A mental health professional must have training and experience in working with children consistent with the age group to which the mental health professional is assigned. A mental health professional must be qualified in at least one of the following ways:~~ qualified according to section 245I.16, subdivision 2.

~~(1) in psychiatric nursing, the mental health professional must be a registered nurse who is licensed under sections 148.171 to 148.285 and who is certified as a clinical specialist in child and adolescent psychiatric or mental health nursing by a national nurse certification organization or who has a master's degree in nursing or one of the behavioral sciences or related fields from an accredited college or university or its equivalent, with at least 4,000 hours of post-master's supervised experience in the delivery of clinical services in the treatment of mental illness;~~

~~(2) in clinical social work, the mental health professional must be a person licensed as an independent clinical social worker under chapter 148D, or a person with a master's degree in social work from an accredited college or university, with at least 4,000 hours of post-master's supervised experience in the delivery of clinical services in the treatment of mental disorders;~~

~~(3) in psychology, the mental health professional must be an individual licensed by the board of psychology under sections 148.88 to 148.98 who has stated to the board of psychology competencies in the diagnosis and treatment of mental disorders;~~

~~(4) in psychiatry, the mental health professional must be a physician licensed under chapter 147 and certified by the American Board of Psychiatry and Neurology or eligible for board certification in psychiatry or an osteopathic physician licensed under chapter 147 and certified by the American Osteopathic Board of Neurology and Psychiatry or eligible for board certification in psychiatry;~~

~~(5) in marriage and family therapy, the mental health professional must be a marriage and family therapist licensed under sections 148B.29 to 148B.39 with at least two years of post-master's supervised experience in the delivery of clinical services in the treatment of mental disorders or emotional disturbances;~~

~~(6) in licensed professional clinical counseling, the mental health professional shall be a licensed professional clinical counselor under section 148B.5301 with at least 4,000 hours of post-master's supervised experience in the delivery of clinical services in the treatment of mental disorders or emotional disturbances; or~~

~~(7) in allied fields, the mental health professional must be a person with a master's degree from an accredited college or university in one of the behavioral sciences or related fields, with at least 4,000 hours of post-master's supervised experience in the delivery of clinical services in the treatment of emotional disturbances.~~

Sec. 31. Minnesota Statutes 2018, section 245.4871, subdivision 29, is amended to read:

Subd. 29. **Outpatient services.** "Outpatient services" means mental health services, excluding day treatment and community support services programs, provided by or under the ~~clinical~~ treatment supervision of a mental health professional to children with emotional disturbances who live outside a hospital. Outpatient services include clinical activities such as individual, group, and family therapy; individual treatment planning; diagnostic assessments; medication management; and psychological testing.

Sec. 32. Minnesota Statutes 2018, section 245.4871, subdivision 32, is amended to read:

Subd. 32. **Residential treatment.** "Residential treatment" means a 24-hour-a-day program under the ~~clinical~~ treatment supervision of a mental health professional, in a community residential setting other than an acute care hospital or regional treatment center inpatient unit, that must be licensed as a residential treatment program for children with emotional disturbances under Minnesota Rules, parts 2960.0580 to 2960.0700, or other rules adopted by the commissioner.

Sec. 33. Minnesota Statutes 2018, section 245.4871, subdivision 34, is amended to read:

Subd. 34. **Therapeutic support of foster care.** "Therapeutic support of foster care" means the mental health training and mental health support services and ~~clinical~~ treatment supervision provided by a mental health professional to foster families caring for children with severe emotional disturbance to provide a therapeutic family environment and support for the child's improved functioning. Therapeutic support of foster care includes services provided under section 256B.0946.

Sec. 34. Minnesota Statutes 2018, section 245.4876, subdivision 2, is amended to read:

Subd. 2. **Diagnostic assessment.** ~~All residential treatment facilities and acute care hospital inpatient treatment facilities that provide mental health services for children must complete a diagnostic assessment for each of their child clients within five working days of admission. Providers of day treatment services for children must complete a diagnostic assessment within five days after the child's second visit or 30 days after intake, whichever occurs first. In cases where a diagnostic assessment is available and has been completed within 180 days preceding admission, only updating is necessary. "Updating" means a written summary by a mental health professional of the child's current mental health status and service needs. If the child's mental health status has changed markedly since the child's most recent diagnostic assessment, a new diagnostic assessment is required. Compliance with the provisions of this subdivision does not ensure eligibility for medical assistance reimbursement under chapter 256B.~~ Providers of services governed by this section shall complete a diagnostic assessment according to the standards of section 256B.0671, including for services to a person not eligible for medical assistance.

Sec. 35. Minnesota Statutes 2018, section 245.4876, subdivision 3, is amended to read:

Subd. 3. **Individual treatment plans.** ~~All providers of outpatient services, day treatment services, professional home-based family treatment, residential treatment, and acute care hospital inpatient treatment, and all regional treatment centers that provide mental health~~

~~services for children must develop an individual treatment plan for each child client. The individual treatment plan must be based on a diagnostic assessment. To the extent appropriate, the child and the child's family shall be involved in all phases of developing and implementing the individual treatment plan. Providers of residential treatment, professional home-based family treatment, and acute care hospital inpatient treatment, and regional treatment centers must develop the individual treatment plan within ten working days of client intake or admission and must review the individual treatment plan every 90 days after intake, except that the administrative review of the treatment plan of a child placed in a residential facility shall be as specified in sections 260C.203 and 260C.212, subdivision 9. Providers of day treatment services must develop the individual treatment plan before the completion of five working days in which service is provided or within 30 days after the diagnostic assessment is completed or obtained, whichever occurs first. Providers of outpatient services must develop the individual treatment plan within 30 days after the diagnostic assessment is completed or obtained or by the end of the second session of an outpatient service, not including the session in which the diagnostic assessment was provided, whichever occurs first. Providers of outpatient and day treatment services must review the individual treatment plan every 90 days after intake.~~ Providers of services governed by this section shall complete an individual treatment plan according to the standards of section 256B.0671, subdivisions 5 and 6, including for services to a person not eligible for medical assistance.

Sec. 36. Minnesota Statutes 2018, section 245.4879, subdivision 1, is amended to read:

Subdivision 1. **Availability of emergency services.** County boards must provide or contract for enough mental health emergency services within the county to meet the needs of children, and children's families when clinically appropriate, in the county who are experiencing an emotional crisis or emotional disturbance. The county board shall ensure that parents, providers, and county residents are informed about when and how to access emergency mental health services for children. A child or the child's parent may be required to pay a fee according to section 245.481. Emergency service providers shall not delay the timely provision of emergency service because of delays in determining this fee or because of the unwillingness or inability of the parent to pay the fee. Emergency services must include assessment, crisis intervention, and appropriate case disposition. A tribal authority that accepts crisis grant funding has the same responsibilities as county boards within the tribal authority's designated service area. Emergency services must:

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

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

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

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

(5) provide support, psychoeducation, and referrals to family members, service providers, or other third parties on behalf of a client in need of emergency services.

Sec. 37. Minnesota Statutes 2018, section 245.4879, subdivision 2, is amended to read:

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

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

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

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

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

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

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

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

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

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

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

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

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

Sec. 38. Minnesota Statutes 2018, section 245.488, subdivision 1, is amended to read:

Subdivision 1. **Availability of outpatient services.** (a) County boards must provide or contract for enough outpatient services within the county to meet the needs of each child with emotional disturbance residing in the county and the child's family. Services may be provided directly by the county through county-operated mental health centers or mental health clinics approved by the commissioner under section 245.69, subdivision 2; by contract with privately operated mental health centers or mental health clinics approved by the commissioner under section 245.69, subdivision 2; by contract with hospital mental health outpatient programs certified by the Joint Commission on Accreditation of Hospital Organizations; or by contract with a licensed mental health professional ~~as defined in section 245.4871, subdivision 27, clauses (1) to (6)~~. A child or a child's parent may be required to pay a fee based in accordance with section 245.481. Outpatient services include:

(1) conducting diagnostic assessments;

(2) conducting psychological testing;

(3) developing or modifying individual treatment plans;

(4) making referrals and recommending placements as appropriate;

(5) treating the child's mental health needs through therapy; and

(6) prescribing and managing medication and evaluating the effectiveness of prescribed medication.

(b) County boards may request a waiver allowing outpatient services to be provided in a nearby trade area if it is determined that the child requires necessary and appropriate services that are only available outside the county.

(c) Outpatient services offered by the county board to prevent placement must be at the level of treatment appropriate to the child's diagnostic assessment.

Sec. 39. Minnesota Statutes 2018, section 245.696, is amended by adding a subdivision to read:

Subd. 3. **Certification of mental health peer specialists and mental health family peer specialists.** The commissioner shall develop a process to certify mental health peer

specialists and mental health family peer specialists according to federal guidelines and section 245I.16, subdivisions 10 to 13, for a provider entity to bill for reimbursable services. The training and certification curriculum must teach individuals specific skills relevant to providing peer support as appropriate for individual or family peers.

Sec. 40. [245I.01] PURPOSE AND CITATION.

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

Subd. 2. **Purpose.** In accordance with sections 245.461 and 245.487, to create a system of mental health care that is unified, accountable, and comprehensive, and to promote the recovery of Minnesotans from mental illnesses, the state's public policy is to support quality outpatient and residential mental health services reimbursable by public and private health insurance programs. Further, the state's public policy is to ensure the safety, rights, and well-being of individuals served in these programs.

Subd. 3. **Variances.** If the conditions in section 245A.04, subdivision 9, are met, the commissioner may grant variances to the requirements in this chapter that do not affect a client's health or safety.

Sec. 41. [245I.02] DEFINITIONS.

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

Subd. 2. **Approval.** "Approval" means the documented review of, opportunity to request changes to, and agreement with a treatment document by a treatment supervisor or by a client. Approval may be demonstrated by written signature, secure electronic signature, or documented oral approval.

Subd. 3. **Behavioral sciences or related fields.** "Behavioral sciences or related fields" means an education from an accredited college or university in a field including but not limited to social work, psychology, sociology, community counseling, family social science, child development, child psychology, community mental health, addiction counseling, counseling and guidance, special education, and other similar fields as approved by the commissioner.

Subd. 4. **Certified rehabilitation specialist.** "Certified rehabilitation specialist" means a staff person qualified according to section 245I.16, subdivision 8.

Subd. 5. **Child.** "Child" means a client under 18 years of age, or a client under 21 years of age who is eligible for a service otherwise provided to persons under 18 years of age.

Subd. 6. **Client.** "Client" means a person who is seeking or receiving services regulated under this chapter. For the purpose of consent to services, this term includes a parent, guardian, or other individual authorized to consent to services by law.

Subd. 7. **Clinical trainee.** "Clinical trainee" means a staff person qualified according to section 245I.16, subdivision 6.

Subd. 8. **Clinician.** "Clinician" means a mental health professional or clinical trainee who is performing diagnostic assessment, testing, or psychotherapy.

Subd. 9. **Commissioner.** "Commissioner" means the commissioner of human services or the commissioner's designee.

Subd. 10. **Diagnostic assessment.** "Diagnostic assessment" means the evaluation and report of a client's potential diagnoses conducted by a clinician. For a client receiving publicly funded services, a diagnostic assessment must meet the standards of section 256B.0671, subdivisions 2 to 4.

Subd. 11. **Diagnostic formulation.** "Diagnostic formulation" means a written analysis and explanation of the information obtained from a clinical assessment to develop a hypothesis about the cause and nature of the presenting problems and identify a framework for developing the most suitable treatment approach.

Subd. 12. **Individual treatment plan.** "Individual treatment plan" means the formulation of planned services that are responsive to the needs and goals of a client. For a client receiving publicly funded services, an individual treatment plan must meet the standards of section 256B.0671, subdivisions 5 and 6.

Subd. 13. **Mental health behavioral aide.** "Mental health behavioral aide" means a staff person qualified according to section 245I.16, subdivision 16.

Subd. 14. **Mental health certified family peer specialist.** "Mental health certified family peer specialist" means a staff person qualified according to section 245I.16, subdivision 12.

Subd. 15. **Mental health certified peer specialist.** "Mental health certified peer specialist" means a staff person qualified according to section 245I.16, subdivision 10.

Subd. 16. **Mental health practitioner.** "Mental health practitioner" means a staff person qualified according to section 245I.16, subdivision 4.

Subd. 17. **Mental health professional.** "Mental health professional" means a staff person qualified according to section 245I.16, subdivision 2.

Subd. 18. **Mental health rehabilitation worker.** "Mental health rehabilitation worker" means a staff person qualified according to section 245I.16, subdivision 14.

Subd. 19. **Personnel file.** "Personnel file" means the set of records under section 245I.13, paragraph (a). Personnel files excludes information related to a person's employment not enumerated in section 245I.13.

Subd. 20. **Provider entity.** "Provider entity" means the organization, governmental unit, corporation, or other legal body that is enrolled, certified, licensed, or otherwise authorized by the commissioner to provide the services described in this chapter.

Subd. 21. **Responsivity factors.** "Responsivity factors" means the factors other than the diagnostic formulation that may modify an individual's treatment needs. This includes learning style, ability, cognitive function, cultural background, and personal circumstance. Documentation of responsivity factors includes an analysis of how an individual's strengths may be reflected in the planned delivery of services.

Subd. 22. **Risk factors.** "Risk factors" means factors that predispose a client to engage in potentially harmful behaviors to themselves or others.

Subd. 23. **Strengths.** "Strengths" means inner characteristics, virtues, external relationships, activities, and connections to resources that contribute to resilience and core competencies and can be built on to support recovery.

Subd. 24. **Trauma.** "Trauma" means an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being. Trauma includes the cumulative emotional or psychological harm of group traumatic experiences, transmitted across generations within a community, often associated with racial and ethnic population groups in the country who have suffered major intergenerational losses.

Subd. 25. **Treatment supervision.** "Treatment supervision" means the direction and evaluation of individual assessment, treatment planning, and service delivery for each client when services are delivered by an individual who is not a licensed mental health professional or certified rehabilitation specialist as provided by section 245I.18.

Sec. 42. [245I.10] TRAINING REQUIRED.

Subdivision 1. **Training plan.** A provider entity must develop a plan to ensure that staff persons receive orientation and ongoing training. The plan must include:

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

(2) a description of how the provider entity conducts annual training, including whether annual training is based on a staff person's hire date or a specified annual cycle determined by the program; and

(3) a description of how the provider entity determines when a staff person needs additional training, including the timelines in which the additional training is provided.

Subd. 2. **Documentation of orientation and training.** (a) The provider entity must provide training in accordance with the training plan and must document that orientation and training was provided. All training programs and materials used by the provider entity

must be available for review by regulatory agencies. The documentation must include the following:

(1) topic covered in the training;

(2) identification of the trainee;

(3) name and credentials of the trainer;

(4) method of evaluating competency upon completion of training;

(5) date of training; and

(6) length of training, in hours.

(b) Documentation of a continuing education credit accepted by the governing health-related licensing board is sufficient for purposes of this subdivision.

Subd. 3. **Orientation.** (a) Before providing direct contact services, a staff person must receive orientation on:

(1) patient rights as identified in section 144.651;

(2) vulnerable adult and minor maltreatment requirements in sections 245A.65, subdivision 3; 626.556, subdivisions 2, 3, and 7; 626.557; and 626.5572;

(3) the Minnesota Health Records Act, including confidentiality, family engagement according to section 144.294, and client privacy;

(4) program policies and procedures;

(5) emergency procedures appropriate to the position, including but not limited to fires, inclement weather, missing persons, and medical emergencies;

(6) professional boundaries;

(7) behavior management, crisis intervention, and stabilization techniques;

(8) specific needs of individuals served by the program, including but not limited to developmental status, cognitive functioning, and physical and mental abilities; and

(9) training related to the specific activities and job functions for which the staff person is responsible to carry out, including documentation of the delivery of services.

(b) A staff person must receive orientation on the following topics within 90 calendar days of a staff person first providing direct contact services:

(1) trauma-informed care;

(2) family- and person-centered individual treatment plans, seeking partnership with parents and identified supports, and shared decision making and engagement;

(3) treatment for co-occurring substance use problems, including the definitions of co-occurring disorders, prevalence of co-occurring disorders, common signs and symptoms of co-occurring disorders, and the etiology of co-occurring disorders;

(4) psychotropic medications, side effects, and safe medication management;

(5) family systems and promoting culturally appropriate support networks;

(6) culturally responsive treatment practices;

(7) recovery concepts and principles;

(8) building resiliency through a strength-based approach;

(9) person-centered planning and positive support strategies; and

(10) other training relevant to the staff person's role and responsibilities.

(c) A provider entity may deem a staff person to have met an orientation requirement in paragraph (b) if the staff person has received equivalent postsecondary education in the previous four years or training experience in the previous two years. The training plan must describe the process and location for verification and documentation of previous training experience.

(d) A provider entity may deem a mental health professional to have met a requirement of paragraph (a), clauses (6) to (9), and paragraph (b) after an evaluation of the mental health professional's competency, including by interview.

Subd. 4. **Annual training.** (a) A provider entity shall ensure that staff persons who are not licensed mental health professionals receive 15 hours of training each year after the first year of employment.

(b) A licensed mental health professional must follow specific training requirements as determined by the professional's governing health-related licensing board.

(c) All staff persons, including licensed mental health professionals, must receive annual training on the topics in subdivision 3, paragraph (a), clauses (2) and (5).

(d) The selection of additional training topics must be based on program needs and staff persons' competency.

Subd. 5. **Training for services provided to children.** (a) Training and orientation required under this section for a staff person working with children must be aligned to the developmental characteristics of the children served in the program and address the needs of children in the context of the family, support system, and culture. This includes orientation under subdivision 3 on the following topics: (1) child development; (2) working with children and children's support systems; (3) adverse childhood experiences, cognitive functioning, and physical and mental abilities; and (4) understanding family perspective.

(b) For a mental health behavioral aide, orientation in the first 90 days of service must include a parent team training utilizing a curriculum approved by the commissioner.

Sec. 43. [245I.13] PERSONNEL FILES.

(a) For each staff person, a provider entity shall maintain a personnel file that includes:

(1) verification of the staff person's qualifications including training, education, and licensure;

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

(3) the date of hire;

(4) the effective date of specific duties and responsibilities including the date that the staff person begins direct contact with a client;

(5) documentation of orientation;

(6) records of training, license renewal, and educational activities completed during the staff person's employment;

(7) annual job performance evaluations; and

(8) records of clinical supervision, if applicable.

(b) Personnel files must be made accessible to the commissioner upon request. Personnel files must be readily accessible for review but need not be kept in a single location.

Sec. 44. [245I.16] PROVIDER QUALIFICATIONS AND SCOPE OF PRACTICE.

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

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

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

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

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

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

(5) a marriage and family therapist licensed under sections 148B.29 to 148B.39; or

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

Subd. 3. **Mental health professional scope of practice.** A mental health professional shall maintain a valid license with the mental health professional's governing health-related licensing board and shall only provide services within the scope of practice as determined by the health-related licensing board.

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

(b) An individual is qualified through relevant coursework if the individual completes at least 30 semester hours or 45 quarter hours in behavioral sciences or related fields and:

(1) has at least 2,000 hours of supervised experience in the delivery of services to adults or children with: (i) mental illness, substance use disorder, or emotional disturbance; or (ii) traumatic brain injury or developmental disabilities and completes training on mental illness, recovery from mental illness, mental health de-escalation techniques, co-occurring mental illness and substance use disorder, and psychotropic medications and side effects;

(2) is fluent in the non-English language of the ethnic group to which at least 50 percent of the individual's clients belong, completes 40 hours of training in the delivery of services to adults with mental illness or children with emotional disturbance, and receives treatment supervision from a mental health professional at least once per week until the requirement of 2,000 hours of supervised experience is met;

(3) is working in a day treatment program under section 245.4712, subdivision 2; or

(4) has completed a practicum or internship that (i) requires direct interaction with adults or children served, and (ii) is focused on behavioral sciences or related fields.

(c) An individual is qualified through work experience if the individual:

(1) has at least 4,000 hours of supervised experience in the delivery of services to adults or children with: (i) mental illness, substance use disorder, or emotional disturbance; or (ii) traumatic brain injury or developmental disabilities and completes training on mental illness, recovery from mental illness, mental health de-escalation techniques, co-occurring mental illness and substance use disorder, and psychotropic medications and side effects; or

(2) has at least 2,000 hours of supervised experience in the delivery of services to adults or children with: (i) mental illness, emotional disturbance, or substance use disorder, and receives treatment supervision as required by applicable statutes and rules from a mental health professional at least once per week until the requirement of 4,000 hours of supervised experience is met; or (ii) traumatic brain injury or developmental disabilities, completes training on mental illness, recovery from mental illness, mental health de-escalation techniques, co-occurring mental illness and substance use disorder, and psychotropic

medications and side effects, and receives treatment supervision as required by applicable statutes and rules at least once per week from a mental health professional until the requirement of 4,000 hours of supervised experience is met.

(d) An individual is qualified by a bachelor's or master's degree if the individual: (1) holds a master's or other graduate degree in behavioral sciences or related fields; or (2) holds a bachelor's degree in behavioral sciences or related fields and completes a practicum or internship that (i) requires direct interaction with adults or children served, and (ii) is focused on behavioral sciences or related fields.

Subd. 5. **Mental health practitioner scope of practice.** (a) A mental health practitioner must perform services under the treatment supervision of a mental health professional.

(b) A mental health practitioner may perform client education, functional assessments for adult clients, level of care assessments, rehabilitative interventions, and skills building; provide direction to a mental health rehabilitation worker or mental health behavioral aide; and propose individual treatment plans.

(c) A mental health practitioner who provides services according to section 256B.0624 or 256B.0944 may perform crisis assessment and intervention.

Subd. 6. **Clinical trainee qualifications.** (a) A clinical trainee is a staff person who is enrolled in or has completed an accredited graduate program of study intended to prepare the individual for independent licensure as a mental health professional and who: (1) participates in a practicum or internship supervised by a mental health professional; or (2) is completing postgraduate hours, according to the requirements of a health-related licensing board.

(b) A clinical trainee is responsible for notifying and applying to a health-related licensing board to ensure the requirements of the health-related licensing board are met. 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.

Subd. 7. **Clinical trainee scope of practice.** (a) A clinical trainee, under treatment supervision of a mental health professional, may perform psychotherapy, diagnostic assessments, and services that a mental health practitioner may deliver. A clinical trainee shall not provide treatment supervision. A clinical trainee may provide direction to a mental health behavioral aide or mental health rehabilitation worker.

(b) A psychological clinical trainee under the treatment supervision of a psychologist may perform psychological testing.

(c) A clinical trainee shall not deliver services in violation of the practice act of a health-related licensing board, including failure to obtain licensure, if required.

Subd. 8. **Certified rehabilitation specialist qualifications.** A certified rehabilitation specialist shall have:

(1) a master's degree from an accredited college or university in behavioral sciences or related fields as defined in section 245I.02, subdivision 3;

(2) at least 4,000 hours of postmaster's supervised experience in the delivery of mental health services; and

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

Subd. 9. **Certified rehabilitation specialist scope of practice.** A certified rehabilitation specialist shall provide services based on a client's diagnostic assessment. A certified rehabilitation specialist may provide supervision for mental health certified peer specialists, mental health practitioners, and mental health rehabilitation workers, but is prohibited from performing a diagnostic assessment.

Subd. 10. **Mental health certified peer specialist qualifications.** A mental health certified peer specialist shall:

(1) be 21 years of age or older;

(2) have been diagnosed with a mental illness;

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

(4) have a valid certification as a mental health certified peer specialist according to section 245.696, subdivision 3.

Subd. 11. **Mental health certified peer specialist scope of practice.** A mental health certified peer specialist shall:

(1) provide peer support that is individualized to the client;

(2) promote recovery goals, self-sufficiency, self-advocacy, and the development of natural supports; and

(3) support the maintenance of skills learned in other services.

Subd. 12. **Mental health certified family peer specialist qualifications.** A mental health certified family peer specialist shall:

(1) be 21 years of age or older;

(2) have raised or be currently raising a child with a mental illness;

(3) have experience navigating the children's mental health system; and

(4) have a valid certification as a mental health certified family peer specialist according to section 245.696, subdivision 3.

Subd. 13. **Mental health certified family peer specialist scope of practice.** A mental health certified family peer specialist shall provide services to increase the child's ability to function better within the child's home, school, and community. The mental health certified family peer specialist shall:

(1) provide family peer support, to build on strengths of families and help families achieve desired outcomes;

(2) provide nonadversarial advocacy that encourages partnership and promotes positive change and growth;

(3) support families to advocate for culturally appropriate services for a child in each treatment setting;

(4) promote resiliency, self-advocacy, and development of natural supports;

(5) support the maintenance of skills learned in other services;

(6) establish and lead parent support groups;

(7) assist parents to develop coping and problem-solving skills; and

(8) educate parents about mental illnesses and community resources, including resources that connect parents with similar experiences.

Subd. 14. **Mental health rehabilitation worker qualifications.** (a) A mental health rehabilitation worker shall (1) be 21 years of age or older; (2) have a high school diploma or equivalent; and (3) meet the qualification requirements in paragraph (b).

(b) In addition to the requirements of paragraph (a), a mental health rehabilitation worker shall also:

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

(2) have an associate of arts degree;

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

(4) be a registered nurse;

(5) have within the previous ten years three years of personal life experience with mental illness;

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

(7) have within the previous ten years 2,000 hours of supervised work experience in delivering mental health services to adults with a mental illness, traumatic brain injury, substance use disorder, or developmental disability.

(c) If the mental health rehabilitation worker provides crisis residential services, intensive residential treatment services, partial hospitalization, or day treatment services, the mental health rehabilitation worker shall: (1) satisfy paragraph (b), clause (1); and (2) have 40 hours of additional continuing education on mental health topics during the first year of employment.

Subd. 15. **Mental health rehabilitation worker scope of practice.** (a) A mental health rehabilitation worker under supervision of a mental health practitioner or mental health professional may provide rehabilitative mental health services identified in the client's individual treatment plan and individual behavior plan.

(b) A mental health rehabilitation worker who solely acts and is scheduled as overnight staff is exempt from the additional qualification requirements in subdivision 14, paragraphs (a), clause (3), and (b).

Subd. 16. **Mental health behavioral aide qualifications.** (a) A level 1 mental health behavioral aide shall:

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

(2) have a high school diploma or commissioner of education-selected high school equivalency certification; or two years of experience as a primary caregiver to a child with severe emotional disturbance within the previous ten years.

(b) A level 2 mental health behavioral aide shall:

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

(2) have an associate or bachelor's degree or be certified by a program under section 256B.0943, subdivision 8a.

Subd. 17. **Mental health behavioral aide scope of practice.** The mental health behavioral aide under supervision of a mental health professional may provide rehabilitative mental health services identified in the client's individual treatment plan and individual behavior plan.

Sec. 45. [245I.18] TREATMENT SUPERVISION.

Subdivision 1. **Generally.** (a) A provider entity shall ensure that a mental health professional provides treatment supervision for each staff person who provides services to

a client and who is not a mental health professional or certified rehabilitation specialist. Treatment supervision shall be based on a staff person's written treatment supervision plan.

(b) Treatment supervision must focus on the client's treatment needs and the ability of the staff person receiving treatment supervision to provide services, including:

(1) review and evaluation of the interventions delivered;

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

(3) review and evaluation of assessments, treatment plans, and progress notes for accuracy and appropriateness;

(4) approval of diagnostic assessments and individual treatment plans within five business days of initial completion by the supervisee;

(5) instruction on the cultural norms or values of the clients and communities served by the provider entity and any impact on treatment;

(6) evaluation of and feedback on the competencies of direct service staff persons; and

(7) coaching, teaching, and practicing skills with staff persons.

(c) A treatment supervisor's responsibility for a supervisee is limited to services provided by the associated provider entity. If a supervisee is employed by multiple provider entities, each entity is responsible for furnishing the necessary treatment supervision.

Subd. 2. **Permitted modalities.** (a) Treatment supervision must be conducted face-to-face, including telemedicine, according to the Minnesota Telemedicine Act, sections 62A.67 to 62A.672.

(b) Treatment supervision may be conducted using individual, small group, or team modalities. "Individual supervision" means one or more mental health professionals and one staff person receiving treatment supervision. "Small group supervision" means one or more mental health professionals and two to six staff persons receiving treatment supervision. "Team supervision" is defined by the service lines for which it may be used.

Subd. 3. **Treatment supervision planning.** (a) A written treatment supervision plan shall be developed by a mental health professional who is qualified to provide treatment supervision and the staff person receiving the treatment supervision. The treatment supervision plan must be completed and implemented within 30 days of a new staff person's employment. The treatment supervision plan must be reviewed and updated at least annually.

(b) The treatment supervision plan must include:

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

(2) the name of the provider entity under which the staff person is receiving treatment supervision;

(3) the name and licensure of a mental health professional providing treatment supervision;

(4) the number of hours of individual and group supervision the staff person receiving treatment supervision must complete and the location of the record if the record is kept outside of an individual personnel file;

(5) procedures that the staff person receiving treatment supervision shall use to respond to client emergencies; and

(6) the authorized scope of practice for the staff person receiving treatment supervision, including a description of responsibilities with the provider entity, a description of client population, and treatment methods and modalities.

Subd. 4. **Treatment supervision record.** (a) A provider entity shall ensure treatment supervision is documented in each staff person's treatment supervision record.

(b) The treatment supervision record must include:

(1) the date and duration of the supervision;

(2) identification of the supervision type as individual, small group, or team supervision;

(3) the name of the mental health professional providing treatment supervision;

(4) subsequent actions that the staff person receiving treatment supervision shall take; and

(5) the date and signature of the mental health professional providing treatment supervision.

Subd. 5. **Supervision and direct observation of mental health rehabilitation workers and behavioral aides.** (a) A mental health practitioner, clinical trainee, or mental health professional shall directly observe a mental health behavioral aide or a mental health rehabilitation worker while the mental health behavioral aide or mental health rehabilitation worker provides services to clients. The amount of direct observation shall be no less than twice per month for the first six months and once per month thereafter. The staff performing the observation shall approve the progress note for the service observed.

(b) For a rehabilitation worker qualified under section 245I.16, subdivision 14, paragraph (b), clause (1), the treatment supervision in the first 2,000 hours of work shall be no less than:

(1) monthly individual treatment supervision; and

(2) twice per month direct observation.

Sec. 46. [245I.32] CLIENT FILES.

Subdivision 1. **Generally.** A provider entity must maintain a file of current and accurate client records on the premises where the service is provided or coordinated. Each entry in the record must be signed and dated by the staff person making the entry.

Subd. 2. **Record retention.** A provider entity must retain client records of a discharged client for a minimum of seven years from the date of discharge. A provider entity that ceases to provide treatment service must retain client records for a minimum of seven years from the date the provider entity stopped providing the service and must notify the commissioner of the location of the client records and the name of the individual responsible for maintaining the client records.

Subd. 3. **Contents.** Client files must contain the following, as applicable:

(1) diagnostic assessments;

(2) functional assessments;

(3) individual treatment plans;

(4) individual abuse prevention plans;

(5) crisis plans;

(6) documentation of releases of information;

(7) emergency contacts for the client;

(8) documentation of the date of service; signature of the person providing the service; nature, extent, and units of service; and place of service delivery;

(9) record of all medication prescribed or administered by staff;

(10) documentation of any contact made with the client's other mental health providers, case manager, family members, primary caregiver, or legal representative or the reason the provider did not contact the client's family members or primary caregiver;

(11) documentation of any contact made with other persons interested in the client, including representatives of the courts, corrections systems, or schools;

(12) written information by the client that the client requests be included in the file;

(13) health care directive; and

(14) the date and reason the provider entity's services are discontinued.

Sec. 47. [245I.33] DOCUMENTATION STANDARDS.

Subdivision 1. **Generally.** As a condition of payment, a provider entity must ensure that documentation complies with this section and Minnesota Rules, parts 9505.2175 and

9505.2197. The department must recover medical assistance payments for a service not documented in a client file according to this section.

Subd. 2. **Documentation standards.** A provider entity must ensure that all documentation required under this chapter:

(1) is typed or legible, if handwritten;

(2) identifies the client or staff person on each page, as applicable;

(3) is signed and dated by the staff person who completes the documentation, including the staff person's credentials; and

(4) is cosigned and dated by the staff person providing treatment supervision as required under this chapter, including the staff person's credentials.

Subd. 3. **Progress notes.** A provider entity shall use a progress note to promptly document each occurrence of a mental health service provided to a client. A progress note must include the following:

(1) the type of service;

(2) the date of service, including the start and stop time;

(3) the location of service;

(4) the scope of service, including: (i) the goal and objective targeted; (ii) the intervention delivered and the methods used; (iii) the client's response or reaction to intervention; (iv) the plan for the next session; and (v) the service modality;

(5) the signature and the printed name and credentials of the staff person who provided the service;

(6) the mental health provider travel documentation requirements under section 256B.0625, if applicable; and

(7) other significant observations, including (i) current risk factors the client may be experiencing; (ii) emergency interventions; (iii) consultations with or referrals to other professionals, family, or significant others; (iv) a summary of the effectiveness of treatment, prognosis, or discharge planning; (v) test results and medications; or (vi) changes in mental or physical symptoms.

Sec. 48. Minnesota Statutes 2018, section 254B.05, subdivision 5, is amended to read:

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

(b) Eligible substance use disorder treatment services include:

(1) outpatient treatment services that are licensed according to sections 245G.01 to 245G.17, or applicable tribal license;

(2) on July 1, 2018, or upon federal approval, whichever is later, comprehensive assessments provided according to sections 245.4863, paragraph (a), and 245G.05~~, and Minnesota Rules, part 9530.6422~~;

(3) on July 1, 2018, or upon federal approval, whichever is later, care coordination services provided according to section 245G.07, subdivision 1, paragraph (a), clause (6);

(4) on July 1, 2018, or upon federal approval, whichever is later, peer recovery support services provided according to section 245G.07, subdivision 1, paragraph (a), clause (5);

(5) on July 1, 2019, or upon federal approval, whichever is later, withdrawal management services provided according to chapter 245F;

(6) medication-assisted therapy services that are licensed according to sections 245G.01 to 245G.17 and 245G.22, or applicable tribal license;

(7) medication-assisted therapy plus enhanced treatment services that meet the requirements of clause (6) and provide nine hours of clinical services each week;

(8) high, medium, and low intensity residential treatment services that are licensed according to sections 245G.01 to 245G.17 and 245G.21 or applicable tribal license which provide, respectively, 30, 15, and five hours of clinical services each week;

(9) hospital-based treatment services that are licensed according to sections 245G.01 to 245G.17 or applicable tribal license and licensed as a hospital under sections 144.50 to 144.56;

(10) adolescent treatment programs that are licensed as outpatient treatment programs according to sections 245G.01 to 245G.18 or as residential treatment programs according to Minnesota Rules, parts 2960.0010 to 2960.0220, and 2960.0430 to 2960.0490, or applicable tribal license;

(11) high-intensity residential treatment services that are licensed according to sections 245G.01 to 245G.17 and 245G.21 or applicable tribal license, which provide 30 hours of clinical services each week provided by a state-operated vendor or to clients who have been civilly committed to the commissioner, present the most complex and difficult care needs, and are a potential threat to the community; and

(12) room and board facilities that meet the requirements of subdivision 1a.

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

(1) programs that serve parents with their children if the program:

(i) provides on-site child care during the hours of treatment activity that:

(A) is licensed under chapter 245A as a child care center under Minnesota Rules, chapter 9503; or

(B) meets the licensure exclusion criteria of section 245A.03, subdivision 2, paragraph (a), clause (6), and meets the requirements under section 245G.19, subdivision 4; or

(ii) arranges for off-site child care during hours of treatment activity at a facility that is licensed under chapter 245A as:

(A) a child care center under Minnesota Rules, chapter 9503; or

(B) a family child care home under Minnesota Rules, chapter 9502;

(2) culturally specific programs as defined in section 254B.01, subdivision 4a, or programs or subprograms serving special populations, if the program or subprogram meets the following requirements:

(i) is designed to address the unique needs of individuals who share a common language, racial, ethnic, or social background;

(ii) is governed with significant input from individuals of that specific background; and

(iii) employs individuals to provide individual or group therapy, at least 50 percent of whom are of that specific background, except when the common social background of the individuals served is a traumatic brain injury or cognitive disability and the program employs treatment staff who have the necessary professional training, as approved by the commissioner, to serve clients with the specific disabilities that the program is designed to serve;

(3) programs that offer medical services delivered by appropriately credentialed health care staff in an amount equal to two hours per client per week if the medical needs of the client and the nature and provision of any medical services provided are documented in the client file; and

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

(i) the program meets the co-occurring requirements in section 245G.20;

(ii) 25 percent of the counseling staff are licensed mental health professionals~~, as defined in section 245.462, subdivision 18, clauses (1) to (6),~~ qualified according to section 245I.16, subdivision 2, or are students or licensing candidates under the supervision of a licensed alcohol and drug counselor supervisor and licensed mental health professional, except that no more than 50 percent of the mental health staff may be students or licensing candidates with time documented to be directly related to provisions of co-occurring services;

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

(iv) the program has standards for multidisciplinary case review that include a monthly review for each client that, at a minimum, includes a licensed mental health professional and licensed alcohol and drug counselor, and their involvement in the review is documented;

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

(vi) co-occurring counseling staff shall receive eight hours of co-occurring disorder training annually.

(d) In order to be eligible for a higher rate under paragraph (c), clause (1), a program that provides arrangements for off-site child care must maintain current documentation at the chemical dependency facility of the child care provider's current licensure to provide child care services. Programs that provide child care according to paragraph (c), clause (1), must be deemed in compliance with the licensing requirements in section 245G.19.

(e) Adolescent residential programs that meet the requirements of Minnesota Rules, parts 2960.0430 to 2960.0490 and 2960.0580 to 2960.0690, are exempt from the requirements in paragraph (c), clause (4), items (i) to (iv).

(f) Subject to federal approval, chemical dependency services that are otherwise covered as direct face-to-face services may be provided via two-way interactive video. The use of two-way interactive video must be medically appropriate to the condition and needs of the person being served. Reimbursement shall be at the same rates and under the same conditions that would otherwise apply to direct face-to-face services. The interactive video equipment and connection must comply with Medicare standards in effect at the time the service is provided.

Sec. 49. Minnesota Statutes 2018, section 256B.0615, subdivision 1, is amended to read:

Subdivision 1. **Scope.** Medical assistance covers mental health certified peer specialist services~~, as established in subdivision 2, subject to federal approval, if provided to recipients who are eligible for services under sections 256B.0622, 256B.0623, and 256B.0624 and~~ ~~are~~ provided by a certified peer specialist who ~~has completed the training under subdivision 5~~ is qualified according to section 245I.16, subdivision 10.

Sec. 50. Minnesota Statutes 2018, section 256B.0616, subdivision 1, is amended to read:

Subdivision 1. **Scope.** Medical assistance covers mental health certified family peer specialists services~~, as established in subdivision 2, subject to federal approval, if provided to recipients who have an emotional disturbance or severe emotional disturbance under chapter 245,~~ and are provided by a certified family peer specialist who ~~has completed the training under subdivision 5~~ is qualified according to section 245I.16, subdivision 12. A family peer specialist cannot provide services to the peer specialist's family.

Sec. 51. Minnesota Statutes 2018, section 256B.0616, subdivision 3, is amended to read:

Subd. 3. **Eligibility.** Family peer support services may be ~~located in~~ provided to recipients of inpatient hospitalization, partial hospitalization, residential treatment, intensive treatment in foster care, day treatment, children's therapeutic services and supports, or crisis services.

Sec. 52. Minnesota Statutes 2018, section 256B.0622, subdivision 1, is amended to read:

Subdivision 1. **Scope.** ~~Subject to federal approval,~~ Medical assistance covers medically necessary, assertive community treatment for clients as defined in subdivision 2a and intensive residential treatment services for clients as defined in subdivision 3, when the services are provided by an entity meeting the standards in this section.

Sec. 53. Minnesota Statutes 2018, section 256B.0622, subdivision 2, is amended to read:

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

(b) "ACT team" means the group of interdisciplinary mental health staff who work as a team to provide assertive community treatment.

(c) "Assertive community treatment" means intensive nonresidential treatment and rehabilitative mental health services provided according to the assertive community treatment model. Assertive community treatment provides a single, fixed point of responsibility for treatment, rehabilitation, and support needs for clients. Services are offered 24 hours per day, seven days per week, in a community-based setting.

~~(d) "Individual treatment plan" means the document that results from a person-centered planning process of determining real-life outcomes with clients and developing strategies to achieve those outcomes.~~

~~(e) "Assertive engagement" means the use of collaborative strategies to engage clients to receive services.~~

~~(f) "Benefits and finance support" means assisting clients in capably managing financial affairs. Services include, but are not limited to, assisting clients in applying for benefits; assisting with redetermination of benefits; providing financial crisis management; teaching and supporting budgeting skills and asset development; and coordinating with a client's representative payee, if applicable.~~

(d) "Clinical trainee" means a staff person qualified according to section 245I.16, subdivision 6.

~~(g)~~ (e) "Co-occurring disorder treatment" means the treatment of co-occurring mental illness and substance use disorders and is characterized by assertive outreach, stage-wise comprehensive treatment, treatment goal setting, and flexibility to work within each stage of treatment. Services include, but are not limited to, assessing and tracking clients' stages of change readiness and treatment; applying the appropriate treatment based on stages of change, such as outreach and motivational interviewing techniques to work with clients in earlier stages of change readiness and cognitive behavioral approaches and relapse prevention to work with clients in later stages of change; and facilitating access to community supports.

~~(h)~~ (f) "Crisis assessment and intervention" means mental health crisis response services as defined in section 256B.0624, subdivision 2, paragraphs (c) to (e).

~~(i) "Employment services" means assisting clients to work at jobs of their choosing. Services must follow the principles of the individual placement and support (IPS) employment model, including focusing on competitive employment; emphasizing individual client preferences and strengths; ensuring employment services are integrated with mental health services; conducting rapid job searches and systematic job development according to client preferences and choices; providing benefits counseling; and offering all services in an individualized and time-unlimited manner. Services shall also include educating clients about opportunities and benefits of work and school and assisting the client in learning job skills, navigating the work place, and managing work relationships.~~

~~(j) "Family psychoeducation and support" means services provided to the client's family and other natural supports to restore and strengthen the client's unique social and family relationships. Services include, but are not limited to, individualized psychoeducation about the client's illness and the role of the family and other significant people in the therapeutic process; family intervention to restore contact, resolve conflict, and maintain relationships with family and other significant people in the client's life; ongoing communication and collaboration between the ACT team and the family; introduction and referral to family self-help programs and advocacy organizations that promote recovery and family engagement, individual supportive counseling, parenting training, and service coordination to help clients fulfill parenting responsibilities; coordinating services for the child and restoring relationships with children who are not in the client's custody; and coordinating with child welfare and family agencies, if applicable. These services must be provided with the client's agreement and consent.~~

~~(k) "Housing access support" means assisting clients to find, obtain, retain, and move to safe and adequate housing of their choice. Housing access support includes, but is not limited to, locating housing options with a focus on integrated independent settings; applying for housing subsidies, programs, or resources; assisting the client in developing relationships with local landlords; providing tenancy support and advocacy for the individual's tenancy rights at the client's home; and assisting with relocation.~~

(g) "Individual treatment plan" means a plan described under section 256B.0671, subdivisions 5 and 6.

~~(l)~~ (h) "Individual treatment team" means a minimum of three members of the ACT team who are responsible for consistently carrying out most of a client's assertive community treatment services.

~~(m)~~ (i) "Intensive residential treatment services treatment team" means all staff who provide intensive residential treatment services under this section to clients. ~~At a minimum, this includes the clinical supervisor; mental health professionals as defined in section 245.462, subdivision 18, clauses (1) to (6); mental health practitioners as defined in section 245.462, subdivision 17; mental health rehabilitation workers under section 256B.0623, subdivision 5, paragraph (a), clause (4); and mental health certified peer specialists under section 256B.0615.~~

~~(n)~~ (j) "Intensive residential treatment services" means short-term, time-limited services provided in a residential setting to clients who are in need of more restrictive settings and are at risk of significant functional deterioration if they do not receive these services. Services are designed to develop and enhance psychiatric stability, personal and emotional adjustment, self-sufficiency, and skills to live in a more independent setting. Services must be directed toward a targeted discharge date with specified client outcomes.

~~(o) "Medication assistance and support" means assisting clients in accessing medication, developing the ability to take medications with greater independence, and providing medication setup. This includes the prescription, administration, and order of medication by appropriate medical staff.~~

~~(p) "Medication education" means educating clients on the role and effects of medications in treating symptoms of mental illness and the side effects of medications.~~

(k) "Mental health certified peer specialist" means a staff person qualified according to section 245I.16, subdivision 10.

(l) "Mental health practitioner" means a staff person qualified according to section 245I.16, subdivision 4.

(m) "Mental health professional" means a staff person qualified according to section 245I.16, subdivision 2.

(n) "Mental health rehabilitation worker" means a staff person qualified according to section 245I.16, subdivision 14.

~~(q)~~ (o) "Overnight staff" means a member of the intensive residential treatment services team who is responsible during hours when clients are typically asleep.

~~(r) "Mental health certified peer specialist services" has the meaning given in section 256B.0615.~~

~~(s)~~ (p) "Physical health services" means any service or treatment to meet the physical health needs of the client to support the client's mental health recovery. Services include, but are not limited to, education on primary health issues, including wellness education; medication administration and monitoring; providing and coordinating medical screening and follow-up; scheduling routine and acute medical and dental care visits; tobacco cessation strategies; assisting clients in attending appointments; communicating with other providers; and integrating all physical and mental health treatment.

~~(t)~~ (q) "Primary team member" means the person who leads and coordinates the activities of the individual treatment team and is the individual treatment team member who has primary responsibility for establishing and maintaining a therapeutic relationship with the client on a continuing basis.

~~(u)~~ (r) "Rehabilitative mental health services" means mental health services that are rehabilitative and enable the client to develop and enhance psychiatric stability, social

competencies, personal and emotional adjustment, independent living, parenting skills, and community skills, when these abilities are impaired by the symptoms of mental illness.

~~(v)~~ (s) "Symptom management" means supporting clients in identifying and targeting the symptoms and occurrence patterns of their mental illness and developing strategies to reduce the impact of those symptoms.

~~(w)~~ (t) "Therapeutic interventions" means empirically supported techniques to address specific symptoms and behaviors such as anxiety, psychotic symptoms, emotional dysregulation, and trauma symptoms. Interventions include empirically supported psychotherapies including, but not limited to, cognitive behavioral therapy, exposure therapy, acceptance and commitment therapy, interpersonal therapy, and motivational interviewing.

~~(x)~~ (u) "Wellness self-management and prevention" means a combination of approaches to working with the client to build and apply skills related to recovery, and to support the client in participating in leisure and recreational activities, civic participation, and meaningful structure.

Sec. 54. Minnesota Statutes 2018, 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 ~~as well as~~, chapter 245I, 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 adequate preservice and ongoing training for staff;~~

~~(4) ensure that staff is capable of implementing culturally specific services that are culturally responsive and appropriate as determined by the client's culture, beliefs, values, and language as identified in the individual treatment plan;~~

~~(5)~~ (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;

~~(6) develop and maintain client files, individual treatment plans, and contact charting;~~

~~(7) develop and maintain staff training and personnel files;~~

~~(8)~~ (4) submit information as required by the state;

~~(9)~~ (5) keep all necessary records required by law;

~~(10) comply with all applicable laws;~~

~~(11)~~ (6) be an enrolled Medicaid provider;

~~(12)~~ (7) establish and maintain a quality assurance plan to determine specific service outcomes and the client's satisfaction with services; and

~~(13)~~ (8) develop and maintain written policies and procedures regarding service provision and administration of the provider entity.

(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. 55. Minnesota Statutes 2018, section 256B.0622, subdivision 4, is amended to read:

Subd. 4. **Provider entity licensure and contract requirements for intensive residential treatment services.** (a) The intensive residential treatment services provider entity must:

(1) be licensed under Minnesota Rules, parts 9520.0500 to 9520.0670;

(2) not exceed 16 beds per site; and

(3) comply with the additional standards in this section and chapter 245I.

(b) The commissioner shall develop procedures for counties and providers to submit other documentation as needed to allow the commissioner to determine whether the standards in this section are met.

(c) A provider entity must specify in the provider entity's application what geographic area and populations will be served by the proposed program. A provider entity must document that the capacity or program specialties of existing programs are not sufficient to meet the service needs of the target population. A provider entity must submit evidence of ongoing relationships with other providers and levels of care to facilitate referrals to and from the proposed program.

(d) A provider entity must submit documentation that the provider entity requested a statement of need from each county board and tribal authority that serves as a local mental health authority in the proposed service area. The statement of need must specify if the local

mental health authority supports or does not support the need for the proposed program and the basis for this determination. If a local mental health authority does not respond within 60 days of the receipt of the request, the commissioner shall determine the need for the program based on the documentation submitted by the provider entity.

Sec. 56. Minnesota Statutes 2018, section 256B.0622, subdivision 5a, is amended to read:

Subd. 5a. **Standards for intensive residential rehabilitative mental health services.** (a) The standards in this subdivision apply to intensive residential mental health services.

(b) The provider of intensive residential treatment services must have sufficient staff to provide 24-hour-per-day coverage to deliver the rehabilitative services described in the treatment plan and to safely supervise and direct the activities of clients, given the client's level of behavioral and psychiatric stability, cultural needs, and vulnerability. The provider must have the capacity within the facility to provide integrated services for chemical dependency, illness management services, and family education, when appropriate.

(c) At a minimum:

(1) staff must provide direction and supervision whenever clients are present in the facility;

(2) staff must remain awake during all work hours;

(3) there must be a staffing ratio of at least one to nine clients for each day and evening shift. If more than nine clients are present at the residential site, there must be a minimum of two staff during day and evening shifts, one of whom must be a mental health practitioner or mental health professional;

(4) if services are provided to clients who need the services of a medical professional, the provider shall ensure that these services are provided either by the provider's own medical staff or through referral to a medical professional; and

(5) the provider must ensure the timely availability of a licensed registered nurse, either directly employed or under contract, who is responsible for ensuring the effectiveness and safety of medication administration in the facility and assessing clients for medication side effects and drug interactions.

(d) Services must be provided by qualified staff as defined in section 256B.0623, subdivision 5~~, who are trained and supervised according to section 256B.0623, subdivision 6, except that mental health rehabilitation workers acting as overnight staff are not required to comply with section 256B.0623, subdivision 5, paragraph (a), clause (4), item (iv)~~.

(e) The ~~clinical~~ treatment supervisor must be an active member of the intensive residential services treatment team. The team must meet with the ~~clinical~~ treatment supervisor at least weekly to discuss clients' progress and make rapid adjustments to meet clients' needs. The team meeting shall include client-specific case reviews and general treatment discussions

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

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

(g) The initial functional assessment must be completed within ten days of intake and updated at least every 30 days, or prior to discharge from the service, whichever comes first.

(h) The initial individual treatment plan must be completed within 24 hours of admission. Within ten days of admission, the initial treatment plan must be refined and further developed, except for providers certified according to Minnesota Rules, parts 9533.0010 to 9533.0180. The individual treatment plan must be reviewed with the client and updated at least monthly.

Sec. 57. Minnesota Statutes 2018, section 256B.0622, subdivision 7, is amended to read:

Subd. 7. **Assertive community treatment service standards.** (a) ACT teams must offer and have the capacity to directly provide the following services:

(1) assertive engagement using collaborative strategies to encourage clients to receive services;

(2) benefits and finance support~~;~~ that assists clients to capably manage financial affairs. Services include but are not limited to assisting clients in applying for benefits, assisting with redetermination of benefits, providing financial crisis management, teaching and supporting budgeting skills and asset development, and coordinating with a client's representative payee, if applicable;

(3) co-occurring disorder treatment;

(4) crisis assessment and intervention;

(5) employment services~~;~~ that assists clients to work at jobs of their choosing. Services must follow the principles of the individual placement and support employment model, including focusing on competitive employment, emphasizing individual client preferences and strengths, ensuring employment services are integrated with mental health services, conducting rapid job searches and systematic job development according to client preferences and choices, providing benefits counseling, and offering all services in an individualized and time-unlimited manner. Services must also include educating clients about opportunities and benefits of work and school and assisting the client in learning job skills, navigating the workplace, workplace accommodations, and managing work relationships;

(6) family psychoeducation and support~~;~~ provided to the client's family and other natural supports to restore and strengthen the client's unique social and family relationships. Services include but are not limited to individualized psychoeducation about the client's illness and

the role of the family and other significant people in the therapeutic process; family intervention to restore contact, resolve conflict, and maintain relationships with family and other significant people in the client's life; ongoing communication and collaboration between the ACT team and the family; introduction and referral to family self-help programs and advocacy organizations that promote recovery and family engagement, individual supportive counseling, parenting training, and service coordination to help clients fulfill parenting responsibilities; coordinating services for the child and restoring relationships with children who are not in the client's custody; and coordinating with child welfare and family agencies, if applicable. These services must be provided with the client's agreement and consent;

(7) housing access support~~;~~ that assists clients to find, obtain, retain, and move to safe and adequate housing of their choice. Housing access support includes but is not limited to locating housing options with a focus on integrated independent settings; applying for housing subsidies, programs, or resources; assisting the client in developing relationships with local landlords; providing tenancy support and advocacy for the individual's tenancy rights at the client's home; and assisting with relocation;

(8) medication assistance and support~~;~~ that assists clients in accessing medication, developing the ability to take medications with greater independence, and providing medication setup. Medication assistance and support includes assisting the client with the prescription, administration, and ordering of medication by appropriate medical staff;

(9) medication education~~;~~ that educates clients on the role and effects of medications in treating symptoms of mental illness and the side effects of medications;

(10) mental health certified peer specialists services;

(11) physical health services;

(12) rehabilitative mental health services;

(13) symptom management;

(14) therapeutic interventions;

(15) wellness self-management and prevention; and

(16) other services based on client needs as identified in a client's assertive community treatment individual treatment plan.

(b) ACT teams must ensure the provision of all services necessary to meet a client's needs as identified in the client's individual treatment plan.

Sec. 58. Minnesota Statutes 2018, 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 ~~licensed~~ mental health professional ~~who is qualified under Minnesota Rules, part 9505.0371, subpart 5, item A~~. 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 ~~clinical oversight~~ 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 overall ~~clinical oversight~~ treatment supervision to the ACT team after regular business hours and on weekends and holidays. The team leader may delegate this duty to another qualified member of the ACT team;

(2) the psychiatric care provider:

(i) must be a ~~licensed psychiatrist certified by the American Board of Psychiatry and Neurology or eligible for board certification or certified by the American Osteopathic Board of Neurology and Psychiatry or eligible for board certification, or a psychiatric nurse who is qualified under Minnesota Rules, part 9505.0371, subpart 5, item A~~ mental health professional permitted to prescribe psychiatric medications as part of the 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 ~~clinical~~ 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;

(vi) may not provide specific roles and responsibilities by telemedicine unless approved by the commissioner; and

(vii) 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) ~~should~~ shall 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 ~~mental health certified peer specialist as defined in section 256B.0615~~. 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 ~~licensed~~ mental health professionals ~~as defined in Minnesota Rules, part 9505.0371, subpart 5, item A~~; mental health practitioners ~~as defined in section 245.462, subdivision 17; a mental health practitioner working as a~~; clinical ~~trainee according to Minnesota Rules, part 9505.0371, subpart 5, item C~~ trainees; or mental health rehabilitation workers ~~as defined in section 256B.0623, subdivision 5, paragraph (a), clause (4)~~. 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. 59. Minnesota Statutes 2018, section 256B.0622, subdivision 7b, is amended to read:

Subd. 7b. **Assertive community treatment program size and opportunities.** (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:

(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 for at least eight-hour shift coverage 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 substance abuse 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, 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 substance abuse 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, 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 substance abuse 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, clinical trainee, 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. 60. Minnesota Statutes 2018, section 256B.0622, subdivision 7d, is amended to read:

Subd. 7d. **Assertive community treatment assessment and individual treatment plan.** (a) An initial assessment, including a diagnostic assessment that meets the requirements of ~~Minnesota Rules, part 9505.0372, subpart 1,~~ section 256B.0671, subdivisions 2 and 3, and a 30-day treatment plan 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 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.

(b) An initial functional assessment must be completed within ten days of intake and updated every six months for assertive community treatment, or prior to discharge from the service, whichever comes first.

(c) Within 30 days of the client's assertive community treatment admission, the ACT team shall complete an in-depth assessment of the domains listed under section 245.462, subdivision 11a.

(d) Each part of the in-depth assessment areas shall be completed by each respective team specialist or an ACT team member with skill and knowledge in the area being assessed. The assessments are based upon all available information, including that from client interview family and identified natural supports, and written summaries from other agencies, including police, courts, county social service agencies, outpatient facilities, and inpatient facilities, where applicable.

(e) 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 in-depth assessments and provide treatment recommendations. The conference must serve as the basis for the first six-month treatment plan, which must be written by the primary team member.

(f) 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.

(g) 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.

(h) 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 ~~signed~~ 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 ~~signed~~ individual treatment plan is made available to the client.

Sec. 61. Minnesota Statutes 2018, section 256B.0623, subdivision 1, is amended to read:

Subdivision 1. **Scope.** Medical assistance covers adult rehabilitative mental health services as defined in subdivision 2, ~~subject to federal approval,~~ if provided to recipients as defined in subdivision 3 and provided by a qualified provider entity meeting the standards in this section and by a qualified individual provider working within the provider's scope of practice and identified in the recipient's individual treatment plan ~~as defined~~ described in section ~~245.462, subdivision 14~~ 256B.0671, subdivisions 5 and 6, and if determined to be medically necessary according to section 62Q.53.

Sec. 62. Minnesota Statutes 2018, section 256B.0623, subdivision 2, is amended to read:

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

(a) "Adult rehabilitative mental health services" means mental health services which are rehabilitative and enable the recipient to develop and enhance psychiatric stability, social competencies, personal and emotional adjustment, independent living, parenting skills, and community skills, when these abilities are impaired by the symptoms of mental illness. ~~Adult rehabilitative mental health services are also appropriate when provided to enable a~~

~~recipient to retain stability and functioning, if the recipient would be at risk of significant functional decompensation or more restrictive service settings without these services.~~

~~(1) Adult rehabilitative mental health services instruct, assist, and support the recipient in areas such as: interpersonal communication skills, community resource utilization and integration skills, crisis assistance, relapse prevention skills, health care directives, budgeting and shopping skills, healthy lifestyle skills and practices, cooking and nutrition skills, transportation skills, medication education and monitoring, mental illness symptom management skills, household management skills, employment-related skills, parenting skills, and transition to community living services.~~

~~(2) These services shall be provided to the recipient on a one-to-one basis in the recipient's home or another community setting or in groups.~~

(b) "Medication education services" means services provided individually or in groups which focus on educating the recipient about mental illness and symptoms; the role and effects of medications in treating symptoms of mental illness; and the side effects of medications. Medication education is coordinated with medication management services and does not duplicate it. Medication education services are provided by physicians, pharmacists, physician assistants, or registered nurses.

(c) "Transition to community living services" means services which maintain continuity of contact between the rehabilitation services provider and the recipient and which facilitate discharge from a hospital, residential treatment program under Minnesota Rules, chapter 9505, board and lodging facility, or nursing home. Transition to community living services are not intended to provide other areas of adult rehabilitative mental health services.

Sec. 63. Minnesota Statutes 2018, section 256B.0623, subdivision 3, is amended to read:

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

(1) is age 18 or older;

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

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

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

Sec. 64. Minnesota Statutes 2018, section 256B.0623, subdivision 4, is amended to read:

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

(b) The certification process is a determination as to whether the entity meets the standards in this subdivision and chapter 245I. The certification must specify which adult rehabilitative mental health services the entity is qualified to provide.

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

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

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

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

(1) have capacity to recruit, hire, manage, and train ~~mental health professionals, mental health practitioners, and mental health rehabilitation workers~~ qualified staff;

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

~~(3) ensure adequate preservice and inservice and ongoing training for staff;~~

~~(4)~~ (3) ensure that ~~mental health professionals, mental health practitioners, and mental health rehabilitation workers~~ staff are skilled in the delivery of the specific adult rehabilitative mental health services provided to the individual eligible recipient;

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

~~(6)~~ (4) ensure enough flexibility in service delivery to respond to the changing and intermittent care needs of a recipient as identified by the recipient and the individual treatment plan;

~~(7) ensure that the mental health professional or mental health practitioner, who is under the clinical supervision of a mental health professional, involved in a recipient's services participates in the development of the individual treatment plan;~~

~~(8)~~ (5) assist the recipient in arranging needed crisis assessment, intervention, and stabilization services;

~~(9)~~ (6) ensure that services are coordinated with other recipient mental health services providers and the county mental health authority and the federally recognized American Indian authority and necessary others after obtaining the consent of the recipient. Services

must also be coordinated with the recipient's case manager or care coordinator if the recipient is receiving case management or care coordination services;

~~(10) develop and maintain recipient files, individual treatment plans, and contact charting;~~

~~(11) develop and maintain staff training and personnel files;~~

~~(12)~~ (7) submit information as required by the state;

~~(13) establish and maintain a quality assurance plan to evaluate the outcome of services provided;~~

~~(14)~~ (8) keep all necessary records required by law;

~~(15)~~ (9) deliver services as required by section 245.461;

~~(16) comply with all applicable laws;~~

~~(17)~~ (10) be an enrolled Medicaid provider;

~~(18)~~ (11) maintain a quality assurance plan to determine specific service outcomes and the recipient's satisfaction with services; and

~~(19)~~ (12) develop and maintain written policies and procedures regarding service provision and administration of the provider entity.

Sec. 65. Minnesota Statutes 2018, section 256B.0623, subdivision 5, is amended to read:

Subd. 5. **Qualifications of provider staff.** ~~(a)~~ Adult rehabilitative mental health services must be provided by qualified individual provider staff of a certified provider entity. Individual provider staff must be qualified ~~under~~ as one of the following ~~criteria~~ providers:

(1) a mental health professional ~~as defined in section 245.462, subdivision 18, clauses (1) to (6). If the recipient has a current diagnostic assessment by a licensed mental health professional as defined in section 245.462, subdivision 18, clauses (1) to (6), recommending receipt of adult mental health rehabilitative services, the definition of mental health professional for purposes of this section includes a person who is qualified under section 245.462, subdivision 18, clause (7), and who holds a current and valid national certification as a certified rehabilitation counselor or certified psychosocial rehabilitation practitioner~~ qualified according to section 245I.16, subdivision 2;

(2) a certified rehabilitation specialist qualified according to section 245I.16, subdivision 8;

(3) a clinical trainee qualified according to section 245I.16, subdivision 6;

~~(2)~~ (4) a mental health practitioner ~~as defined in section 245.462, subdivision 17. The mental health practitioner must work under the clinical supervision of a mental health professional~~ qualified according to section 245I.16, subdivision 4;

~~(3)~~ (5) a mental health certified peer specialist ~~under section 256B.0615. The certified peer specialist must work under the clinical supervision of a mental health professional~~ qualified according to section 245I.16, subdivision 10; or

~~(4)~~ (6) a mental health rehabilitation worker qualified according to section 245I.16, subdivision 14. ~~A mental health rehabilitation worker means a staff person working under the direction of a mental health practitioner or mental health professional and under the clinical supervision of a mental health professional in the implementation of rehabilitative mental health services as identified in the recipient's individual treatment plan who:~~

~~(i) is at least 21 years of age;~~

~~(ii) has a high school diploma or equivalent;~~

~~(iii) has successfully completed 30 hours of training during the two years immediately prior to the date of hire, or before provision of direct services, in all of the following areas: recovery from mental illness, mental health de-escalation techniques, recipient rights, recipient-centered individual treatment planning, behavioral terminology, mental illness, co-occurring mental illness and substance abuse, psychotropic medications and side effects, functional assessment, local community resources, adult vulnerability, recipient confidentiality; and~~

~~(iv) meets the qualifications in paragraph (b).~~

~~(b) In addition to the requirements in paragraph (a), a mental health rehabilitation worker must also meet the qualifications in clause (1), (2), or (3):~~

~~(1) has an associates of arts degree, two years of full-time postsecondary education, or a total of 15 semester hours or 23 quarter hours in behavioral sciences or related fields; is a registered nurse; or within the previous ten years has:~~

~~(i) three years of personal life experience with serious mental illness;~~

~~(ii) three years of life experience as a primary caregiver to an adult with a serious mental illness, traumatic brain injury, substance use disorder, or developmental disability; or~~

~~(iii) 2,000 hours of supervised work experience in the delivery of mental health services to adults with a serious mental illness, traumatic brain injury, substance use disorder, or developmental disability;~~

~~(2)(i) is fluent in the non-English language or competent in the culture of the ethnic group to which at least 20 percent of the mental health rehabilitation worker's clients belong;~~

~~(ii) receives during the first 2,000 hours of work, monthly documented individual clinical supervision by a mental health professional;~~

~~(iii) has 18 hours of documented field supervision by a mental health professional or mental health practitioner during the first 160 hours of contact work with recipients, and at least six hours of field supervision quarterly during the following year;~~

~~(iv) has review and cosignature of charting of recipient contacts during field supervision by a mental health professional or mental health practitioner; and~~

~~(v) has 15 hours of additional continuing education on mental health topics during the first year of employment and 15 hours during every additional year of employment; or~~

~~(3) for providers of crisis residential services, intensive residential treatment services, partial hospitalization, and day treatment services:~~

~~(i) satisfies clause (2), items (ii) to (iv); and~~

~~(ii) has 40 hours of additional continuing education on mental health topics during the first year of employment.~~

~~(c) A mental health rehabilitation worker who solely acts and is scheduled as overnight staff is not required to comply with paragraph (a), clause (4), item (iv).~~

~~(d) For purposes of this subdivision, "behavioral sciences or related fields" means an education from an accredited college or university and includes but is not limited to social work, psychology, sociology, community counseling, family social science, child development, child psychology, community mental health, addiction counseling, counseling and guidance, special education, and other fields as approved by the commissioner.~~

Sec. 66. Minnesota Statutes 2018, section 256B.0623, subdivision 6, is amended to read:

Subd. 6. **Required training and supervision.** (a) ~~Mental health rehabilitation workers must receive ongoing continuing education training of at least 30 hours every two years in areas of mental illness and mental health services and other areas specific to the population being served. Mental health rehabilitation workers must also be subject to the ongoing direction and clinical supervision standards in paragraphs (c) and (d)~~ Staff must receive training in accordance with section 245I.10.

~~(b) Mental health practitioners must receive ongoing continuing education training as required by their professional license; or if the practitioner is not licensed, the practitioner must receive ongoing continuing education training of at least 30 hours every two years in areas of mental illness and mental health services. Mental health practitioners must meet the ongoing clinical supervision standards in paragraph (c).~~

~~(c) Clinical supervision may be provided by a full- or part-time qualified professional employed by or under contract with the provider entity. Clinical supervision may be provided by interactive videoconferencing according to procedures developed by the commissioner.~~ (b) Treatment supervision must be provided according to section 245I.18. A mental health professional providing ~~clinical~~ treatment supervision of staff delivering adult rehabilitative mental health services must provide the following guidance:

~~(1) review the information in the recipient's file;~~

~~(2) review and approve initial and updates of individual treatment plans;~~

~~(3)~~ (1) meet with ~~mental health rehabilitation workers and practitioners, individually or in small groups,~~ staff receiving direction at least monthly to discuss treatment topics of interest ~~to the workers and practitioners~~;

~~(4) meet with mental health rehabilitation workers and practitioners, individually or in small groups, at least monthly to~~ (2) discuss treatment plans of recipients~~, and approve by signature and document in the recipient's file any resulting plan updates~~;

~~(5) meet at least monthly with the directing mental health practitioner, if there is one, to~~ (3) review needs of the adult rehabilitative mental health services program, review staff on-site observations and evaluate mental health rehabilitation workers, plan staff training, and review program evaluation and development~~, and consult with the directing practitioner; and~~;

~~(6) be available for urgent consultation as the individual recipient needs or the situation necessitates.~~

~~(d) An adult rehabilitative mental health services provider entity must have a treatment director who is a mental health practitioner or mental health professional. The treatment director must ensure the following:~~

~~(1) while delivering direct services to recipients, a newly hired mental health rehabilitation worker must be directly observed delivering services to recipients by a mental health practitioner or mental health professional for at least six hours per 40 hours worked during the first 160 hours that the mental health rehabilitation worker works;~~

~~(2) the mental health rehabilitation worker must receive ongoing on-site direct service observation by a mental health professional or mental health practitioner for at least six hours for every six months of employment;~~

~~(3)~~ (4) review progress notes ~~are reviewed~~ from on-site service observation prepared by the mental health rehabilitation worker and mental health practitioner for accuracy and consistency with actual recipient contact and the individual treatment plan and goals;

~~(4)~~ (5) ensure immediate availability by phone or in person for consultation by a mental health professional or a mental health practitioner to the mental health rehabilitation services worker during service provision; and

~~(5) oversee the identification of changes in individual recipient treatment strategies, revise the plan, and communicate treatment instructions and methodologies as appropriate to ensure that treatment is implemented correctly;~~

~~(6) model service practices which: respect the recipient, include the recipient in planning and implementation of the individual treatment plan, recognize the recipient's strengths, collaborate and coordinate with other involved parties and providers;~~

~~(7)~~ (6) ensure that mental health practitioners and mental health rehabilitation workers are able to effectively communicate with the recipients, significant others, and providers~~;~~ ~~and~~.

~~(8) oversee the record of the results of on-site observation and charting evaluation and corrective actions taken to modify the work of the mental health practitioners and mental health rehabilitation workers.~~

~~(c) A mental health practitioner who is providing treatment direction for a provider entity must receive supervision at least monthly from a mental health professional to:~~

~~(1) identify and plan for general needs of the recipient population served;~~

~~(2) identify and plan to address provider entity program needs and effectiveness;~~

~~(3) identify and plan provider entity staff training and personnel needs and issues; and~~

~~(4) plan, implement, and evaluate provider entity quality improvement programs.~~

Sec. 67. Minnesota Statutes 2018, section 256B.0623, subdivision 7, is amended to read:

Subd. 7. **Personnel file.** The adult rehabilitative mental health services provider entity must maintain a personnel file on each staff in accordance with section 245I.13. ~~Each file must contain:~~

~~(1) an annual performance review;~~

~~(2) a summary of on-site service observations and charting review;~~

~~(3) a criminal background check of all direct service staff;~~

~~(4) evidence of academic degree and qualifications;~~

~~(5) a copy of professional license;~~

~~(6) any job performance recognition and disciplinary actions;~~

~~(7) any individual staff written input into own personnel file;~~

~~(8) all clinical supervision provided; and~~

~~(9) documentation of compliance with continuing education requirements.~~

Sec. 68. Minnesota Statutes 2018, section 256B.0623, subdivision 8, is amended to read:

Subd. 8. **Diagnostic assessment.** Providers of adult rehabilitative mental health services must obtain or complete a diagnostic assessment ~~as defined in~~ according to section ~~245.462, subdivision 9, within five days after the recipient's second visit or within 30 days after~~

~~intake, whichever occurs first. In cases where a diagnostic assessment is available that reflects the recipient's current status, and has been completed within three years preceding admission, an adult diagnostic assessment update must be completed. An update shall include a face-to-face interview with the recipient and a written summary by a mental health professional of the recipient's current mental health status and service needs. If the recipient's mental health status has changed significantly since the adult's most recent diagnostic assessment, a new diagnostic assessment is required~~ 256B.0671, subdivisions 2 and 3.

Sec. 69. Minnesota Statutes 2018, section 256B.0623, subdivision 10, is amended to read:

Subd. 10. **Individual treatment plan.** All providers of adult rehabilitative mental health services must develop and implement an individual treatment plan for each recipient~~. The provisions in clauses (1) and (2) apply:~~ according to section 256B.0671, subdivisions 5 and 6.

~~(1) Individual treatment plan means a plan of intervention, treatment, and services for an individual recipient written by a mental health professional or by a mental health practitioner under the clinical supervision of a mental health professional. The individual treatment plan must be based on diagnostic and functional assessments. To the extent possible, the development and implementation of a treatment plan must be a collaborative process involving the recipient, and with the permission of the recipient, the recipient's family and others in the recipient's support system. Providers of adult rehabilitative mental health services must develop the individual treatment plan within 30 calendar days of intake.~~ The treatment plan must be updated at least every six months thereafter, or more often when there is significant change in the recipient's situation or functioning, or in services or service methods to be used, or at the request of the recipient or the recipient's legal guardian.

~~(2) The individual treatment plan must include:~~

~~(i) a list of problems identified in the assessment;~~

~~(ii) the recipient's strengths and resources;~~

~~(iii) concrete, measurable goals to be achieved, including time frames for achievement;~~

~~(iv) specific objectives directed toward the achievement of each one of the goals;~~

~~(v) documentation of participants in the treatment planning. The recipient, if possible, must be a participant. The recipient or the recipient's legal guardian must sign the treatment plan, or documentation must be provided why this was not possible. A copy of the plan must be given to the recipient or legal guardian. Referral to formal services must be arranged, including specific providers where applicable;~~

~~(vi) cultural considerations, resources, and needs of the recipient must be included;~~

~~(vii) planned frequency and type of services must be initiated; and~~

~~(viii) clear progress notes on outcome of goals.~~

~~(3) The individual community support plan defined in section 245.462, subdivision 12, may serve as the individual treatment plan if there is involvement of a mental health case manager, and with the approval of the recipient. The individual community support plan must include the criteria in clause (2).~~

Sec. 70. Minnesota Statutes 2018, section 256B.0623, subdivision 11, is amended to read:

Subd. 11. **Recipient file.** Providers of adult rehabilitative mental health services must maintain a file for each recipient ~~that contains the following information:~~ according to section 245I.32.

~~(1) diagnostic assessment or verification of its location that is current and that was reviewed by a mental health professional who is employed by or under contract with the provider entity;~~

~~(2) functional assessments;~~

~~(3) individual treatment plans signed by the recipient and the mental health professional, or if the recipient refused to sign the plan, the date and reason stated by the recipient as to why the recipient would not sign the plan;~~

~~(4) recipient history;~~

~~(5) signed release forms;~~

~~(6) recipient health information and current medications;~~

~~(7) emergency contacts for the recipient;~~

~~(8) case records which document the date of service, the place of service delivery, signature of the person providing the service, nature, extent and units of service, and place of service delivery;~~

~~(9) contacts, direct or by telephone, with recipient's family or others, other providers, or other resources for service coordination;~~

~~(10) summary of recipient case reviews by staff; and~~

~~(11) written information by the recipient that the recipient requests be included in the file.~~

Sec. 71. Minnesota Statutes 2018, section 256B.0623, subdivision 12, is amended to read:

Subd. 12. **Additional requirements.** (a) Providers of adult rehabilitative mental health services must comply with the requirements relating to referrals for case management in section 245.467, subdivision 4.

(b) Adult rehabilitative mental health services are provided for most recipients in the recipient's home and community. Services may also be provided at the home of a relative

or significant other, job site, psychosocial clubhouse, drop-in center, social setting, classroom, or other places in the community. Except for "transition to community services," the place of service does not include a regional treatment center, nursing home, residential treatment facility licensed under Minnesota Rules, parts 9520.0500 to 9520.0670 (Rule 36), or an acute care hospital.

(c) Adult rehabilitative mental health services may be provided in group settings if appropriate to each participating recipient's needs and treatment plan. A group is defined as two to ten clients, at least one of whom is a recipient, who is concurrently receiving a service which is identified in this section. The service and group must be specified in the recipient's treatment plan. No more than two qualified staff may bill Medicaid for services provided to the same group of recipients. If two adult rehabilitative mental health workers bill for recipients in the same group session, they must each bill for different recipients.

(d) Adult rehabilitative mental health services are appropriate if provided to enable a recipient to retain stability and functioning, when the recipient is at risk of significant functional decompensation or requiring more restrictive service settings without these services.

(e) Adult rehabilitative mental health services instruct, assist, and support the recipient in areas including: interpersonal communication skills, community resource utilization and integration skills, crisis planning, relapse prevention skills, health care directives, budgeting and shopping skills, healthy lifestyle skills and practices, cooking and nutrition skills, transportation skills, medication education and monitoring, mental illness symptom management skills, household management skills, employment-related skills, parenting skills, and transition to community living services.

(f) Community intervention, including consultation with relatives, guardians, friends, employers, treatment providers, and other significant individuals, is appropriate when directed exclusively to the treatment of the client.

Sec. 72. Minnesota Statutes 2018, section 256B.0624, subdivision 2, is amended to read:

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

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

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

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

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

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

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

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

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

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

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

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

(e) "Mental health crisis stabilization services" means individualized mental health services provided to a recipient following crisis intervention services which are designed to restore the recipient to the recipient's prior functional level. Mental health crisis stabilization services may be provided in the recipient's home, the home of a family member or friend of the recipient, another community setting, or a short-term supervised, licensed

residential program. Mental health crisis stabilization does not include partial hospitalization or day treatment. Mental health crisis stabilization services includes family psychoeducation.

(f) "Clinical trainee" means a person qualified according to section 245I.16, subdivision 6.

(g) "Mental health certified family peer specialist" means a person qualified according to section 245I.16, subdivision 12.

(h) "Mental health certified peer specialist" means a person qualified according to section 245I.16, subdivision 10.

(i) "Mental health practitioner" means a person qualified according to section 245I.16, subdivision 4.

(j) "Mental health professional" means a person qualified according to section 245I.16, subdivision 2.

(k) "Mental health rehabilitation worker" means a person qualified according to section 245I.16, subdivision 14.

Sec. 73. Minnesota Statutes 2018, section 256B.0624, subdivision 4, is amended to read:

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

(1) is a county board operated entity; ~~or~~

(2) is an Indian health service facility or facility owned and operated by a tribe or a tribal organization operating under United States Code, title 25, section 450f; or

(3) is a provider entity that is under contract with the county board in the county where the potential crisis or emergency is occurring. To provide services under this section, the provider entity must directly provide the services; or if services are subcontracted, the provider entity must maintain responsibility for services and billing.

(b) A provider entity that provides crisis stabilization services in a residential setting under subdivision 7 is not required to meet the requirements of paragraph (a), clauses (1) ~~and (2)~~ to (3), and paragraph (c), clauses (9), (20), and (21), but must meet all other requirements of this subdivision. Upon approval by the commissioner, a residential crisis services provider meeting relevant standards for supervision and assessment may allow a practitioner to perform a crisis assessment to establish eligibility for admission to the program. A provider performing an assessment under this paragraph shall not bill separately beyond the daily rate for the residential stabilization program.

(c) The adult mental health crisis response services provider entity must have the capacity to meet and carry out the requirements in chapter 245I and the following standards:

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

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

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

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

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

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

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

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

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

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

(11) is able to coordinate services with detoxification according to Minnesota Rules, parts 9530.6605 to 9530.6655, or withdrawal management according to chapter 245F to ensure a recipient receives care that is responsive to the recipient's chemical and mental health needs;

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

~~(12)~~ (13) is able to submit information as required by the state, including the number of people served, response times, number of face-to-face contacts, call outcomes, and protocols for when to respond face-to-face;

~~(13)~~ (14) maintains staff training and personnel files, including documentation of staff completion of required training modules;

~~(14)~~ (15) is able to establish and maintain a quality assurance and evaluation plan to evaluate the outcomes of services and recipient satisfaction, including notifying recipients of the process by which the provider, county, or tribe accepts and responds to concerns, and the process to file a complaint with the department;

~~(15)~~ (16) is able to keep records as required by applicable laws;

~~(16)~~ (17) is able to comply with all applicable laws and statutes;

~~(17)~~ (18) is an enrolled medical assistance provider; ~~and~~

~~(18)~~ (19) develops and maintains written policies and procedures regarding service provision and administration of the provider entity, including safety of staff and recipients in high-risk situations~~.~~;

(20) is able to respond to a call for crisis services in a designated service area or according to a written agreement with the local mental health authority for an adjacent area; and

(21) documents protocol used when delivering services by telemedicine, according to sections 62A.67 to 62A.672, including responsibilities of the originating site, means to promote recipient safety, timeliness for connection and response, and steps to take in the event of a lost connection.

Sec. 74. Minnesota Statutes 2018, section 256B.0624, subdivision 5, is amended to read:

Subd. 5. **Mobile crisis intervention staff qualifications.** ~~For provision of adult mental health mobile crisis intervention services, a mobile crisis intervention team is comprised of at least two mental health professionals as defined in section 245.462, subdivision 18, clauses (1) to (6), or a combination of at least one mental health professional and one mental health practitioner as defined in section 245.462, subdivision 17, with the required mental health crisis training and under the clinical supervision of a mental health professional on the team.~~

(a) Mobile crisis intervention team staff must be qualified to provide services as mental health professionals, mental health practitioners, clinical trainees, mental health certified family peer specialists, or mental health certified peer specialists.

(b) A mobile crisis intervention team is comprised of at least two members, one of whom must be qualified as a mental health professional. A second member must be qualified as a mental health professional, clinical trainee, or mental health practitioner. A provider entity must consider the needs of the area served when adding staff.

(c) Mental health crisis assessment and intervention services must be led by a mental health professional, or under the supervision of a mental health professional according to subdivision 9, by a clinical trainee or mental health practitioner.

(d) The team must have ~~at least two people with~~ at least one member providing on-site crisis intervention services when needed. Team members must be experienced in mental health assessment, crisis intervention techniques, treatment engagement strategies, working

with families, and clinical decision-making under emergency conditions and have knowledge of local services and resources. The team must recommend and coordinate the team's services with appropriate local resources such as the county social services agency, mental health services, and local law enforcement when necessary.

Sec. 75. Minnesota Statutes 2018, section 256B.0624, subdivision 6, is amended to read:

Subd. 6. **Crisis assessment and mobile intervention treatment planning.** (a) Prior to initiating mobile crisis intervention services, a screening of the potential crisis situation must be conducted. The screening may use the resources of crisis assistance and emergency services as defined in sections 245.462, subdivision 6, and 245.469, subdivisions 1 and 2. The screening must gather information, determine whether a crisis situation exists, identify parties involved, and determine an appropriate response. Nothing in this section precludes crisis staff from answering a call from a third party.

(b) In conducting the screening, a provider shall:

(1) employ evidence-based practices as identified by the commissioner in collaboration with the commissioner of health to reduce the risk of the recipient's suicide and self-injurious behavior;

(2) work with the recipient to establish a plan and time frame for responding to the crisis, including immediate needs for support by telephone or text message until a face-to-face response arrives;

(3) document significant factors related to the determination of a crisis, including prior calls to the crisis team, recent presentation at an emergency department, known calls to 911 or law enforcement, or third parties with knowledge of a potential recipient's history or current needs;

(4) screen for the needs of a third-party caller, including a recipient who primarily identifies as a family member or a caregiver but also presents signs of a crisis; and

(5) provide psychoeducation, including education on the available means for reducing self-harm, to relevant third parties, including family members or other persons living in the home.

(c) A provider entity shall consider the following to indicate a positive screening unless the provider entity documents specific evidence to show why crisis response was clinically inappropriate:

(1) the recipient presented in an emergency department or urgent care setting, and the health care team at that location requested crisis services; or

(2) a peace officer requested crisis services for a recipient who may be subject to transportation under section 253B.05 for a mental health crisis.

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

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

(f) Direct contact with the recipient is not required before initiating a crisis assessment or intervention service. A crisis team may gather relevant information from a third party at the scene to establish the need for services and potential safety factors. A crisis assessment is provided face-to-face by a mobile crisis intervention team outside of an inpatient hospital setting. A service must be provided promptly and respond to the recipient's location whenever possible, including community or clinical settings. As clinically appropriate, a mobile crisis intervention team must coordinate a response with other health care providers if a recipient requires detoxification, withdrawal management, or medical stabilization services in addition to crisis services.

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

~~(e)~~ (h) The team must document which short-term goals have been met and when no further crisis intervention services are required. If after an assessment a crisis provider entity refers a recipient to an intensive setting, including an emergency department, in-patient hospitalization, or crisis residential treatment, one of the crisis team members who performed or conferred on the assessment must immediately contact the provider entity and consult with the triage nurse or other staff responsible for intake. The crisis team member must convey key findings or concerns that led to the referral. The consultation shall occur with the recipient's consent, the recipient's legal guardian's consent, or as allowed by section 144.293, subdivision 5. Any available written documentation, including a crisis treatment plan, must be sent no later than the next business day.

~~(f)~~ (i) If the recipient's crisis is stabilized, but the recipient needs a referral to other services, the team must provide referrals to these services. If the recipient has a case manager, planning for other services must be coordinated with the case manager. If the recipient is unable to follow up on the referral, the team must link the recipient to the service and follow up to ensure the recipient is receiving the service.

~~(g)~~ (j) If the recipient's crisis is stabilized and the recipient does not have an advance directive, the case manager or crisis team shall offer to work with the recipient to develop one.

(k) If an intervention service is provided without the recipient present, the provider shall document the reasons why the service is more effective without the recipient present.

Sec. 76. Minnesota Statutes 2018, 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 stabilization treatment plan must be developed which meets the criteria in subdivision 11;

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

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

(4) if a stabilization service is provided without the recipient present, the provider shall document the reasons why the service is more effective without the recipient present.

(b) If crisis stabilization services are provided in a supervised, licensed residential setting, the recipient must be contacted face-to-face daily by a qualified mental health practitioner or mental health professional. The program must have 24-hour-a-day residential staffing which may include staff who do not meet the qualifications in subdivision 8. The residential staff must have 24-hour-a-day immediate direct or telephone access to a qualified mental health professional or practitioner.

(c) 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 services, the residential staff must include, for at least eight hours per day, at least one individual who meets the qualifications in subdivision 8, paragraph (a), clause (1) or (2).

(d) If crisis stabilization services are provided in a supervised, licensed residential setting that serves more than four adult residents, and one or more are recipients of crisis stabilization services, the residential staff must include, for 24 hours a day, at least one individual who

meets the qualifications in subdivision 8. When more than four residents are present at the setting during the first 48 hours that a recipient is in the residential program, the residential program must have at least two staff working 24 hours a day. Staffing levels may be adjusted thereafter according to the needs of the recipient as specified in the crisis stabilization treatment plan.

Sec. 77. Minnesota Statutes 2018, section 256B.0624, subdivision 8, is amended to read:

Subd. 8. **Adult crisis stabilization staff qualifications.** ~~(a)~~ Adult mental health crisis stabilization services must be provided by qualified individual staff of a qualified provider entity. Individual provider staff must ~~have the following qualifications~~ be:

(1) ~~be~~ a mental health professional ~~as defined in section 245.462, subdivision 18, clauses (1) to (6)~~;

(2) ~~be~~ a mental health practitioner ~~as defined in section 245.462, subdivision 17. The mental health practitioner must work under the clinical supervision of a mental health professional~~;

(3) ~~be~~ a mental health certified peer specialist ~~under section 256B.0615. The certified peer specialist must work under the clinical supervision of a mental health professional~~; or

(4) ~~be~~ a mental health rehabilitation worker ~~who meets the criteria in section 256B.0623, subdivision 5, paragraph (a), clause (4); works under the direction of a mental health practitioner as defined in section 245.462, subdivision 17, or under direction of a mental health professional; and works under the clinical supervision of a mental health professional~~.

~~(b) Mental health practitioners and mental health rehabilitation workers must have completed at least 30 hours of training in crisis intervention and stabilization during the past two years.~~

Sec. 78. Minnesota Statutes 2018, section 256B.0624, subdivision 9, is amended to read:

Subd. 9. **Supervision.** Mental health practitioners or clinical trainees may provide crisis assessment and mobile crisis intervention services if the following ~~clinical~~ treatment supervision requirements are met:

(1) the mental health provider entity must accept full responsibility for the services provided;

(2) the mental health professional of the provider entity, who is an employee or under contract with the provider entity, must be immediately available by phone or in person for clinical supervision;

(3) the mental health professional is consulted, in person or by phone, during the first three hours when a mental health practitioner or clinical trainee provides on-site service;

(4) the mental health professional must:

(i) review and approve of the tentative crisis assessment and crisis treatment plan;

(ii) document the consultation; and

(iii) sign the crisis assessment and treatment plan within the next business day; and

~~(5) if the mobile crisis intervention services continue into a second calendar day, a mental health professional must contact the recipient face-to-face on the second day to provide services and update the crisis treatment plan; and~~

~~(6)~~ (5) the on-site observation must be documented in the recipient's record and signed by the mental health professional.

Sec. 79. Minnesota Statutes 2018, section 256B.0624, subdivision 11, is amended to read:

Subd. 11. **Treatment plan.** The individual crisis stabilization treatment plan must include, at a minimum:

(1) a list of problems identified in the assessment;

(2) a list of the recipient's strengths and resources;

(3) concrete, measurable short-term goals and tasks to be achieved, including time frames for achievement;

(4) specific objectives directed toward the achievement of each one of the goals;

(5) documentation of the participants involved in the service planning. The recipient, if possible, must be a participant. The recipient or the recipient's legal guardian must sign the service plan or documentation must be provided why this was not possible. A copy of the plan must be given to the recipient and the recipient's legal guardian. The plan should include services arranged, including specific providers where applicable;

(6) planned frequency and type of services initiated;

(7) a crisis response action plan if a crisis should occur;

(8) clear progress notes on outcome of goals;

(9) a written plan must be completed within 24 hours of beginning services with the recipient; and

(10) a treatment plan must be developed by a mental health professional, clinical trainee, or mental health practitioner ~~under the clinical supervision of a mental health professional~~. The mental health professional must approve and sign all treatment plans.

Sec. 80. Minnesota Statutes 2018, section 256B.0625, subdivision 3b, is amended to read:

Subd. 3b. **Telemedicine services.** (a) Medical assistance covers medically necessary services and consultations delivered by a licensed health care provider via telemedicine in the same manner as if the service or consultation was delivered in person. Coverage is

limited to three telemedicine services per enrollee per calendar week. Telemedicine services shall be paid at the full allowable rate.

(b) The commissioner shall establish criteria that a health care provider must attest to in order to demonstrate the safety or efficacy of delivering a particular service via telemedicine. The attestation may include that the health care provider:

(1) has identified the categories or types of services the health care provider will provide via telemedicine;

(2) has written policies and procedures specific to telemedicine services that are regularly reviewed and updated;

(3) has policies and procedures that adequately address patient safety before, during, and after the telemedicine service is rendered;

(4) has established protocols addressing how and when to discontinue telemedicine services; and

(5) has an established quality assurance process related to telemedicine services.

(c) As a condition of payment, a licensed health care provider must document each occurrence of a health service provided by telemedicine to a medical assistance enrollee. Health care service records for services provided by telemedicine must meet the requirements set forth in Minnesota Rules, part 9505.2175, subparts 1 and 2, and must document:

(1) the type of service provided by telemedicine;

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

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

(4) the mode of transmission of the telemedicine service and records evidencing that a particular mode of transmission was utilized;

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

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

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

(d) For purposes of this subdivision, unless otherwise covered under this chapter, "telemedicine" is defined as the delivery of health care services or consultations while the patient is at an originating site and the licensed health care provider is at a distant site. A communication between licensed health care providers, or a licensed health care provider

and a patient that consists solely of a telephone conversation, e-mail, or facsimile transmission does not constitute telemedicine consultations or services. Telemedicine may be provided by means of real-time two-way, interactive audio and visual communications, including the application of secure video conferencing or store-and-forward technology to provide or support health care delivery, which facilitate the assessment, diagnosis, consultation, treatment, education, and care management of a patient's health care.

(e) For purposes of this section, "licensed health care provider" means a licensed health care provider under section 62A.671, subdivision 6, a clinical trainee, and a mental health practitioner defined under section 245.462, subdivision 17~~, or 245.4871, subdivision 26~~, working under the general supervision of a mental health professional; "health care provider" is defined under section 62A.671, subdivision 3; and "originating site" is defined under section 62A.671, subdivision 7.

Sec. 81. Minnesota Statutes 2018, section 256B.0625, subdivision 5, is amended to read:

Subd. 5. **Community mental health center services.** Medical assistance covers community mental health center services provided by a community mental health center that meets the requirements in paragraphs (a) to (j).

(a) The provider is licensed under Minnesota Rules, parts 9520.0750 to 9520.0870, and in compliance with requirements under chapter 245I and section 256B.0671.

(b) The provider provides mental health services under the ~~clinical~~ treatment supervision of a mental health professional who is licensed for independent practice at the doctoral level or by a board-certified psychiatrist or a psychiatrist who is eligible for board certification. ~~Clinical supervision has the meaning given in Minnesota Rules, part 9505.0370, subpart 6.~~ Treatment supervision means the treatment supervision described under section 245I.18.

(c) The provider must be a private nonprofit corporation or a governmental agency and have a community board of directors as specified by section 245.66.

(d) The provider must have a sliding fee scale that meets the requirements in section 245.481, and agree to serve within the limits of its capacity all individuals residing in its service delivery area.

(e) At a minimum, the provider must provide the following outpatient mental health services: diagnostic assessment; explanation of findings; and family, group, and individual psychotherapy, including crisis intervention psychotherapy services~~, multiple family group psychotherapy~~, psychological testing, and medication management. In addition, the provider must provide or be capable of providing upon request of the local mental health authority day treatment services, multiple family group psychotherapy, and professional home-based mental health services. The provider must have the capacity to provide such services to specialized populations such as the elderly, families with children, persons who are seriously and persistently mentally ill, and children who are seriously emotionally disturbed.

(f) The provider must be capable of providing the services specified in paragraph (e) to individuals who are dually diagnosed with ~~both~~ a mental illness or emotional disturbance~~,~~ and ~~chemical dependency~~ substance use disorder, and to individuals who are dually diagnosed with a mental illness or emotional disturbance and developmental disability.

(g) The provider must provide 24-hour emergency care services or demonstrate the capacity to assist recipients in need of such services to access such services on a 24-hour basis.

(h) The provider must have a contract with the local mental health authority to provide one or more of the services specified in paragraph (e).

(i) The provider must agree, upon request of the local mental health authority, to enter into a contract with the county to provide mental health services not reimbursable under the medical assistance program.

(j) The provider may not be enrolled with the medical assistance program as both a hospital and a community mental health center. The community mental health center's administrative, organizational, and financial structure must be separate and distinct from that of the hospital.

Sec. 82. Minnesota Statutes 2018, section 256B.0625, subdivision 5l, is amended to read:

Subd. 5l. **Intensive mental health outpatient treatment.** (a) Medical assistance covers intensive mental health outpatient treatment for dialectical behavioral therapy for adults. The commissioner shall establish:

(1) certification procedures to ensure that providers of these services are qualified and meet the standards in chapter 245I; and

(2) treatment protocols including required service components and criteria for admission, continued treatment, and discharge.

(b) "Dialectical behavior therapy" means an evidence-based treatment approach provided in an intensive outpatient treatment program using a combination of individualized rehabilitative and psychotherapeutic interventions. A dialectical behavior therapy program involves the following service components: individual dialectical behavior therapy, group skills training, telephone coaching, and team consultation meetings.

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

(1) be 18 years of age or older;

(2) have mental health needs that cannot be met with other available community-based services or that must be provided concurrently with other community-based services;

(3) meet one of the following criteria:

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

(ii) have multiple mental health diagnoses, exhibit behaviors characterized by impulsivity or intentional self-harm, and be at significant risk of death, morbidity, disability, or severe dysfunction across multiple life areas;

(4) understand and be cognitively capable of participating in dialectical behavior therapy as an intensive therapy program and be able and willing to follow program policies and rules ensuring safety of self and others; and

(5) be at significant risk of one or more of the following if dialectical behavior therapy is not provided:

(i) having a mental health crisis;

(ii) requiring a more restrictive setting including hospitalization;

(iii) decompensation; or

(iv) engaging in intentional self-harm behavior.

(d) Individual dialectical behavior therapy combines individualized rehabilitative and psychotherapeutic interventions to treat suicidal and other dysfunctional behaviors and reinforce the use of adaptive skillful behaviors. Individual dialectical behavior therapy must be provided by a mental health professional or a clinical trainee. The mental health professional or clinical trainee must:

(1) identify, prioritize, and sequence behavioral targets;

(2) treat behavioral targets;

(3) generalize dialectical behavior therapy skills to the client's natural environment through telephone coaching outside of the treatment session;

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

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

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

(e) Group skills training combines individualized psychotherapeutic and psychiatric rehabilitative interventions conducted in a group setting to reduce the client's suicidal and other dysfunctional coping behaviors and restore function. Group skills training must teach the client adaptive skills in the following areas:

(1) mindfulness;

(2) interpersonal effectiveness;

(3) emotional regulation; and

(4) distress tolerance.

(f) Group skills training must be provided by two mental health professionals, or by a mental health professional co-facilitating with a clinical trainee or a mental health practitioner as specified in section 245I.16, subdivision 4. Individual skills training must be provided by a mental health professional, a clinical trainee, or a mental health practitioner as specified in section 245I.16, subdivision 4.

(g) A program must be certified by the commissioner as a dialectical behavior therapy provider. To qualify for certification, a provider must:

(1) submit to the commissioner's inspection;

(2) provide evidence that the dialectical behavior therapy program's policies, procedures, and practices continuously meet the requirements of this subdivision;

(3) be enrolled as a MHCP provider;

(4) collect and report client outcomes as specified by the commissioner; and

(5) have a manual that outlines the dialectical behavior therapy program's policies, procedures, and practices that meet the requirements of this subdivision.

Sec. 83. Minnesota Statutes 2018, section 256B.0625, subdivision 19c, is amended to read:

Subd. 19c. **Personal care.** Medical assistance covers personal care assistance services provided by an individual who is qualified to provide the services according to subdivision 19a and sections 256B.0651 to 256B.0654, provided in accordance with a plan, and supervised by a qualified professional.

"Qualified professional" means a mental health professional ~~as defined in section 245.462, subdivision 18, clauses (1) to (6), or 245.4871, subdivision 27, clauses (1) to (6)~~; a registered nurse as defined in sections 148.171 to 148.285, a licensed social worker as defined in sections 148E.010 and 148E.055, or a qualified designated coordinator under section 245D.081, subdivision 2. The qualified professional shall perform the duties required in section 256B.0659.

Sec. 84. Minnesota Statutes 2018, section 256B.0625, subdivision 23, is amended to read:

Subd. 23. **Adult day treatment services.** (a) Medical assistance covers adult day treatment services as specified in sections 245.462, subdivision 8, and 245.4871, subdivision 10, that are provided under contract with the county board. The commissioner may set authorization thresholds for day treatment for adults according to subdivision 25. Medical assistance covers day treatment services for children as specified under section 256B.0943. Adult day treatment payment is limited to the conditions in paragraphs (b) to (e).

(b) Adult day treatment is an intensive psychotherapeutic treatment to reduce or relieve the effects of mental illness to enable the client to benefit from a lower level of care and to live and function more independently in the community. Adult day treatment services must stabilize the client's mental health status and develop and improve the client's independent living and socialization skills. Adult day treatment must consist of at least one hour of group psychotherapy and must include group time focused on rehabilitative interventions or other therapeutic services that are provided by a multidisciplinary staff person. Adult day treatment services are not a part of inpatient or residential treatment services.

(c) To be eligible for medical assistance payment, an adult day treatment service must:

(1) be reviewed by and approved by the commissioner;

(2) be provided to a group of clients by a multidisciplinary staff person under the treatment supervision of a mental health professional as described under section 245I.18;

(3) be available to the client at least two days a week for at least three consecutive hours per day. The adult day treatment may be longer than three hours per day, but medical assistance must not reimburse a provider for more than 15 hours per week;

(4) include group psychotherapy by a mental health professional or clinical trainee and daily rehabilitative interventions by a mental health professional qualified according to section 245I.16, subdivision 2, clinical trainee qualified according to section 245I.16, subdivision 6, or mental health practitioner qualified according to section 245I.16, subdivision 4;

(5) be included in the client's individual treatment plan as described under section 256B.0671, subdivisions 5 and 6, as appropriate. The individual treatment plan must include attainable, measurable goals related to services and must be completed before the first adult day treatment session. The vendor must review the client's progress and update the treatment plan at least every 30 days until the client is discharged and include an available discharge plan for the client in the treatment plan; and

(6) document the daily interventions provided and the client's response according to section 245I.33.

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

(1) be 18 years of age or older;

(2) not be residing in a nursing facility, hospital, institute of mental disease, or regional treatment center unless the client has an active discharge plan that indicates a move to an independent living arrangement within 180 days;

(3) have a diagnosis of mental illness as determined by a diagnostic assessment;

(4) have the capacity to engage in the rehabilitative nature, the structured setting, and the therapeutic parts of psychotherapy and skills activities of an adult day treatment program

and demonstrate measurable improvements in the client's functioning related to the client's mental illness that would result from participating in the adult day treatment program;

(5) have at least three areas of functional impairment as determined by a functional assessment with the domains prescribed by section 245.462, subdivision 11a;

(6) have a level of care determination that supports the need for the level of intensity and duration of an adult day treatment program; and

(7) be determined to need adult day treatment services by a mental health professional who must deem the adult day treatment services medically necessary.

(e) The following services are not covered by medical assistance as an adult day treatment service:

(1) a service that is primarily recreation-oriented or that is provided in a setting that is not medically supervised. This includes sports activities, exercise groups, craft hours, leisure time, social hours, meal or snack time, trips to community activities, and tours;

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

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

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

(5) day treatment for clients with primary diagnoses of alcohol or other drug abuse;

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

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

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

Sec. 85. Minnesota Statutes 2018, section 256B.0625, subdivision 42, is amended to read:

Subd. 42. **Mental health professional.** Notwithstanding Minnesota Rules, part 9505.0175, subpart 28, the definition of a mental health professional shall include a person who is qualified as specified in section ~~245.462, subdivision 18, clauses (1) to (6); or 245.4871, subdivision 27, clauses (1) to (6),~~ 245I.16, subdivision 2, for the purpose of this section and Minnesota Rules, parts 9505.0170 to 9505.0475.

Sec. 86. Minnesota Statutes 2018, section 256B.0625, subdivision 48, is amended to read:

Subd. 48. **Psychiatric consultation to primary care practitioners.** Medical assistance covers consultation provided by a ~~psychiatrist, a psychologist, an advanced practice registered nurse certified in psychiatric mental health, a licensed independent clinical social worker, as defined in section 245.462, subdivision 18, clause (2), or a licensed marriage and family~~

~~therapist, as defined in section 245.462, subdivision 18, clause (5),~~ mental health professional except one licensed under section 148B.5301 via telephone, e-mail, facsimile, or other means of communication to primary care practitioners, including pediatricians. The need for consultation and the receipt of the consultation must be documented in the patient record maintained by the primary care practitioner. If the patient consents, and subject to federal limitations and data privacy provisions, the consultation may be provided without the patient present.

Sec. 87. Minnesota Statutes 2018, section 256B.0625, subdivision 49, is amended to read:

Subd. 49. **Community health worker.** (a) Medical assistance covers the care coordination and patient education services provided by a community health worker if the community health worker has~~: (1)~~ received a certificate from the Minnesota State Colleges and Universities System approved community health worker curriculum~~; or~~.

~~(2) at least five years of supervised experience with an enrolled physician, registered nurse, advanced practice registered nurse, mental health professional as defined in section 245.462, subdivision 18, clauses (1) to (6), and section 245.4871, subdivision 27, clauses (1) to (5), or dentist, or at least five years of supervised experience by a certified public health nurse operating under the direct authority of an enrolled unit of government.~~

~~Community health workers eligible for payment under clause (2) must complete the certification program by January 1, 2010, to continue to be eligible for payment.~~

(b) Community health workers must work under the supervision of a medical assistance enrolled physician, registered nurse, advanced practice registered nurse, mental health professional ~~as defined in section 245.462, subdivision 18, clauses (1) to (6), and section 245.4871, subdivision 27, clauses (1) to (5)~~, or dentist, or work under the supervision of a certified public health nurse operating under the direct authority of an enrolled unit of government.

(c) Care coordination and patient education services covered under this subdivision include, but are not limited to, services relating to oral health and dental care.

Sec. 88. Minnesota Statutes 2018, section 256B.0625, subdivision 56a, is amended to read:

Subd. 56a. **~~Post-arrest~~ Officer-involved community-based ~~service~~ care coordination.** (a) Medical assistance covers ~~post-arrest~~ officer-involved community-based ~~service~~ care coordination for an individual who:

(1) has ~~been identified as having~~ screened positive for benefiting from treatment for a mental illness or substance use disorder using a ~~screening~~ tool approved by the commissioner;

(2) does not require the security of a public detention facility and is not considered an inmate of a public institution as defined in Code of Federal Regulations, title 42, section 435.1010;

(3) meets the eligibility requirements in section 256B.056; and

(4) has agreed to participate in ~~post-arrest~~ officer-involved community-based ~~service~~ care coordination ~~through a diversion contract in lieu of incarceration~~.

(b) ~~Post-arrest~~ Officer-involved community-based ~~service~~ care coordination means navigating services to address a client's mental health, chemical health, social, economic, and housing needs, or any other activity targeted at reducing the incidence of jail utilization and connecting individuals with existing covered services available to them, including, but not limited to, targeted case management, waiver case management, or care coordination.

(c) ~~Post-arrest~~ Officer-involved community-based ~~service~~ care coordination must be provided by an individual who is an employee of ~~a county~~ or is under contract with a county, or is an employee of or under contract with an Indian health service facility or facility owned and operated by a tribe or a tribal organization operating under Public Law 93-638 as a 638 facility to provide ~~post-arrest~~ officer-involved community-based care coordination and is qualified under one of the following criteria:

(1) a licensed mental health professional ~~as defined in section 245.462, subdivision 18, clauses (1) to (6);~~

(2) a mental health practitioner as defined in section 245.462, subdivision 17, working under the ~~clinical~~ treatment supervision of a mental health professional; ~~or~~

(3) a certified peer specialist under section 256B.0615, working under the ~~clinical~~ treatment supervision of a mental health professional~~.~~;

(4) a clinical trainee;

(5) an individual qualified as an alcohol and drug counselor under section 245G.11, subdivision 5; or

(6) a recovery peer qualified under section 245G.11, subdivision 8, working under the supervision of an individual qualified as an alcohol and drug counselor under section 245G.11, subdivision 5.

(d) Reimbursement is allowed for up to 60 days following the initial determination of eligibility.

(e) Providers of ~~post-arrest~~ officer-involved community-based ~~service~~ care coordination shall annually report to the commissioner on the number of individuals served, and number of the community-based services that were accessed by recipients. The commissioner shall ensure that services and payments provided under ~~post-arrest~~ officer-involved community-based ~~service~~ care coordination do not duplicate services or payments provided under section 256B.0625, subdivision 20, 256B.0753, 256B.0755, or 256B.0757.

(f) Notwithstanding section 256B.19, subdivision 1, the nonfederal share of cost for post-arrest community-based service coordination services shall be provided by the county

providing the services, from sources other than federal funds or funds used to match other federal funds.

Sec. 89. Minnesota Statutes 2018, section 256B.0625, subdivision 61, is amended to read:

Subd. 61. **Family psychoeducation services.** ~~Effective July 1, 2013, or upon federal approval, whichever is later,~~ Medical assistance covers family psychoeducation services provided to a child up to age 21 with a diagnosed mental health condition when identified in the child's individual treatment plan and provided by a licensed mental health professional~~, as defined in Minnesota Rules, part 9505.0371, subpart 5, item A,~~ or a clinical trainee~~, as defined in Minnesota Rules, part 9505.0371, subpart 5, item C,~~ who has determined it medically necessary to involve family members in the child's care. For the purposes of this subdivision, "family psychoeducation services" means information or demonstration provided to an individual or family as part of an individual, family, multifamily group, or peer group session to explain, educate, and support the child and family in understanding a child's symptoms of mental illness, the impact on the child's development, and needed components of treatment and skill development so that the individual, family, or group can help the child to prevent relapse, prevent the acquisition of comorbid disorders, and achieve optimal mental health and long-term resilience.

Sec. 90. Minnesota Statutes 2018, section 256B.0625, subdivision 62, is amended to read:

Subd. 62. **Mental health clinical care consultation.** ~~Effective July 1, 2013, or upon federal approval, whichever is later,~~ Medical assistance covers clinical care consultation for a person up to age 21 who is diagnosed with a complex mental health condition or a mental health condition that co-occurs with other complex and chronic conditions, when described in the person's individual treatment plan and provided by a licensed mental health professional~~, as defined in Minnesota Rules, part 9505.0371, subpart 5, item A,~~ or a clinical trainee~~, as defined in Minnesota Rules, part 9505.0371, subpart 5, item C~~. For the purposes of this subdivision, "clinical care consultation" means communication from a treating mental health professional to other providers or educators not under the clinical supervision of the treating mental health professional who are working with the same client to inform, inquire, and instruct regarding the client's symptoms; strategies for effective engagement, care, and intervention needs; and treatment expectations across service settings; and to direct and coordinate clinical service components provided to the client and family.

Sec. 91. Minnesota Statutes 2018, section 256B.0625, subdivision 65, is amended to read:

Subd. 65. **Outpatient mental health services.** For the purposes of this section, "clinical trainee" has the meaning given in section 245I.16, subdivision 6. Medical assistance covers diagnostic assessment, explanation of findings, and psychotherapy according to ~~Minnesota Rules, part 9505.0372,~~ subdivision 69 and section 256B.0671 when the mental health services are performed by ~~a mental health practitioner working as~~ a clinical trainee ~~according to section 245.462, subdivision 17, paragraph (g)~~.

Sec. 92. Minnesota Statutes 2018, section 256B.0625, is amended by adding a subdivision to read:

Subd. 66. **Neuropsychological assessment.** (a) "Neuropsychological assessment" means a specialized clinical assessment of the client's underlying cognitive abilities related to thinking, reasoning, and judgment that is conducted by a qualified neuropsychologist. A neuropsychological assessment must include a face-to-face interview with the client, interpretation of the test results, and preparation and completion of a report.

(b) A client is eligible for a neuropsychological assessment if at least one of the following criteria is met:

(1) there is a known or strongly suspected brain disorder based on medical history or neurological evaluation, including a history of significant head trauma, brain tumor, stroke, seizure disorder, multiple sclerosis, neurodegenerative disorder, significant exposure to neurotoxins, central nervous system infection, metabolic or toxic encephalopathy, fetal alcohol syndrome, or congenital malformation of the brain; or

(2) there are cognitive or behavioral symptoms that suggest that the client has an organic condition that cannot be readily attributed to functional psychopathology or suspected neuropsychological impairment in addition to functional psychopathology. This includes:

(i) poor memory or impaired problem solving;

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

(iii) deterioration in level of functioning;

(iv) marked behavioral or personality change;

(v) in children or adolescents, significant delays in academic skill acquisition or poor attention relative to peers;

(vi) in children or adolescents, significant plateau in expected development of cognitive, social, emotional, or physical function relative to peers; and

(vii) in children or adolescents, significant inability to develop expected knowledge, skills, or abilities as required to adapt to new or changing cognitive, social, emotional, or physical demands.

(c) The neuropsychological assessment must be conducted by a neuropsychologist competent in the area of neuropsychological assessment who:

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

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

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

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

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

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

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

Sec. 93. Minnesota Statutes 2018, section 256B.0625, is amended by adding a subdivision to read:

Subd. 67. **Neuropsychological testing.** (a) "Neuropsychological testing" means administering standardized tests and measures designed to evaluate the client's ability to attend to, process, interpret, comprehend, communicate, learn, and recall information and use problem solving and judgment.

(b) Medical assistance covers neuropsychological testing when the client:

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

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

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

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

(i) traumatic brain injury;

(ii) stroke;

(iii) brain tumor;

(iv) substance use disorder;

(v) cerebral anoxic or hypoxic episode;

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

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

(viii) neurodegenerative disorders;

(ix) demyelinating disease;

(x) extrapyramidal disease;

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

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

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

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

(xv) a condition presenting in a manner difficult for a clinician to distinguish between the neurocognitive effects of a neurogenic syndrome, including dementia or encephalopathy; and a major depressive disorder when adequate treatment for major depressive disorder has not resulted in improvement in neurocognitive function; or another disorder, including autism, selective mutism, anxiety disorder, or reactive attachment disorder.

(c) Neuropsychological testing must be administered or clinically supervised by a neuropsychologist qualified as defined in subdivision 66, paragraph (c).

(d) Neuropsychological testing is not covered when performed: (1) primarily for educational purposes; (2) primarily for vocational counseling or training; (3) for personnel or employment testing; (4) as a routine battery of psychological tests given at inpatient admission or during a continued stay; or (5) for legal or forensic purposes.

Sec. 94. Minnesota Statutes 2018, section 256B.0625, is amended by adding a subdivision to read:

Subd. 68. **Psychological testing.** (a) "Psychological testing" means the use of tests or other psychometric instruments to determine the status of the client's mental, intellectual, and emotional functioning.

(b) The psychological testing must:

(1) be administered or clinically supervised by a licensed psychologist qualified according to section 245I.16, subdivision 2, clause (3), competent in the area of psychological testing; and

(2) be validated in a face-to-face interview between the client and a licensed psychologist or a clinical psychology trainee qualified according to section 245I.16, subdivision 6, under the treatment supervision of a licensed psychologist according to section 245I.18.

(c) The administration, scoring, and interpretation of the psychological tests must be done under the treatment supervision of a licensed psychologist when performed by a clinical psychology trainee, technician, psychometrist, or psychological assistant or as part of a computer-assisted psychological testing program. The report resulting from the psychological testing must be signed by the psychologist conducting the face-to-face interview, placed in the client's record, and released to each person authorized by the client.

Sec. 95. Minnesota Statutes 2018, section 256B.0625, is amended by adding a subdivision to read:

Subd. 69. **Psychotherapy.** (a) "Psychotherapy" means treatment of a client with mental illness that applies to the most appropriate psychological, psychiatric, psychosocial, or interpersonal method that conforms to prevailing community standards of professional practice to meet the mental health needs of the client. Medical assistance covers psychotherapy if conducted by a mental health professional qualified according to section 245I.16, subdivision 2, or a clinical trainee qualified according to section 245I.16, subdivision 6.

(b) Individual psychotherapy is psychotherapy designed for one client.

(c) Family psychotherapy is designed for the client and one or more family members or the client's primary caregiver whose participation is necessary to accomplish the client's treatment goals. Family members or primary caregivers participating in a therapy session do not need to be eligible for medical assistance. For purposes of this paragraph, "primary caregiver whose participation is necessary to accomplish the client's treatment goals" excludes shift or facility staff persons at the client's residence. Medical assistance payment for family psychotherapy is limited to face-to-face sessions at which the client is present throughout the family psychotherapy session unless the mental health professional believes the client's absence from the family psychotherapy session is necessary to carry out the client's individual treatment plan. If the client is excluded, the mental health professional must document the reason for and the length of time of the exclusion. The mental health professional must also document any reason a member of the client's family is excluded.

(d) Group psychotherapy is appropriate for a client who, because of the nature of the client's emotional, behavioral, or social dysfunctions, can derive mutual benefit from treatment in a group setting. For a group of three to eight persons, one mental health professional or clinical trainee is required to conduct the group. For a group of nine to 12 persons, a team of at least two mental health professionals or two clinical trainees or one

mental health professional and one clinical trainee is required to co-conduct the group. Medical assistance payment is limited to a group of no more than 12 persons.

(e) A multiple-family group psychotherapy session is eligible for medical assistance payment if the psychotherapy session is designed for at least two but not more than five families. Multiple-family group psychotherapy is clearly directed toward meeting the identified treatment needs of each client as indicated in each client's treatment plan. If the client is excluded, the mental health professional or clinical trainee must document the reason for and the length of time of the exclusion. The mental health professional or clinical trainee must document any reason a member of the client's family is excluded.

Sec. 96. Minnesota Statutes 2018, section 256B.0625, is amended by adding a subdivision to read:

Subd. 70. **Partial hospitalization.** "Partial hospitalization" means a provider's time-limited, structured program of psychotherapy and other therapeutic services, as defined in United States Code, title 42, chapter 7, subchapter XVIII, part E, section 1395x(ff), that is provided in an outpatient hospital facility or community mental health center that meets Medicare requirements to provide partial hospitalization services. Partial hospitalization is a covered service when it is an appropriate alternative to inpatient hospitalization for a client who is experiencing an acute episode of mental illness that meets the criteria for an inpatient hospital admission under Minnesota Rules, part 9505.0520, subpart 1, and who has the family and community resources necessary and appropriate to support the client's residence in the community. Partial hospitalization consists of multiple intensive short-term therapeutic services provided by a multidisciplinary staff person to treat the client's mental illness.

Sec. 97. [256B.0671] CLIENT ELIGIBILITY FOR MENTAL HEALTH SERVICES.

Subdivision 1. **Definitions.** For the purposes of this section, the definitions in section 245I.02 apply.

Subd. 1a. **Generally.** (a) The provider must use a diagnostic assessment or crisis assessment to determine a client's eligibility for mental health services, except as provided in this section.

(b) Prior to completion of a client's initial diagnostic assessment, a client is eligible for:

(1) one explanation of findings;

(2) one psychological testing;

(3) any combination of individual psychotherapy sessions, family psychotherapy sessions, group psychotherapy sessions, and individual or family psychoeducation sessions not to exceed three sessions; and

(4) crisis assessment and intervention services provided according to section 256B.0624 or 256B.0944.

(c) Based on the needs identified in a crisis assessment as specified in section 256B.0624 or 256B.0944, a client may receive: (1) crisis stabilization services; and (2) any combination of individual psychotherapy sessions, family psychotherapy sessions, or family psychoeducation sessions not to exceed ten sessions within a 12-month period without prior authorization.

(d) Based on the needs identified in a brief diagnostic assessment, a client may receive a combination of individual psychotherapy sessions, family psychotherapy sessions, or family psychoeducation sessions not to exceed ten sessions within a 12-month period without prior authorization for any new client or for an existing client who is projected to need fewer than ten sessions in the next 12 months.

(e) If the amount of services or intensity required by the client exceeds the coverage limits in this section, a provider shall complete a standard diagnostic assessment.

(f) A new standard diagnostic assessment must be completed:

(1) when the client requires services of a greater number or intensity than those permitted by paragraphs (b) to (d);

(2) at least annually following the initial diagnostic assessment if additional services are needed and the client does not meet the criteria for brief assessment.

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

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

(g) For an existing client, a new standard diagnostic assessment shall include a written update of the parts where significant new or changed information exists, and documentation where there has not been significant change, including discussion with the client about changes in the client's life situation, functioning, presenting problems, and progress on treatment goals since the last diagnostic assessment was completed.

Subd. 1b. **Continuity of services.** (a) For any client served with a diagnostic assessment completed under Minnesota Rules, parts 9505.0370 to 9505.0372, before the effective date, the diagnostic assessment is valid for purposes of authorizing treatment and billing for one calendar year after completion.

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

(c) This subdivision expires July 1, 2021.

Subd. 2. **Diagnostic assessment.** To be eligible for medical assistance payment, a diagnostic assessment must (1) identify at least one mental health diagnosis and recommend mental health services to develop the client's mental health services and treatment plan, or (2) include a finding that the client does not meet the criteria for a mental health disorder.

Subd. 3. **Standard diagnostic assessment requirements.** (a) A standard diagnostic assessment must include a face-to-face interview with the client and contain a written evaluation of a client by a mental health professional or clinical trainee. The standard diagnostic assessment must be completed within the cultural context of the client.

(b) The clinician shall gather and document information related to the client's current life situation and the client's:

(1) age;

(2) current living situation, including household membership and housing status;

(3) basic needs status;

(4) education level and employment status;

(5) family and other significant personal relationships, including the client's evaluation of relationship quality;

(6) strengths and resources, including the extent and quality of social networks;

(7) belief systems;

(8) current medications; and

(9) immediate risks to health and safety.

(c) The clinician shall gather and document information related to the elements of the assessment, including the client's:

(1) perceptions of the client's condition;

(2) description of symptoms, including reason for referral;

(3) history of mental health treatment; and

(4) cultural influences and the impact on the client.

(d) A clinician completing a diagnostic assessment shall use professional judgment in making inquiries under this paragraph. If information cannot be obtained without retraumatizing the client or harming the client's willingness to engage in treatment, the clinician shall document which topics require further attention in the course of treatment. A clinician must, as clinically appropriate, include the following information related to a client in a diagnostic assessment:

(1) important developmental incidents;

(2) maltreatment, trauma, potential brain injuries, or abuse issues;

(3) history of alcohol and drug usage and treatment; and

(4) health history and family health history, including physical, chemical, and mental health history.

(e) The clinician must perform and document the following components of the assessment:

(1) the client's mental status examination;

(2) information gathered concerning the client's baseline measurements; symptoms; behavior; skills; abilities; resources; vulnerabilities; safety needs, including client data adequate to support findings based on the current edition of the Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association; and any differential diagnosis;

(3) for a child younger than 6 years of age, a clinician may use the current edition of the DC: 0-5 Diagnostic Classification of Mental Health and Development Disorders of Infancy and Early Childhood instead of the Diagnostic and Statistical Manual of Mental Disorders;

(4) the screenings used to determine the client's substance use, abuse, or dependency and other standardized screening instruments determined by the commissioner;

(5) use of standardized outcome measurements by the provider as determined and periodically updated by the commissioner; and

(6) a case conceptualization that explains: (i) the diagnostic formulation made based on the information gathered through the interview, assessment, available psychological testing, and collateral information; (ii) the needs of the client; (iii) risk factors; (iv) strengths; and (v) responsivity factors.

(f) The diagnostic assessment must include recommendations, client and family participation in assessment and service preferences, and referrals to services required by law.

Subd. 4. **Brief diagnostic assessment requirements.** (a) A brief diagnostic assessment must include a face-to-face interview with the client and a written evaluation of the client by a mental health professional or a clinical trainee. The mental health professional or clinical trainee must gather initial components of a standard diagnostic assessment, including the client's:

(1) age;

(2) description of symptoms, including reason for referral;

(3) history of mental health treatment;

(4) cultural influences and their impact on the client; and

(5) mental status examination.

(b) On the basis of the initial components, the mental health professional or clinical trainee must draw a provisional diagnostic formulation. The diagnostic formulation may be used to address the client's immediate needs or presenting problem.

(c) Treatment sessions conducted under authorization of a brief diagnostic assessment may be used to gather additional information necessary to complete a standard diagnostic assessment if coverage limits in subdivision 1 will be exceeded.

Subd. 5. **Individual treatment plan.** Medical assistance payment is available only for mental health services provided in accordance with the client's written individual treatment plan, with the following exceptions: (1) services that do not require a standard diagnostic assessment prior to service delivery; (2) service plan development; and (3) re-engagement of a client as described in subdivision 6, clause (6).

Subd. 6. **Individual treatment plan; required elements.** An individual treatment plan must:

(1) be based on the information in the client's diagnostic assessment and baselines;

(2) identify goals and objectives of treatment, the treatment strategy, the schedule for accomplishing treatment goals and measurable objectives, and the individuals responsible for providing treatment services and supports;

(3) be developed after completion of the client's diagnostic assessment, within three visits unless otherwise specified by a service line;

(4) for a child client, be developed through a child-centered, family-driven, culturally appropriate planning process, including allowing parents and guardians to observe or participate in individual and family treatment services, assessment, and treatment planning. For an adult client, the individual treatment plan must be developed through a person-centered, culturally appropriate planning process, including allowing identified supports to observe or participate in treatment services, assessment, and treatment planning;

(5) be reviewed at least every 90 days unless otherwise specified by the requirements of a service line and revised to document treatment progress on each treatment objective and next goals or, if progress is not documented, to document changes in treatment; and

(6) be approved by the client, the client's parent, another person authorized by law to consent to mental health services for the client, or a treatment plan ordered by the court under chapter 253B. If approval cannot be obtained, a mental health professional shall make efforts to obtain approval from an authorized person for a period of 30 days following the date the previous individual treatment plan expired. A client shall not be denied service in

this time period solely on the basis of an unapproved individual treatment plan. A provider entity may continue to bill for otherwise eligible services during a period of re-engagement.

Sec. 98. Minnesota Statutes 2018, section 256B.0757, subdivision 2, is amended to read:

Subd. 2. **Eligible individual.** An individual is eligible for health home services under this section if the individual is eligible for medical assistance under this chapter and has at least:

(1) two chronic conditions;

(2) one chronic condition and is at risk of having a second chronic condition;

(3) one serious and persistent mental health condition; or

(4) a condition that meets the definition in section 245.462, subdivision 20, paragraph (a), or 245.4871, subdivision 15, clause (2); and has a current diagnostic assessment as ~~defined in Minnesota Rules, part 9505.0372, subpart 1, item B or C~~ that meets the requirements of section 256B.0671, subdivisions 2 and 3, as performed or reviewed by a mental health professional employed by or under contract with the behavioral health home. The commissioner shall establish criteria for determining continued eligibility.

Sec. 99. Minnesota Statutes 2018, section 256B.0941, subdivision 1, is amended to read:

Subdivision 1. **Eligibility.** (a) An individual who is eligible for mental health treatment services in a psychiatric residential treatment facility must meet all of the following criteria:

(1) before admission, services are determined to be medically necessary by the state's medical review agent according to Code of Federal Regulations, title 42, section 441.152;

(2) is younger than 21 years of age at the time of admission. Services may continue until the individual meets criteria for discharge or reaches 22 years of age, whichever occurs first;

(3) has a mental health diagnosis as defined in the most recent edition of the Diagnostic and Statistical Manual for Mental Disorders, as well as clinical evidence of severe aggression, or a finding that the individual is a risk to self or others;

(4) has functional impairment and a history of difficulty in functioning safely and successfully in the community, school, home, or job; an inability to adequately care for one's physical needs; or caregivers, guardians, or family members are unable to safely fulfill the individual's needs;

(5) requires psychiatric residential treatment under the direction of a physician to improve the individual's condition or prevent further regression so that services will no longer be needed;

(6) utilized and exhausted other community-based mental health services, or clinical evidence indicates that such services cannot provide the level of care needed; and

(7) was referred for treatment in a psychiatric residential treatment facility by a qualified mental health professional ~~licensed as defined in section 245.4871, subdivision 27, clauses (1) to (6)~~ qualified according to section 245I.16, subdivision 2.

(b) A mental health professional making a referral shall submit documentation to the state's medical review agent containing all information necessary to determine medical necessity, including a standard diagnostic assessment completed within 180 days of the individual's admission. Documentation shall include evidence of family participation in the individual's treatment planning and signed consent for services.

Sec. 100. Minnesota Statutes 2018, section 256B.0943, subdivision 1, is amended to read:

Subdivision 1. **Definitions.** For purposes of this section, the following terms have the meanings given them.

(a) "Children's therapeutic services and supports" means the flexible package of mental health services for children who require varying therapeutic and rehabilitative levels of intervention to treat a diagnosed emotional disturbance~~, as defined in section 245.4871, subdivision 15,~~ or ~~a diagnosed~~ mental illness~~, as defined in section 245.462, subdivision 20~~. The services are time-limited interventions that are delivered using various treatment modalities and combinations of services designed to reach treatment outcomes identified in the individual treatment plan.

~~(b) "Clinical supervision" means the overall responsibility of the mental health professional for the control and direction of individualized treatment planning, service delivery, and treatment review for each client. A mental health professional who is an enrolled Minnesota health care program provider accepts full professional responsibility for a supervisee's actions and decisions, instructs the supervisee in the supervisee's work, and oversees or directs the supervisee's work.~~

~~(c)~~ (b) "Clinical trainee" ~~means a mental health practitioner who meets the qualifications specified in Minnesota Rules, part 9505.0371, subpart 5, item C~~ means a staff person qualified according to section 245I.16, subdivision 6.

~~(d) "Crisis assistance" has the meaning given in section 245.4871, subdivision 9a. Crisis assistance entails the development of a written plan to assist a child's family to contend with a potential crisis and is distinct from the immediate provision of crisis intervention services.~~

(c) "Crisis planning" means the support and planning activities described under section 245.4871, subdivision 9a.

~~(c)~~ (d) "Culturally competent provider" means a provider who understands and can utilize to a client's benefit the client's culture when providing services to the client. A provider may be culturally competent because the provider is of the same cultural or ethnic group as the client or the provider has developed the knowledge and skills through training and experience to provide services to culturally diverse clients.

~~(f)~~ (e) "Day treatment program" for children means a site-based structured mental health program consisting of psychotherapy for three or more individuals and individual or group skills training provided by a ~~multidisciplinary~~ treatment team, under the ~~clinical~~ treatment supervision of a mental health professional.

~~(g)~~ (f) "Diagnostic assessment" ~~has the meaning given in Minnesota Rules, part 9505.0372, subpart 1~~ means the assessment described under section 256B.0671, subdivisions 2 and 3.

~~(h)~~ (g) "Direct service time" means the time that a mental health professional, clinical trainee, mental health practitioner, or mental health behavioral aide spends face-to-face with a client and the client's family or providing covered telemedicine services. Direct service time includes time in which the provider obtains a client's history, develops a client's treatment plan, records individual treatment outcomes, or provides service components of children's therapeutic services and supports. Direct service time does not include time doing work before and after providing direct services, including scheduling or maintaining clinical records.

~~(i)~~ (h) "Direction of mental health behavioral aide" means the activities of a mental health professional, clinical trainee, or mental health practitioner in guiding the mental health behavioral aide in providing services to a client. The direction of a mental health behavioral aide must be based on the client's individualized treatment plan and meet the requirements in subdivision 6, paragraph (b), clause (5).

~~(j)~~ (i) "Emotional disturbance" has the meaning given in section 245.4871, subdivision 15.

~~(k)~~ (j) "Individual behavioral plan" means a plan of intervention, treatment, and services for a child written by a mental health professional, clinical trainee, or mental health practitioner, under the ~~clinical~~ treatment supervision of a mental health professional, to guide the work of the mental health behavioral aide. The individual behavioral plan may be incorporated into the child's individual treatment plan so long as the behavioral plan is separately communicable to the mental health behavioral aide.

~~(l)~~ (k) "Individual treatment plan" ~~has the meaning given in Minnesota Rules, part 9505.0371, subpart 7~~ means the plan described under section 256B.0671, subdivisions 5 and 6.

~~(m)~~ (l) "Mental health behavioral aide services" means medically necessary ~~one-on-one~~ activities performed by a trained paraprofessional ~~qualified as provided in subdivision 7, paragraph (b), clause (3),~~ to assist a child retain or generalize psychosocial skills as previously trained by a mental health professional, clinical trainee, or mental health practitioner and as described in the child's individual treatment plan and individual behavior plan. Activities involve working directly with the child or child's family as provided in subdivision 9, paragraph (b), clause (4).

(m) "Mental health certified family peer specialist" means a staff person qualified according to section 245I.16, subdivision 12.

(n) "Mental health practitioner" ~~has the meaning given in~~ means a staff person qualified according to section ~~245.462, subdivision 17, except that a practitioner working in a day treatment setting may qualify as a mental health practitioner if the practitioner holds a bachelor's degree in one of the behavioral sciences or related fields from an accredited college or university, and: (1) has at least 2,000 hours of clinically supervised experience in the delivery of mental health services to clients with mental illness; (2) is fluent in the language, other than English, of the cultural group that makes up at least 50 percent of the practitioner's clients, completes 40 hours of training on the delivery of services to clients with mental illness, and receives clinical supervision from a mental health professional at least once per week until meeting the required 2,000 hours of supervised experience; or (3) receives 40 hours of training on the delivery of services to clients with mental illness within six months of employment, and clinical supervision from a mental health professional at least once per week until meeting the required 2,000 hours of supervised experience~~ 245I.16, subdivision 4.

(o) "Mental health professional" means ~~an individual as defined in Minnesota Rules, part 9505.0370, subpart 18~~ a staff person qualified according to section 245I.16, subdivision 2.

(p) "Mental health service plan development" includes:

(1) the development, review, and revision of a child's individual treatment plan, ~~as provided in Minnesota Rules, part 9505.0371, subpart 7~~ according to section 256B.0671, subdivisions 5 and 6, including involvement of the client or client's parents, primary caregiver, or other person authorized to consent to mental health services for the client, and including arrangement of treatment and support activities specified in the individual treatment plan; and

(2) administering standardized outcome measurement instruments, determined and updated by the commissioner, as periodically needed to evaluate the effectiveness of treatment for children receiving clinical services and reporting outcome measures, as required by the commissioner.

(q) "Mental illness," for persons at least age 18 but under age 21, has the meaning given in section 245.462, subdivision 20, paragraph (a).

(r) "Psychotherapy" means the treatment of mental or emotional disorders or maladjustment by psychological means. Psychotherapy may be provided in many modalities ~~in accordance with Minnesota Rules, part 9505.0372, subpart 6,~~ including patient and/or family psychotherapy; family psychotherapy; psychotherapy for crisis; group psychotherapy; or multiple-family psychotherapy. ~~Beginning with the American Medical Association's Current Procedural Terminology, standard edition, 2014, the procedure "individual psychotherapy" is replaced with "patient and/or family psychotherapy," a substantive change~~

~~that permits the therapist to work with the client's family without the client present to obtain information about the client or to explain the client's treatment plan to the family.~~ Psychotherapy for crisis is appropriate ~~for crisis response~~ when a child has become dysregulated or experienced new trauma since the diagnostic assessment was completed and needs psychotherapy to address issues not currently included in the child's individual treatment plan.

(s) "Rehabilitative services" or "psychiatric rehabilitation services" means ~~a series or multidisciplinary combination of psychiatric and psychosocial~~ interventions to: (1) restore a child or adolescent to an age-appropriate developmental trajectory that had been disrupted by a psychiatric illness; or (2) enable the child to self-monitor, compensate for, cope with, counteract, or replace psychosocial skills deficits or maladaptive skills acquired over the course of a psychiatric illness. Psychiatric rehabilitation services for children combine coordinated psychotherapy to address internal psychological, emotional, and intellectual processing deficits, and skills training to restore personal and social functioning. Psychiatric rehabilitation services establish a progressive series of goals with each achievement building upon a prior achievement. ~~Continuing progress toward goals is expected, and rehabilitative potential ceases when successive improvement is not observable over a period of time.~~

(t) "Skills training" means individual, family, or group training, delivered by or under the supervision of a mental health professional, designed to facilitate the acquisition of psychosocial skills that are medically necessary to rehabilitate the child to an age-appropriate developmental trajectory heretofore disrupted by a psychiatric illness or to enable the child to self-monitor, compensate for, cope with, counteract, or replace skills deficits or maladaptive skills acquired over the course of a psychiatric illness. Skills training is subject to the service delivery requirements under subdivision 9, paragraph (b), clause (2).

(u) "Treatment supervision" means the supervision described under section 245I.18.

Sec. 101. Minnesota Statutes 2018, section 256B.0943, subdivision 2, is amended to read:

Subd. 2. **Covered service components of children's therapeutic services and supports.** (a) ~~Subject to federal approval,~~ Medical assistance covers medically necessary children's therapeutic services and supports as defined in this section that an eligible provider entity certified under subdivision 4 provides to a client eligible under subdivision 3.

(b) The service components of children's therapeutic services and supports are:

(1) patient and/or family psychotherapy, family psychotherapy, psychotherapy for crisis, and group psychotherapy;

(2) individual, family, or group skills training provided by a mental health professional or mental health practitioner;

(3) crisis ~~assistance~~ planning;

(4) mental health behavioral aide services;

(5) direction of a mental health behavioral aide;

(6) mental health service plan development; and

(7) children's day treatment.

Sec. 102. Minnesota Statutes 2018, section 256B.0943, subdivision 3, is amended to read:

Subd. 3. **Determination of client eligibility.** A client's eligibility to receive children's therapeutic services and supports under this section shall be determined based on a diagnostic assessment by a mental health professional or ~~a mental health practitioner who meets the requirements of~~ a clinical trainee ~~as defined in Minnesota Rules, part 9505.0371, subpart 5, item C,~~ that is performed within one year before the initial start of service. The diagnostic assessment must meet the requirements for a standard ~~or extended~~ diagnostic assessment ~~as defined in Minnesota Rules, part 9505.0372, subpart 1, items B and C~~, and:

(1) ~~include current diagnoses, including any differential diagnosis, in accordance with all criteria for a complete diagnosis and diagnostic profile as specified in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association, or,~~ for children under age ~~five, as~~ six, follow the requirements specified in the current edition of the Diagnostic Classification of Mental Health Disorders of Infancy and Early Childhood;

(2) 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;

(3) 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

(4) be used in the development of the individualized treatment plan~~; and~~.

~~(5) be completed annually until age 18. For individuals between age 18 and 21, unless a client's mental health condition has changed markedly since the client's most recent diagnostic assessment, annual updating is necessary. For the purpose of this section, "updating" means an adult diagnostic update as defined in Minnesota Rules, part 9505.0371, subpart 2, item E.~~

Sec. 103. Minnesota Statutes 2018, section 256B.0943, subdivision 4, is amended to read:

Subd. 4. **Provider entity certification.** (a) The commissioner shall establish an initial provider entity application and certification process and recertification process to determine whether a provider entity has an administrative and clinical infrastructure that meets the requirements in subdivisions 5 and 6. A provider entity must be certified for the three core rehabilitation services of psychotherapy, skills training, and crisis ~~assistance~~ planning. The commissioner shall recertify a provider entity at least every three years. 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.

(b) For purposes of this section, a provider entity must meet all requirements in chapter 245I and be:

(1) an Indian health services facility or a facility owned and operated by a tribe or tribal organization operating as a 638 facility under Public Law 93-638 certified by the state;

(2) a county-operated entity certified by the state; or

(3) a noncounty entity certified by the state.

Sec. 104. Minnesota Statutes 2018, section 256B.0943, subdivision 5, is amended to read:

Subd. 5. **Provider entity administrative infrastructure requirements.** (a) To be an eligible provider entity under this section, a provider entity must have an administrative infrastructure that establishes authority and accountability for decision making and oversight of functions, including finance, personnel, system management, clinical practice, and individual treatment outcomes measurement. An eligible provider entity shall demonstrate the availability, by means of employment or contract, of at least one backup mental health professional in the event of the primary mental health professional's absence. The provider must have written policies and procedures that it reviews and updates every three years and distributes to staff initially and upon each subsequent update.

(b) The administrative infrastructure written policies and procedures must be in accordance with sections 245I.10 and 245I.13 and must include:

(1) personnel procedures, including a process for: (i) recruiting, hiring, training, and retention of culturally and linguistically competent providers; (ii) conducting a criminal background check on all direct service providers and volunteers; (iii) investigating, reporting, and acting on violations of ethical conduct standards; (iv) investigating, reporting, and acting on violations of data privacy policies that are compliant with federal and state laws; (v) utilizing volunteers, including screening applicants, training and supervising volunteers, and providing liability coverage for volunteers; and (vi) documenting that each ~~mental health professional, mental health practitioner, or mental health behavioral aide meets the applicable provider qualification criteria~~ staff person meets the applicable qualifications under section 245I.16, training criteria under ~~subdivision 8~~ section 245I.10, and ~~clinical~~ treatment supervision ~~or direction of a mental health behavioral aide~~ requirements under ~~subdivision 6~~ section 245I.18;

(2) fiscal procedures, including internal fiscal control practices and a process for collecting revenue that is compliant with federal and state laws;

(3) a client-specific treatment outcomes measurement system, including baseline measures, to measure a client's progress toward achieving mental health rehabilitation goals.

~~Effective July 1, 2017.~~ To be eligible for medical assistance payment, a provider entity must

report individual client outcomes to the commissioner, using instruments and protocols approved by the commissioner; and

(4) a process to establish and maintain individual client records in accordance with section 245I.32. ~~The client's records must include:~~

~~(i) the client's personal information;~~

~~(ii) forms applicable to data privacy;~~

~~(iii) the client's diagnostic assessment, updates, results of tests, individual treatment plan, and individual behavior plan, if necessary;~~

~~(iv) documentation of service delivery as specified under subdivision 6;~~

~~(v) telephone contacts;~~

~~(vi) discharge plan; and~~

~~(vii) if applicable, insurance information.~~

(c) A provider entity that uses a restrictive procedure with a client must meet the requirements of section 245.8261.

Sec. 105. Minnesota Statutes 2018, section 256B.0943, subdivision 6, is amended to read:

Subd. 6. **Provider entity clinical infrastructure requirements.** (a) To be an eligible provider entity under this section, a provider entity must have a clinical infrastructure that utilizes diagnostic assessment, individualized treatment plans, service delivery, and individual treatment plan review that are culturally competent, child-centered, and family-driven to achieve maximum benefit for the client. The provider entity must review, and update as necessary, the clinical policies and procedures every three years, must distribute the policies and procedures to staff initially and upon each subsequent update, and must train staff accordingly.

(b) The clinical infrastructure written policies and procedures must include policies and procedures for:

(1) providing or obtaining a client's diagnostic assessment, including a diagnostic assessment performed by an outside or independent clinician, that identifies acute and chronic clinical disorders, co-occurring medical conditions, and sources of psychological and environmental problems, including baselines, and a functional assessment. The functional assessment component must clearly summarize the client's individual strengths and needs. When required components of the diagnostic assessment, such as baseline measures, are not provided in an outside or independent assessment or when baseline measures cannot be attained in a ~~one-session~~ standard diagnostic assessment, the provider entity must determine the missing information within 30 days and amend the child's diagnostic assessment or incorporate the baselines into the child's individual treatment plan;

(2) developing an individual treatment plan ~~that:~~ according to section 256B.0671, subdivisions 5 and 6;

~~(i) is based on the information in the client's diagnostic assessment and baselines;~~

~~(ii) identified goals and objectives of treatment, treatment strategy, schedule for accomplishing treatment goals and objectives, and the individuals responsible for providing treatment services and supports;~~

~~(iii) is developed after completion of the client's diagnostic assessment by a mental health professional or clinical trainee and before the provision of children's therapeutic services and supports;~~

~~(iv) is developed through a child-centered, family-driven, culturally appropriate planning process, including allowing parents and guardians to observe or participate in individual and family treatment services, assessment, and treatment planning;~~

~~(v) is reviewed at least once every 90 days and revised to document treatment progress on each treatment objective and next goals or, if progress is not documented, to document changes in treatment; and~~

~~(vi) is signed by the clinical supervisor and by the client or by the client's parent or other person authorized by statute to consent to mental health services for the client. A client's parent may approve the client's individual treatment plan by secure electronic signature or by documented oral approval that is later verified by written signature;~~

(3) developing an individual behavior plan that documents ~~treatment strategies~~ and describes interventions to be provided by the mental health behavioral aide. The individual behavior plan must include:

(i) detailed instructions on the ~~treatment strategies to be provided~~ psychosocial skills to be practiced;

(ii) time allocated to each ~~treatment strategy~~ intervention;

(iii) methods of documenting the child's behavior;

(iv) methods of monitoring the child's progress in reaching objectives; and

(v) goals to increase or decrease targeted behavior as identified in the individual treatment plan;

(4) providing ~~clinical~~ treatment supervision plans ~~for mental health practitioners and mental health behavioral aides~~ according to section 245I.18. ~~A mental health professional must document the clinical supervision the professional provides by cosigning individual treatment plans and making entries in the client's record on supervisory activities. The clinical supervisor also shall document supervisee-specific supervision in the supervisee's personnel file. Clinical~~ Treatment supervision does not include the authority to make or terminate court-ordered placements of the child. ~~A clinical supervisor must be available for~~

~~urgent consultation as required by the individual client's needs or the situation. Clinical supervision may occur individually or in a small group to discuss treatment and review progress toward goals. The focus of clinical supervision must be the client's treatment needs and progress and the mental health practitioner's or behavioral aide's ability to provide services~~;

(4a) meeting day treatment program conditions in items (i) to (iii):

(i) the ~~clinical~~ treatment supervisor must be present and available on the premises more than 50 percent of the time in a provider's standard working week during which the supervisee is providing a mental health service;

(ii) the treatment supervisor must review and approve the client's diagnosis and the client's individual treatment plan or a change in the diagnosis or individual treatment plan ~~must be made by or reviewed, approved, and signed by the clinical supervisor~~; and

(iii) every 30 days, the ~~clinical~~ treatment supervisor must review and sign the record indicating the supervisor has reviewed the client's care for all activities in the preceding 30-day period;

(4b) meeting the ~~clinical~~ treatment supervision standards in items (i) ~~to (iv)~~ and (ii) for all other services provided under CTSS:

~~(i) medical assistance shall reimburse for services provided by a mental health practitioner who is delivering services that fall within the scope of the practitioner's practice and who is supervised by a mental health professional who accepts full professional responsibility;~~

~~(ii) medical assistance shall reimburse for services provided by a mental health behavioral aide who is delivering services that fall within the scope of the aide's practice and who is supervised by a mental health professional who accepts full professional responsibility and has an approved plan for clinical supervision of the behavioral aide. Plans must be developed in accordance with supervision standards defined in Minnesota Rules, part 9505.0371, subpart 4, items A to D;~~

~~(iii)~~ (i) the mental health professional is required to be present at the site of service delivery for observation as clinically appropriate when the mental health practitioner or mental health behavioral aide is providing CTSS services; and

~~(iv)~~ (ii) when conducted, the on-site presence of the mental health professional must be documented in the child's record and signed by the mental health professional who accepts full professional responsibility;

(5) providing direction to a mental health behavioral aide. For entities that employ mental health behavioral aides, the ~~clinical~~ treatment supervisor must be employed by the provider entity or other provider certified to provide mental health behavioral aide services to ensure necessary and appropriate oversight for the client's treatment and continuity of care. The ~~mental health professional or mental health practitioner~~ staff giving direction must begin with the goals on the individualized treatment plan, and instruct the mental health behavioral

aide on how to implement therapeutic activities and interventions that will lead to goal attainment. The ~~professional or practitioner~~ staff giving direction must also instruct the mental health behavioral aide about the client's diagnosis, functional status, and other characteristics that are likely to affect service delivery. Direction must also include determining that the mental health behavioral aide has the skills to interact with the client and the client's family in ways that convey personal and cultural respect and that the aide actively solicits information relevant to treatment from the family. The aide must be able to clearly explain or demonstrate the activities the aide is doing with the client and the activities' relationship to treatment goals. Direction is more didactic than is supervision and requires the ~~professional or practitioner~~ staff providing it to continuously evaluate the mental health behavioral aide's ability to carry out the activities of the individualized treatment plan and the individualized behavior plan. When providing direction, the ~~professional or practitioner~~ staff must:

(i) review progress notes prepared by the mental health behavioral aide for accuracy and consistency with diagnostic assessment, treatment plan, and behavior goals and the professional or practitioner must approve and sign the progress notes;

(ii) identify changes in treatment strategies, revise the individual behavior plan, and communicate treatment instructions and methodologies as appropriate to ensure that treatment is implemented correctly;

(iii) demonstrate family-friendly behaviors that support healthy collaboration among the child, the child's family, and providers as treatment is planned and implemented;

(iv) ensure that the mental health behavioral aide is able to effectively communicate with the child, the child's family, and the provider; and

(v) record the results of any evaluation and corrective actions taken to modify the work of the mental health behavioral aide;

(6) providing service delivery that implements the individual treatment plan and meets the requirements under subdivision 9; and

(7) individual treatment plan review. The review must determine the extent to which the services have met each of the goals and objectives in the treatment plan. The review must assess the client's progress and ensure that services and treatment goals continue to be necessary and appropriate to the client and the client's family or foster family. ~~Revision of the individual treatment plan does not require a new diagnostic assessment unless the client's mental health status has changed markedly. The updated treatment plan must be signed by the clinical supervisor and by the client, if appropriate, and by the client's parent or other person authorized by statute to give consent to the mental health services for the child.~~

Sec. 106. Minnesota Statutes 2018, section 256B.0943, subdivision 7, is amended to read:

Subd. 7. **Qualifications of individual and team providers.** (a) An individual or team provider working within the scope of the provider's practice or qualifications may provide service components of children's therapeutic services and supports that are identified as medically necessary in a client's individual treatment plan.

(b) An individual provider must be qualified as:

(1) a mental health professional ~~as defined in subdivision 1, paragraph (o)~~; ~~or~~

(2) a mental health practitioner or clinical trainee~~. The mental health practitioner or clinical trainee must work under the clinical supervision of a mental health professional~~; ~~or~~

(3) a mental health behavioral aide ~~working under the clinical supervision of a mental health professional to implement the rehabilitative mental health services previously introduced by a mental health professional or practitioner and identified in the client's individual treatment plan and individual behavior plan.~~; or

(4) a mental health certified family peer specialist.

~~(A) A level I mental health behavioral aide must:~~

~~(i) be at least 18 years old;~~

~~(ii) have a high school diploma or commissioner of education-selected high school equivalency certification or two years of experience as a primary caregiver to a child with severe emotional disturbance within the previous ten years; and~~

~~(iii) meet preservice and continuing education requirements under subdivision 8.~~

~~(B) A level II mental health behavioral aide must:~~

~~(i) be at least 18 years old;~~

~~(ii) have an associate or bachelor's degree or 4,000 hours of experience in delivering clinical services in the treatment of mental illness concerning children or adolescents or complete a certificate program established under subdivision 8a; and~~

~~(iii) meet preservice and continuing education requirements in subdivision 8.~~

~~(c) A day treatment multidisciplinary team must include at least one mental health professional or clinical trainee and one mental health practitioner.~~

Sec. 107. Minnesota Statutes 2018, section 256B.0943, subdivision 8, is amended to read:

Subd. 8. **Required preservice and continuing education.** ~~(a)~~ A provider entity shall establish a plan to provide preservice and continuing education for staff according to section 245I.10. ~~The plan must clearly describe the type of training necessary to maintain current skills and obtain new skills and that relates to the provider entity's goals and objectives for services offered.~~

~~(b) A provider that employs a mental health behavioral aide under this section must require the mental health behavioral aide to complete 30 hours of preservice training. The preservice training must include parent team training. The preservice training must include 15 hours of in-person training of a mental health behavioral aide in mental health services delivery and eight hours of parent team training. Curricula for parent team training must be approved in advance by the commissioner. Components of parent team training include:~~

~~(1) partnering with parents;~~

~~(2) fundamentals of family support;~~

~~(3) fundamentals of policy and decision making;~~

~~(4) defining equal partnership;~~

~~(5) complexities of the parent and service provider partnership in multiple service delivery systems due to system strengths and weaknesses;~~

~~(6) sibling impacts;~~

~~(7) support networks; and~~

~~(8) community resources.~~

~~(c) A provider entity that employs a mental health practitioner and a mental health behavioral aide to provide children's therapeutic services and supports under this section must require the mental health practitioner and mental health behavioral aide to complete 20 hours of continuing education every two calendar years. The continuing education must be related to serving the needs of a child with emotional disturbance in the child's home environment and the child's family.~~

~~(d) The provider entity must document the mental health practitioner's or mental health behavioral aide's annual completion of the required continuing education. The documentation must include the date, subject, and number of hours of the continuing education, and attendance records, as verified by the staff member's signature, job title, and the instructor's name. The provider entity must keep documentation for each employee, including records of attendance at professional workshops and conferences, at a central location and in the employee's personnel file.~~

Sec. 108. Minnesota Statutes 2018, section 256B.0943, subdivision 9, is amended to read:

Subd. 9. **Service delivery criteria.** (a) In delivering services under this section, a certified provider entity must ensure that:

(1) ~~each individual provider's caseload size permits the provider to deliver services to both clients with severe, complex needs and clients with less intensive needs.~~ the provider's caseload size ~~should~~ reasonably ~~enable~~ enables the provider to play an active role in service planning, monitoring, and delivering services to meet the client's and client's family's needs, as specified in each client's individual treatment plan;

(2) site-based programs, including day treatment programs, provide staffing and facilities to ensure the client's health, safety, and protection of rights, and that the programs are able to implement each client's individual treatment plan; and

(3) a day treatment program is provided to a group of clients by a ~~multidisciplinary~~ team under the ~~clinical~~ treatment supervision of a mental health professional. The day treatment program must be provided in and by: (i) an outpatient hospital accredited by the Joint Commission on Accreditation of Health Organizations and licensed under sections 144.50 to 144.55; (ii) a community mental health center under section 245.62; or (iii) an entity that is certified under subdivision 4 to operate a program that meets the requirements of section 245.4884, subdivision 2, and Minnesota Rules, parts 9505.0170 to 9505.0475. The day treatment program must stabilize the client's mental health status while developing and improving the client's independent living and socialization skills. The goal of the day treatment program must be to reduce or relieve the effects of mental illness and provide training to enable the client to live in the community. The program must be available year-round at least three to five days per week, two or three hours per day, unless the normal five-day school week is shortened by a holiday, weather-related cancellation, or other districtwide reduction in a school week. A child transitioning into or out of day treatment must receive a minimum treatment of one day a week for a two-hour time block. The two-hour time block must include at least one hour of patient and/or family or group psychotherapy. The remainder of the structured treatment program may include patient and/or family or group psychotherapy, and individual or group skills training, if included in the client's individual treatment plan. Day treatment programs are not part of inpatient or residential treatment services. When a day treatment group that meets the minimum group size requirement temporarily falls below the minimum group size because of a member's temporary absence, medical assistance covers a group session conducted for the group members in attendance. A day treatment program may provide fewer than the minimally required hours for a particular child during a billing period in which the child is transitioning into, or out of, the program.

(b) To be eligible for medical assistance payment, a provider entity must deliver the service components of children's therapeutic services and supports in compliance with the following requirements:

(1) patient and/or family, family, and group psychotherapy must be delivered as specified in ~~Minnesota Rules, part 9505.0372, subpart 6~~ section 256B.0625, subdivision 69. Psychotherapy to address the child's underlying mental health disorder must be documented as part of the child's ongoing treatment. A provider must deliver, or arrange for, medically necessary psychotherapy, unless the child's parent or caregiver chooses not to receive it. When a provider delivering other services to a child under this section deems it not medically necessary to provide psychotherapy to the child for a period of 90 days or longer, the provider entity must document the medical reasons why psychotherapy is not necessary. When a provider determines that a child needs psychotherapy but psychotherapy cannot be delivered due to a shortage of licensed mental health professionals in the child's community, the provider must document the lack of access in the child's medical record;

(2) individual, family, or group skills training ~~must be provided by a mental health professional or a mental health practitioner who is delivering services that fall within the scope of the provider's practice and is supervised by a mental health professional who accepts full professional responsibility for the training. Skills training~~ is subject to the following requirements:

(i) a mental health professional, clinical trainee, or mental health practitioner shall provide skills training;

(ii) skills training delivered to a child or the child's family must be targeted to the specific deficits or maladaptations of the child's mental health disorder and must be prescribed in the child's individual treatment plan;

(iii) the mental health professional delivering or supervising the delivery of skills training must document any underlying psychiatric condition and must document how skills training is being used in conjunction with psychotherapy to address the underlying condition;

(iv) skills training delivered to the child's family must teach skills needed by parents or primary caregivers to enhance the child's skill development, to help the child utilize daily life skills taught by a mental health professional, clinical trainee, or mental health practitioner, and to develop or maintain a home environment that supports the child's progressive use of skills;

(v) group skills training may be provided to multiple recipients who, because of the nature of their emotional, behavioral, or social dysfunction, can derive mutual benefit from interaction in a group setting, which must be staffed as follows:

(A) one mental health professional or one clinical trainee or mental health practitioner ~~under supervision of a licensed mental health professional~~ must work with a group of three to eight clients; or

(B) any combination of two mental health professionals, ~~two~~ clinical trainees, or mental health practitioners ~~under supervision of a licensed mental health professional, or one mental health professional or clinical trainee and one mental health practitioner~~ must work with a group of nine to 12 clients;

(vi) a mental health professional, clinical trainee, or mental health practitioner must have taught the psychosocial skill before a mental health behavioral aide may practice that skill with the client; and

(vii) for group skills training, when a skills group that meets the minimum group size requirement temporarily falls below the minimum group size because of a group member's temporary absence, the provider may conduct the session for the group members in attendance;

(3) crisis ~~assistance~~ planning to a child and family must include development of a written plan that anticipates the particular factors specific to the child that may precipitate a psychiatric crisis for the child in the near future. The written plan must document actions

that the family should be prepared to take to resolve or stabilize a crisis, such as advance arrangements for direct intervention and support services to the child and the child's family. Crisis ~~assistance~~ planning must include preparing resources designed to address abrupt or substantial changes in the functioning of the child or the child's family when sudden change in behavior or a loss of usual coping mechanisms is observed, or the child begins to present a danger to self or others;

(4) mental health behavioral aide services must be medically necessary treatment services, identified in the child's individual treatment plan and individual behavior plan, ~~which are performed minimally by a paraprofessional qualified according to subdivision 7, paragraph (b), clause (3), and~~ which are designed to improve the functioning of the child in the progressive use of developmentally appropriate psychosocial skills. Activities involve working directly with the child, child-peer groupings, or child-family groupings to practice, repeat, reintroduce, and master the skills defined in subdivision 1, paragraph (t), as previously taught by a mental health professional, clinical trainee, or mental health practitioner including:

(i) providing cues or prompts in skill-building peer-to-peer or parent-child interactions so that the child progressively recognizes and responds to the cues independently;

(ii) performing as a practice partner or role-play partner;

(iii) reinforcing the child's accomplishments;

(iv) generalizing skill-building activities in the child's multiple natural settings;

(v) assigning further practice activities; and

(vi) intervening as necessary to redirect the child's target behavior and to de-escalate behavior that puts the child or other person at risk of injury.

To be eligible for medical assistance payment, mental health behavioral aide services must be delivered to a child who has been diagnosed with an emotional disturbance or a mental illness, as provided in subdivision 1, paragraph (a). The mental health behavioral aide must implement treatment strategies in the individual treatment plan and the individual behavior plan as developed by the mental health professional, clinical trainee, or mental health practitioner providing direction for the mental health behavioral aide. The mental health behavioral aide must document the delivery of services in written progress notes. Progress notes must reflect implementation of the treatment strategies, as performed by the mental health behavioral aide and the child's responses to the treatment strategies;

(5) direction of a mental health behavioral aide must include ~~the following:~~

~~(i) ongoing face-to-face observation of the mental health behavioral aide delivering services to a child by a mental health professional or mental health practitioner for at least a total of one hour during every 40 hours of service provided to a child; and~~

~~(ii)~~ immediate accessibility of the mental health professional, clinical trainee, or mental health practitioner to the mental health behavioral aide during service provision; and

(6) mental health service plan development must be performed in consultation with the child's family and, when appropriate, with other key participants in the child's life by the child's treating mental health professional or clinical trainee or by a mental health practitioner and approved by the treating mental health professional. Treatment plan drafting consists of development, review, and revision by face-to-face or electronic communication. The provider must document events, including the time spent with the family and other key participants in the child's life to ~~review, revise, and sign~~ approve the individual treatment plan. ~~Notwithstanding Minnesota Rules, part 9505.0371, subpart 7, medical assistance covers service plan development before completion of the child's individual treatment plan.~~ Service plan development is covered only if a treatment plan is completed for the child. If upon review it is determined that a treatment plan was not completed for the child, the commissioner shall recover the payment for the service plan development~~; and~~.

~~(7) to be eligible for payment, a diagnostic assessment must be complete with regard to all required components, including multiple assessment appointments required for an extended diagnostic assessment and the written report. Dates of the multiple assessment appointments must be noted in the client's clinical record.~~

Sec. 109. Minnesota Statutes 2018, section 256B.0943, subdivision 11, is amended to read:

Subd. 11. **Documentation and billing.** (a) A provider entity must document the services it provides under this section according to section 245I.33. ~~The provider entity must ensure that documentation complies with Minnesota Rules, parts 9505.2175 and 9505.2197. Services billed under this section that are not documented according to this subdivision shall be subject to monetary recovery by the commissioner. Billing for covered service components under subdivision 2, paragraph (b), must not include anything other than direct service time.~~

~~(b) An individual mental health provider must promptly document the following in a client's record after providing services to the client:~~

~~(1) each occurrence of the client's mental health service, including the date, type, start and stop times, scope of the service as described in the child's individual treatment plan, and outcome of the service compared to baselines and objectives;~~

~~(2) the name, dated signature, and credentials of the person who delivered the service;~~

~~(3) contact made with other persons interested in the client, including representatives of the courts, corrections systems, or schools. The provider must document the name and date of each contact;~~

~~(4) any contact made with the client's other mental health providers, case manager, family members, primary caregiver, legal representative, or the reason the provider did not contact the client's family members, primary caregiver, or legal representative, if applicable;~~

~~(5) required clinical supervision directly related to the identified client's services and needs, as appropriate, with co-signatures of the supervisor and supervisee; and~~

~~(6) the date when services are discontinued and reasons for discontinuation of services.~~

Sec. 110. Minnesota Statutes 2018, section 256B.0944, subdivision 1, is amended to read:

Subdivision 1. **Definitions.** For purposes of this section, the following terms have the meanings given them.

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

(b) "Mental health emergency" means a child's behavioral, emotional, or psychiatric situation that causes an immediate need for mental health services and is consistent with section 62Q.55. A physician, mental health professional, or ~~crisis mental health practitioner~~ qualified member of a crisis team determines a mental health crisis or emergency for medical assistance reimbursement with input from the client and the client's family, if possible.

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

(d) "Mental health mobile crisis intervention services" means face-to-face, short-term intensive mental health services initiated during a mental health crisis or mental health emergency. Mental health mobile crisis services must help the recipient cope with immediate stressors, identify and utilize available resources and strengths, and begin to return to the recipient's baseline level of functioning. Mental health mobile services ~~must be provided on site by a mobile crisis intervention team outside of an emergency room, urgent care, or an inpatient hospital setting.~~, including screening and treatment plan recommendations, must be culturally and linguistically appropriate.

(e) "Mental health crisis stabilization services" means individualized mental health services provided to a recipient following crisis intervention services that are designed to restore the recipient to the recipient's prior functional level. The individual treatment plan recommending mental health crisis stabilization must be completed by the intervention team or by staff after an inpatient or urgent care visit. Mental health crisis stabilization services may be provided in the recipient's home, the home of a family member or friend of the

recipient, schools, another community setting, or a short-term supervised, licensed residential program if the service is not included in the facility's cost pool or per diem. Mental health crisis stabilization is not reimbursable when provided as part of a partial hospitalization or day treatment program.

(f) "Clinical trainee" means a person qualified according to section 245I.16, subdivision 6.

(g) "Mental health certified family peer specialist" means a person qualified according to section 245I.16, subdivision 12.

(h) "Mental health practitioner" means a person qualified according to section 245I.16, subdivision 4.

(i) "Mental health professional" means a person qualified according to section 245I.16, subdivision 2.

Sec. 111. Minnesota Statutes 2018, section 256B.0944, subdivision 3, is amended to read:

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

(1) is eligible for medical assistance;

(2) is under age 18 or between the ages of 18 and 21;

(3) is screened as possibly experiencing a mental health crisis or mental health emergency where a mental health crisis assessment is needed; and

(4) is assessed as experiencing a mental health crisis or mental health emergency, and mental health mobile crisis intervention or mental health crisis stabilization services are determined to be medically necessary~~; and~~.

~~(5) meets the criteria for emotional disturbance or mental illness.~~

Sec. 112. Minnesota Statutes 2018, section 256B.0944, subdivision 4, is amended to read:

Subd. 4. **Provider entity standards.** ~~(a)~~ A crisis intervention and crisis stabilization provider entity must meet the administrative and clinical standards specified in ~~section 256B.0943, subdivisions 5 and 6, meet the standards listed in paragraph (b), and be:~~ section 256B.0624, subdivision 4, and ensure services are developmentally appropriate and responsive to the needs of the families.

~~(1) an Indian health service facility or facility owned and operated by a tribe or a tribal organization operating under Public Law 93-638 as a 638 facility;~~

~~(2) a county board-operated entity; or~~

~~(3) a provider entity that is under contract with the county board in the county where the potential crisis or emergency is occurring.~~

~~(b) The children's mental health crisis response services provider entity must:~~

~~(1) ensure that mental health crisis assessment and mobile crisis intervention services are available 24 hours a day, seven days a week;~~

~~(2) directly provide the services or, if services are subcontracted, the provider entity must maintain clinical responsibility for services and billing;~~

~~(3) ensure that crisis intervention services are provided in a manner consistent with sections 245.487 to 245.4889; and~~

~~(4) develop and maintain written policies and procedures regarding service provision that include safety of staff and recipients in high-risk situations.~~

Sec. 113. Minnesota Statutes 2018, section 256B.0944, subdivision 5, is amended to read:

Subd. 5. **Mobile crisis intervention staff qualifications.** ~~(a) To provide children's mental health mobile crisis intervention services, a mobile crisis intervention team must include:~~

~~(1) at least two mental health professionals as defined in section 256B.0943, subdivision 1, paragraph (o); or~~

~~(2) a combination of at least one mental health professional and one mental health practitioner as defined in section 245.4871, subdivision 26, with the required mental health crisis training and under the clinical supervision of a mental health professional on the team.~~ (a) Mobile crisis intervention team staff must be qualified to provide services as mental health professionals, mental health practitioners, clinical trainees, or mental health certified family peer specialists.

(b) A mobile crisis intervention team is comprised of at least two members, one of whom must be qualified as a mental health professional. A second member must be qualified as a mental health professional, clinical trainee, or mental health practitioner. Additional staff must be added to reflect the needs of the area served.

(c) Mental health crisis assessment and intervention services must be led by a mental health professional, or under the supervision of a mental health professional according to subdivision 9, by a clinical trainee or mental health practitioner.

~~(b)~~ (d) The team must have ~~at least two people with~~ at least one member providing on-site crisis intervention services when needed. Team members must be experienced in mental health assessment, crisis intervention techniques, and clinical decision making under emergency conditions and have knowledge of local services and resources. The team must recommend and coordinate the team's services with appropriate local resources, including the county social services agency, mental health service providers, and local law enforcement, if necessary.

Sec. 114. Minnesota Statutes 2018, section 256B.0944, subdivision 6, is amended to read:

Subd. 6. **Initial screening and crisis assessment planning.** (a) Before initiating mobile crisis intervention services, a screening of the potential crisis situation must be conducted. The screening may use the resources of crisis assistance and emergency services as defined in sections 245.4871, subdivision 14, and 245.4879, subdivisions 1 and 2. The screening must gather information, determine whether a crisis situation exists, identify the parties involved, and determine an appropriate response.

(b) In conducting the screening, a provider shall:

(1) employ evidence-based practices as identified by the commissioner in collaboration with the commissioner of health to reduce the risk of the recipient's suicide and self-injurious behavior;

(2) work with the recipient to establish a plan and time frame for responding to the crisis, including immediate needs for support by telephone or text message until a face-to-face response arrives;

(3) document significant factors related to the determination of a crisis, including prior calls to the crisis team, recent presentation at an emergency department, known calls to 911 or law enforcement, or the presence of third parties with knowledge of a potential recipient's history or current needs;

(4) screen for the needs of a third-party caller, including a recipient who primarily identifies as a family member or a caregiver but also presents signs of a crisis; and

(5) provide psychoeducation, including education on the available means for reducing self-harm, to relevant third parties, including family members or other persons living in the home.

(c) A provider entity shall consider the following to indicate a positive screening unless the provider entity documents specific evidence to show why crisis response was clinically inappropriate:

(1) the recipient presented in an emergency department or urgent care setting, and the health care team at that location requested crisis services;

(2) a peace officer requested crisis services for a recipient who may be subject to transportation under section 253B.05 for a mental health crisis.

~~(b)~~ (d) If a crisis exists, a crisis assessment must be completed. A crisis assessment must evaluate any immediate needs for which emergency services are needed and, as time permits, the recipient's current life situation, health information including current medications, sources of stress, mental health problems and symptoms, strengths, cultural considerations, support network, vulnerabilities, and current functioning.

~~(c)~~ (e) If the crisis assessment determines mobile crisis intervention services are needed, the intervention services must be provided promptly. As the opportunity presents itself during the intervention, at least two members of the mobile crisis intervention team must

confer directly or by telephone about the assessment, treatment plan, and actions taken and needed. At least one of the team members must be on site providing crisis intervention services. If providing on-site crisis intervention services, a mental health practitioner must seek ~~clinical~~ treatment supervision as required under subdivision 9.

(f) Direct contact with the recipient is not required before initiating a crisis assessment or intervention service. A crisis team may gather relevant information from a third party at the scene to establish the need for services and potential safety factors. A crisis assessment is provided face-to-face by a mobile crisis intervention team outside of an inpatient hospital setting. A service must be provided promptly and respond to the recipient's location whenever possible, including community or clinical settings. As clinically appropriate, a mobile crisis intervention team must coordinate a response with other health care providers if a recipient requires detoxification, withdrawal management, or medical stabilization services in addition to crisis services.

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

~~(e)~~ (h) The team must document in progress notes which short-term goals have been met and when no further crisis intervention services are required. If after an assessment a crisis provider entity refers a recipient to an intensive setting, including an emergency department, in-patient hospitalization, or residential treatment, one of the crisis team members who performed or conferred on the assessment must immediately contact the provider entity and consult with the triage nurse or other staff responsible for intake. The crisis team member must convey key findings or concerns that led to the referral. The consultation must occur with the recipient's consent, the recipient's legal guardian's consent, or as allowed by section 144.293, subdivision 5. Any available written documentation, including a crisis treatment plan, must be sent no later than the next business day.

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

(j) If an intervention service is provided without the recipient present, the provider shall document the reasons why the service is more effective without the recipient present.

Sec. 115. Minnesota Statutes 2018, section 256B.0944, subdivision 7, is amended to read:

Subd. 7. **Crisis stabilization services.** Crisis stabilization services ~~must be provided by a mental health professional or a mental health practitioner, as defined in section 245.462,~~

~~subdivision 17, who works under the clinical supervision of a mental health professional and for a crisis stabilization services provider entity and~~ must meet the following standards:

(1) a crisis stabilization treatment plan must be developed which meets the criteria in subdivision 8;

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

~~(3) mental health practitioners must have completed at least 30 hours of training in crisis intervention and stabilization during the past two years.~~

(3) if an intervention is provided without the recipient present, the provider shall document the reasons why the intervention is more effective without the recipient present.

Sec. 116. Minnesota Statutes 2018, section 256B.0944, subdivision 8, is amended to read:

Subd. 8. **Treatment plan.** (a) The individual crisis stabilization treatment plan must include, at a minimum:

(1) a list of problems identified in the assessment;

(2) a list of the recipient's strengths and resources;

(3) concrete, measurable short-term goals and tasks to be achieved, including time frames for achievement of the goals;

(4) specific objectives directed toward the achievement of each goal;

(5) documentation of the participants involved in the service planning;

(6) planned frequency and type of services initiated;

(7) a crisis response action plan if a crisis should occur; and

(8) clear progress notes on the outcome of goals.

(b) The client, if clinically appropriate, must be a participant in the development of the crisis stabilization treatment plan. The client or the client's legal guardian must sign the service plan or documentation must be provided why this was not possible. A copy of the plan must be given to the client and the client's legal guardian. The plan should include services arranged, including specific providers where applicable.

(c) A treatment plan must be developed by a mental health professional, clinical trainee, or mental health practitioner ~~under the clinical supervision of a mental health professional~~. A written plan must be completed within 24 hours of beginning services with the client.

Sec. 117. Minnesota Statutes 2018, section 256B.0944, subdivision 9, is amended to read:

Subd. 9. **Supervision.** ~~(a)~~ A mental health practitioner or clinical trainee may provide crisis assessment and mobile crisis intervention services if the following ~~clinical~~ treatment supervision requirements are met:

(1) the mental health provider entity must accept full responsibility for the services provided;

(2) the mental health professional of the provider entity, who is an employee or under contract with the provider entity, must be immediately available by telephone or in person for ~~clinical~~ treatment supervision;

(3) the mental health professional is consulted, in person or by telephone, during the first three hours when a mental health practitioner provides on-site service; and

(4) the mental health professional must review and approve the tentative crisis assessment and crisis treatment plan, document the consultation, and sign the crisis assessment and treatment plan within the next business day.

~~(b) If the mobile crisis intervention services continue into a second calendar day, a mental health professional must contact the client face-to-face on the second day to provide services and update the crisis treatment plan. The on-site observation must be documented in the client's record and signed by the mental health professional.~~

Sec. 118. Minnesota Statutes 2018, section 256B.0946, subdivision 1, is amended to read:

Subdivision 1. **Required covered service components.** (a) ~~Effective May 23, 2013, and subject to federal approval,~~ Medical assistance covers medically necessary intensive treatment services described under paragraph (b) that are provided by a provider entity eligible under subdivision 3 to a client eligible under subdivision 2 who is placed in a foster home licensed under Minnesota Rules, parts 2960.3000 to 2960.3340, or placed in a foster home licensed under the regulations established by a federally recognized Minnesota tribe.

(b) Intensive treatment services to children with mental illness residing in foster family settings that comprise specific required service components provided in clauses (1) to (5) are reimbursed by medical assistance when they meet the following standards:

(1) psychotherapy provided by a mental health professional ~~as defined in Minnesota Rules, part 9505.0371, subpart 5, item A,~~ or a clinical trainee~~, as defined in Minnesota Rules, part 9505.0371, subpart 5, item C~~;

(2) crisis ~~assistance~~ planning provided according to standards for children's therapeutic services and supports in section 256B.0943;

(3) individual, family, and group psychoeducation services, defined in subdivision 1a, paragraph ~~(c)~~ (o), provided by a mental health professional or a clinical trainee;

(4) clinical care consultation, as defined in subdivision 1a, and provided by a mental health professional or a clinical trainee; and

(5) service delivery payment requirements as provided under subdivision 4.

Sec. 119. Minnesota Statutes 2018, section 256B.0946, subdivision 1a, is amended to read:

Subd. 1a. **Definitions.** For the purposes of this section, the following terms have the meanings given them.

(a) "Clinical care consultation" means communication from a treating clinician to other providers working with the same client to inform, inquire, and instruct regarding the client's symptoms, strategies for effective engagement, care and intervention needs, and treatment expectations across service settings, including but not limited to the client's school, social services, day care, probation, home, primary care, medication prescribers, disabilities services, and other mental health providers and to direct and coordinate clinical service components provided to the client and family.

~~(b) "Clinical supervision" means the documented time a clinical supervisor and supervisee spend together to discuss the supervisee's work, to review individual client cases, and for the supervisee's professional development. It includes the documented oversight and supervision responsibility for planning, implementation, and evaluation of services for a client's mental health treatment.~~

~~(c) "Clinical supervisor" means the mental health professional who is responsible for clinical supervision.~~

~~(d)~~ (b) "Clinical trainee" ~~has the meaning given in Minnesota Rules, part 9505.0371, subpart 5, item C~~ means a staff person qualified according to section 245I.16, subdivision 6;

~~(e)~~ (c) "Crisis ~~assistance~~ planning" has the meaning given in section 245.4871, subdivision 9a, including the development of a plan that addresses prevention and intervention strategies to be used in a potential crisis, but does not include actual crisis intervention.

~~(f)~~ (d) "Culturally appropriate" means providing mental health services in a manner that incorporates the child's cultural influences~~, as defined in Minnesota Rules, part 9505.0370, subpart 9,~~ into interventions as a way to maximize resiliency factors and utilize cultural strengths and resources to promote overall wellness.

~~(g)~~ (e) "Culture" means the distinct ways of living and understanding the world that are used by a group of people and are transmitted from one generation to another or adopted by an individual.

~~(h)~~ (f) "Diagnostic assessment" ~~has the meaning given in Minnesota Rules, part 9505.0370, subpart 11~~ means an assessment described under section 256B.0671, subdivisions 2 and 3.

~~(i)~~ (g) "Family" means a person who is identified by the client or the client's parent or guardian as being important to the client's mental health treatment. Family may include,

but is not limited to, parents, foster parents, children, spouse, committed partners, former spouses, persons related by blood or adoption, persons who are a part of the client's permanency plan, or persons who are presently residing together as a family unit.

~~(j)~~ (h) "Foster care" has the meaning given in section 260C.007, subdivision 18.

~~(k)~~ (i) "Foster family setting" means the foster home in which the license holder resides.

~~(l)~~ (j) "Individual treatment plan" ~~has the meaning given in Minnesota Rules, part 9505.0370, subpart 15~~ means the plan described under section 256B.0671, subdivisions 5 and 6.

~~(m) "Mental health practitioner" has the meaning given in section 245.462, subdivision 17, and a mental health practitioner working as a clinical trainee according to Minnesota Rules, part 9505.0371, subpart 5, item C.~~

(k) "Mental health certified family peer specialist" means a staff person qualified according to section 245I.16, subdivision 12.

~~(n)~~ (l) "Mental health professional" ~~has the meaning given in Minnesota Rules, part 9505.0370, subpart 18~~ means a staff person qualified according to section 245I.16, subdivision 2.

~~(o)~~ (m) "Mental illness" has the meaning given in ~~Minnesota Rules, part 9505.0370, subpart 20~~ section 245.462, subdivision 20, paragraph (a), and includes emotional disturbance as defined in section 245.4871, subdivision 15.

~~(p)~~ (n) "Parent" has the meaning given in section 260C.007, subdivision 25.

~~(q)~~ (o) "Psychoeducation services" means information or demonstration provided to an individual, family, or group to explain, educate, and support the individual, family, or group in understanding a child's symptoms of mental illness, the impact on the child's development, and needed components of treatment and skill development so that the individual, family, or group can help the child to prevent relapse, prevent the acquisition of comorbid disorders, and achieve optimal mental health and long-term resilience.

~~(r)~~ (p) "Psychotherapy" has the meaning given in ~~Minnesota Rules, part 9505.0370, subpart 27~~ section 256B.0625, subdivision 69.

~~(s)~~ (q) "Team consultation and treatment planning" means the coordination of treatment plans and consultation among providers in a group concerning the treatment needs of the child, including disseminating the child's treatment service schedule to all members of the service team. Team members must include all mental health professionals working with the child, a parent, the child unless the team lead or parent deem it clinically inappropriate, and at least two of the following: an individualized education program case manager; probation agent; children's mental health case manager; child welfare worker, including adoption or guardianship worker; primary care provider; foster parent; and any other member of the child's service team.

(r) "Trauma" has the meaning given in section 245I.02, subdivision 24.

(s) "Treatment supervision" means the supervision described under section 245I.18.

(t) "Treatment supervisor" means the mental health professional who is responsible for treatment supervision.

Sec. 120. Minnesota Statutes 2018, section 256B.0946, subdivision 2, is amended to read:

Subd. 2. **Determination of client eligibility.** (a) An eligible recipient is an individual, from birth through age 20, who is currently placed in a foster home licensed under Minnesota Rules, parts 2960.3000 to 2960.3340, and has received a diagnostic assessment and an evaluation of level of care needed, as defined in paragraphs ~~(a)~~ (b) and ~~(b)~~ (c).

~~(a)~~ (b) The diagnostic assessment must:

~~(1) meet criteria described in Minnesota Rules, part 9505.0372, subpart 1, and be conducted by a mental health professional or a clinical trainee;~~

~~(2) determine whether or not a child meets the criteria for mental illness, as defined in Minnesota Rules, part 9505.0370, subpart 20;~~

~~(3)~~ (1) document that intensive treatment services are medically necessary within a foster family setting to ameliorate identified symptoms and functional impairments; and

~~(4)~~ (2) be performed within 180 days before the start of service~~; and~~.

~~(5) be completed as either a standard or extended diagnostic assessment annually to determine continued eligibility for the service.~~

~~(b)~~ (c) The evaluation of level of care must be conducted by the placing county, tribe, or case manager in conjunction with the diagnostic assessment ~~as described by Minnesota Rules, part 9505.0372, subpart 1, item B~~, using a validated tool approved by the commissioner of human services and not subject to the rulemaking process, consistent with section 245.4885, subdivision 1, paragraph (d), the result of which evaluation demonstrates that the child requires intensive intervention without 24-hour medical monitoring. The commissioner shall update the list of approved level of care tools annually and publish on the department's website.

Sec. 121. Minnesota Statutes 2018, section 256B.0946, subdivision 3, is amended to read:

Subd. 3. **Eligible mental health services providers.** (a) Eligible providers for intensive children's mental health services in a foster family setting must be certified by the state and have a service provision contract with a county board or a reservation tribal council and must be able to demonstrate the ability to provide all of the services required in this section and meet the requirements under chapter 245I.

(b) For purposes of this section, a provider agency must be:

(1) a county-operated entity certified by the state;

(2) an Indian Health Services facility operated by a tribe or tribal organization under funding authorized by United States Code, title 25, sections 450f to 450n, or title 3 of the Indian Self-Determination Act, Public Law 93-638, section 638 (facilities or providers); or

(3) a noncounty entity.

(c) Certified providers that do not meet the service delivery standards required in this section shall be subject to a decertification process.

(d) For the purposes of this section, all services delivered to a client must be provided by a mental health professional ~~or~~, a clinical trainee, or a mental health certified family peer specialist.

Sec. 122. Minnesota Statutes 2018, section 256B.0946, subdivision 4, is amended to read:

Subd. 4. **Service delivery payment requirements.** (a) To be eligible for payment under this section, a provider must develop and practice written policies and procedures for intensive treatment in foster care, consistent with subdivision 1, paragraph (b), and comply with the following requirements in paragraphs (b) to ~~(n)~~ (m).

~~(b) A qualified clinical supervisor, as defined in and performing in compliance with Minnesota Rules, part 9505.0371, subpart 5, item D, must supervise the treatment and provision of services described in this section.~~

~~(c) Each client receiving treatment services must receive an extended diagnostic assessment, as described in Minnesota Rules, part 9505.0372, subpart 1, item C, within 30 days of enrollment in this service unless the client has a previous extended diagnostic assessment that the client, parent, and mental health professional agree still accurately describes the client's current mental health functioning.~~

(b) For children under age six, each client must receive a diagnostic assessment according to the requirements in the current edition of the Diagnostic Classification of Mental Health Disorders of Infancy and Early Childhood.

~~(d)~~ (c) Each previous and current mental health, school, and physical health treatment provider must be contacted to request documentation of treatment and assessments that the eligible client has received. This information must be reviewed and incorporated into the diagnostic assessment and team consultation and treatment planning review process.

~~(e)~~ (d) Each client receiving treatment must be assessed for a trauma history, and the client's treatment plan must document how the results of the assessment will be incorporated into treatment.

~~(f)~~ (e) Each client receiving treatment services must have an individual treatment plan that is reviewed, evaluated, and ~~signed~~ approved every 90 days using the team consultation and treatment planning process, as defined in subdivision 1a, paragraph ~~(s)~~ (p).

~~(g)~~ (f) Clinical care consultation, as defined in subdivision 1a, paragraph (a), must be provided in accordance with the client's individual treatment plan.

~~(h)~~ (g) Each client must have a crisis ~~assistance~~ plan within ten days of initiating services and must have access to clinical phone support 24 hours per day, seven days per week, during the course of treatment. The crisis plan must demonstrate coordination with the local or regional mobile crisis intervention team.

~~(i)~~ (h) Services must be delivered and documented at least three days per week, equaling at least six hours of treatment per week, unless reduced units of service are specified on the treatment plan as part of transition or on a discharge plan to another service or level of care. ~~Documentation must comply with Minnesota Rules, parts 9505.2175 and 9505.2197.~~

~~(j)~~ (i) Location of service delivery must be in the client's home, day care setting, school, or other community-based setting that is specified on the client's individualized treatment plan.

~~(k)~~ (j) Treatment must be developmentally and culturally appropriate for the client.

~~(l)~~ (k) Services must be delivered in continual collaboration and consultation with the client's medical providers and, in particular, with prescribers of psychotropic medications, including those prescribed on an off-label basis. Members of the service team must be aware of the medication regimen and potential side effects.

~~(m)~~ (l) Parents, siblings, foster parents, and members of the child's permanency plan must be involved in treatment and service delivery unless otherwise noted in the treatment plan.

~~(n)~~ (m) Transition planning for the child must be conducted starting with the first treatment plan and must be addressed throughout treatment to support the child's permanency plan and postdischarge mental health service needs.

Sec. 123. Minnesota Statutes 2018, section 256B.0946, subdivision 6, is amended to read:

Subd. 6. **Excluded services.** (a) Services in clauses (1) to (7) are not covered under this section and are not eligible for medical assistance payment as components of intensive treatment in foster care services, but may be billed separately:

(1) inpatient psychiatric hospital treatment;

(2) mental health targeted case management;

(3) partial hospitalization;

(4) medication management;

(5) children's mental health day treatment services;

(6) crisis response services under section 256B.0944; and

(7) transportation.

(b) Children receiving intensive treatment in foster care services are not eligible for medical assistance reimbursement for the following services while receiving intensive treatment in foster care:

(1) psychotherapy and skills training components of children's therapeutic services and supports under section 256B.0625, subdivision 35b;

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

(3) home and community-based waiver services;

(4) mental health residential treatment; and

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

Sec. 124. Minnesota Statutes 2018, section 256B.0947, subdivision 1, is amended to read:

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

Sec. 125. Minnesota Statutes 2018, section 256B.0947, subdivision 2, is amended to read:

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

(a) "Intensive nonresidential rehabilitative mental health services" means child rehabilitative mental health services as defined in section 256B.0943, except that these services are provided by a multidisciplinary staff using ~~a total team~~ an approach consistent with assertive community treatment, as adapted for youth, and are directed to recipients ~~ages 16, 17, 18, 19, or 20 with a serious mental illness or co-occurring mental illness and substance abuse addiction~~ who require intensive services to prevent admission to an inpatient psychiatric hospital or placement in a residential treatment facility or who require intensive services to step down from inpatient or residential care to community-based care.

(b) "Co-occurring mental illness and substance abuse addiction" means a dual diagnosis of at least one form of mental illness and at least one substance use disorder. Substance use disorders include alcohol or drug abuse or dependence, excluding nicotine use.

(c) "Diagnostic assessment" ~~has the meaning given to it in Minnesota Rules, part 9505.0370, subpart 11. A diagnostic assessment must be provided according to Minnesota Rules, part 9505.0372, subpart 1,~~ means the assessment described under section 256B.0671, subdivisions 2 and 3, and for this section must incorporate a determination of the youth's necessary level of care using a standardized functional assessment instrument approved and periodically updated by the commissioner.

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

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

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

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

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

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

(3) the side effects of medications.

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

(h) "Peer specialist" means an employed team member who is a mental health certified peer specialist according to section 256B.0615 and also a former children's mental health consumer ~~who:~~.

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

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

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

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

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

~~(6) meets the following criteria:~~

~~(i) is at least 22 years of age;~~

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

~~(iii) is a former consumer of child and adolescent mental health services, or a former or current consumer of adult mental health services for a period of at least two years;~~

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

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

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

~~(vii) must be free of substance use problems for at least one year.~~

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

~~(j)~~ (i) "Substance use disorders" means one or more of the disorders defined in the Diagnostic and Statistical Manual of Mental Disorders, current edition.

~~(k)~~ (j) "Transition services" means:

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

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

(3) establishing communication between sending and receiving entities;

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

(5) establishing and enforcing procedures and schedules.

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

~~(l)~~ (k) "Treatment team" means all staff who provide services to recipients under this section.

Sec. 126. Minnesota Statutes 2018, section 256B.0947, subdivision 3, is amended to read:

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

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

(2) is diagnosed with a serious mental illness or co-occurring mental illness and substance abuse addiction, for which intensive nonresidential rehabilitative mental health services are needed;

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

(4) has a functional impairment and a history of difficulty in functioning safely and successfully in the community, school, home, or job; or who is likely to need services from the adult mental health system within the next two years; and

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

Sec. 127. Minnesota Statutes 2018, section 256B.0947, subdivision 3a, is amended to read:

Subd. 3a. **Required service components.** ~~(a) Subject to federal approval, medical assistance covers all medically necessary intensive nonresidential rehabilitative mental health services and supports, as defined in this section, under a single daily rate per client. Services and supports must be delivered by an eligible provider under subdivision 5 to an eligible client under subdivision 3.~~

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

(1) individual, family, and group psychotherapy;

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

(3) crisis ~~assistance~~ planning as defined in section ~~245.4871, subdivision 9a, which includes recognition of factors precipitating a mental health crisis, identification of behaviors related to the crisis, and the development of a plan to address prevention, intervention, and follow-up strategies to be used in the lead-up to or onset of, and conclusion of, a mental health crisis; crisis assistance does not mean crisis response services or crisis intervention services provided in section 256B.0944~~ 256B.0943, subdivision 1, paragraph (c);

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

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

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

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

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

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

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

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

(12) transition services as defined in this section;

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

(14) housing access support.

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

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

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

~~(3)~~ (2) determination of the client's needed level of care using an instrument approved and periodically updated by the commissioner.

Sec. 128. Minnesota Statutes 2018, section 256B.0947, subdivision 5, is amended to read:

Subd. 5. **Standards for intensive nonresidential rehabilitative providers.** (a) Services must be provided by a provider entity as provided in subdivision 4.

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

(1) ~~The core treatment team is an entity that operates under the direction of an independently licensed mental health professional, who is qualified under Minnesota Rules, part 9505.0371, subpart 5, item A, and that assumes comprehensive clinical responsibility for clients.~~ Based on professional qualifications and client needs, clinically qualified core

team members are assigned on a rotating basis as the client's lead worker to coordinate a client's care. The core team must comprise at least four full-time equivalent direct care staff and must include~~, but is not limited to~~ at a minimum:

(i) ~~an independently licensed~~ a mental health professional~~, qualified under Minnesota Rules, part 9505.0371, subpart 5, item A,~~ who serves as team leader to provide administrative direction and ~~clinical~~ 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) a peer specialist ~~as defined in subdivision 2, paragraph (h)~~.

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

(i) additional mental health professionals;

(ii) a vocational specialist;

(iii) an educational specialist;

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

(v) a mental health practitioner~~, as defined in~~ qualified according to section ~~245.4871, subdivision 26~~ 245I.16, subdivision 4;

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

(vii) a housing access specialist~~.~~; and

(viii) a clinical trainee qualified according to section 245I.16, subdivision 6.

(3) A treatment team may include, in addition to those in ~~clause~~ clauses (1) ~~or~~ and (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~~ entity. Client-specific treatment team members may include:

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

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

(iii) a lead member of the client's 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.

(c) The ~~clinical~~ 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 ~~clinical~~ 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.

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

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

(f) Nonclinical staff shall have prompt access in person or by telephone to a mental health practitioner 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 assure the health and safety of clients.

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

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

Sec. 129. Minnesota Statutes 2018, section 256B.0947, subdivision 6, is amended to read:

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

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

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

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

(d) An individual treatment plan must be completed for each client, according to criteria specified in section ~~256B.0943, subdivision 6, paragraph (b), clause (2)~~ 256B.0671, subdivisions 5 and 6, and, additionally, must:

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

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

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

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

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

~~(4)~~ (3) provide for the client's transition out of intensive nonresidential rehabilitative mental health services by defining the team's actions to assist the client and subsequent providers in the transition to less intensive or "stepped down" services.

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

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

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

Sec. 130. Minnesota Statutes 2018, section 256B.0947, subdivision 7a, is amended to read:

Subd. 7a. **Noncovered services.** (a) The rate for intensive rehabilitative mental health services does not include medical assistance payment for services in clauses (1) to (7). Services not covered under this paragraph may be billed separately:

(1) inpatient psychiatric hospital treatment;

(2) partial hospitalization;

(3) children's mental health day treatment services;

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

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

(6) home and community-based waiver services; and

(7) other mental health services identified in the child's individualized education program.

(b) The following services are not covered under this section and are not eligible for medical assistance payment while youth are receiving intensive rehabilitative mental health services:

(1) mental health residential treatment; and

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

Sec. 131. Minnesota Statutes 2018, section 256B.0949, subdivision 2, is amended to read:

Subd. 2. **Definitions.** (a) The terms used in this section have the meanings given in this subdivision.

(b) "Agency" means the legal entity that is enrolled with Minnesota health care programs as a medical assistance provider according to Minnesota Rules, part 9505.0195, to provide EIDBI services and that has the legal responsibility to ensure that its employees or contractors carry out the responsibilities defined in this section. Agency includes a licensed individual professional who practices independently and acts as an agency.

(c) "Autism spectrum disorder or a related condition" or "ASD or a related condition" means either autism spectrum disorder (ASD) as defined in the current version of the Diagnostic and Statistical Manual of Mental Disorders (DSM) or a condition that is found to be closely related to ASD, as identified under the current version of the DSM, and meets all of the following criteria:

(1) is severe and chronic;

(2) results in impairment of adaptive behavior and function similar to that of a person with ASD;

(3) requires treatment or services similar to those required for a person with ASD; and

(4) results in substantial functional limitations in three core developmental deficits of ASD: social interaction; nonverbal or social communication; and restrictive, repetitive behaviors or hyperreactivity or hyporeactivity to sensory input; and may include deficits or a high level of support in one or more of the following domains:

(i) self-regulation;

(ii) self-care;

(iii) behavioral challenges;

(iv) expressive communication;

(v) receptive communication;

(vi) cognitive functioning; or

(vii) safety.

(d) "Person" means a person under 21 years of age.

(e) "Clinical supervision" means the overall responsibility for the control and direction of EIDBI service delivery, including individual treatment planning, staff supervision, individual treatment plan progress monitoring, and treatment review for each person. Clinical supervision is provided by a qualified supervising professional (QSP) who takes full professional responsibility for the service provided by each supervisee.

(f) "Commissioner" means the commissioner of human services, unless otherwise specified.

(g) "Comprehensive multidisciplinary evaluation" or "CMDE" means a comprehensive evaluation of a person to determine medical necessity for EIDBI services based on the requirements in subdivision 5.

(h) "Department" means the Department of Human Services, unless otherwise specified.

(i) "Early intensive developmental and behavioral intervention benefit" or "EIDBI benefit" means a variety of individualized, intensive treatment modalities approved by the commissioner that are based in behavioral and developmental science consistent with best practices on effectiveness.

(j) "Generalizable goals" means results or gains that are observed during a variety of activities over time with different people, such as providers, family members, other adults, and people, and in different environments including, but not limited to, clinics, homes, schools, and the community.

(k) "Incident" means when any of the following occur:

(1) an illness, accident, or injury that requires first aid treatment;

(2) a bump or blow to the head; or

(3) an unusual or unexpected event that jeopardizes the safety of a person or staff, including a person leaving the agency unattended.

(l) "Individual treatment plan" or "ITP" means the person-centered, individualized written plan of care that integrates and coordinates person and family information from the CMDE for a person who meets medical necessity for the EIDBI benefit. An individual treatment plan must meet the standards in subdivision 6.

(m) "Legal representative" means the parent of a child who is under 18 years of age, a court-appointed guardian, or other representative with legal authority to make decisions about service for a person. For the purpose of this subdivision, "other representative with legal authority to make decisions" includes a health care agent or an attorney-in-fact authorized through a health care directive or power of attorney.

(n) "Mental health professional" has the meaning given in section 245.4871, subdivision 27~~, clauses (1) to (6)~~.

(o) "Person-centered" means a service that both responds to the identified needs, interests, values, preferences, and desired outcomes of the person or the person's legal representative and respects the person's history, dignity, and cultural background and allows inclusion and participation in the person's community.

(p) "Qualified EIDBI provider" means a person who is a QSP or a level I, level II, or level III treatment provider.

Sec. 132. Minnesota Statutes 2018, section 256B.0949, subdivision 4, is amended to read:

Subd. 4. **Diagnosis.** (a) A diagnosis of ASD or a related condition must:

(1) be based upon current DSM criteria including direct observations of the person and information from the person's legal representative or primary caregivers;

(2) be completed by either (i) a licensed physician or advanced practice registered nurse or (ii) a mental health professional; and

(3) meet the requirements of ~~Minnesota Rules, part 9505.0372, subpart 1, items B and C~~ section 256B.071, subdivisions 2 and 3.

(b) Additional assessment information may be considered to complete a diagnostic assessment including specialized tests administered through special education evaluations and licensed school personnel, and from professionals licensed in the fields of medicine, speech and language, psychology, occupational therapy, and physical therapy. A diagnostic assessment may include treatment recommendations.

Sec. 133. Minnesota Statutes 2018, section 256B.0949, subdivision 5a, is amended to read:

Subd. 5a. **Comprehensive multidisciplinary evaluation provider qualification.** A CMDE provider must:

(1) be a licensed physician, advanced practice registered nurse, a mental health professional, or a ~~mental health practitioner who meets the requirements of a~~ clinical trainee ~~as defined in Minnesota Rules, part 9505.0371, subpart 5, item C~~ described under section 245I.16, subdivision 6;

(2) have at least 2,000 hours of clinical experience in the evaluation and treatment of people with ASD or a related condition or equivalent documented coursework at the graduate level by an accredited university in the following content areas: ASD or a related condition diagnosis, ASD or a related condition treatment strategies, and child development; and

(3) be able to diagnose, evaluate, or provide treatment within the provider's scope of practice and professional license.

Sec. 134. **DIRECTION TO COMMISSIONER; SINGLE COMPREHENSIVE LICENSE STRUCTURE.**

The commissioner of human services, in consultation with stakeholders including but not limited to counties, tribes, managed care organizations, provider organizations, advocacy groups, and individuals and families served, shall develop recommendations to provide a single comprehensive license structure for mental health service programs, including community mental health centers according to Minnesota Rules, part 9520.0750, intensive residential treatment services, assertive community treatment, adult rehabilitative mental health services, children's therapeutic services and supports, intensive rehabilitative mental health services, intensive treatment in foster care, and children's residential treatment programs currently approved under Minnesota Rules, chapter 2960. The recommendations must prioritize program integrity, the welfare of individuals and families served, improved integration of mental health and substance use disorder services, and the reduction of administrative burden on providers.

Sec. 135. **REPEALER.**

(a) Minnesota Statutes 2018, sections 245.462, subdivision 4a; 256B.0615, subdivisions 2, 4, and 5; 256B.0616, subdivisions 2, 4, and 5; 256B.0624, subdivision 10; 256B.0943, subdivision 10; 256B.0944, subdivision 10; 256B.0946, subdivision 5; and 256B.0947, subdivision 9, are repealed.

(b) Minnesota Rules, parts 9505.0370; 9505.0371; 9505.0372; 9520.0010; 9520.0020; 9520.0030; 9520.0040; 9520.0050; 9520.0060; 9520.0070; 9520.0080; 9520.0090; 9520.0100; 9520.0110; 9520.0120; 9520.0130; 9520.0140; 9520.0150; 9520.0160; 9520.0170; 9520.0180; 9520.0190; 9520.0200; 9520.0210; and 9520.0230, are repealed.