ARTICLE 6

CHEMICAL AND MENTAL HEALTH

Section 1. Minnesota Statutes 2018, section 13.851, is amended by adding a subdivision to read:

Subd. 12. **Mental health screening.** The treatment of data collected by a sheriff or local corrections agency related to individuals who may have a mental illness is governed by section 641.15, subdivision 3a.

Sec. 2. Minnesota Statutes 2018, section 245.4661, subdivision 9, is amended to read:

Subd. 9. **Services and programs.** (a) The following ~~three~~ four distinct grant programs are funded under this section:

(1) mental health crisis services;

(2) housing with supports for adults with serious mental illness; ~~and~~

(3) projects for assistance in transitioning from homelessness (PATH program)~~.~~; and

(4) culturally specific mental health and substance use disorder provider consultation.

(b) In addition, the following are eligible for grant funds:

(1) community education and prevention;

(2) client outreach;

(3) early identification and intervention;

(4) adult outpatient diagnostic assessment and psychological testing;

(5) peer support services;

(6) community support program services (CSP);

(7) adult residential crisis stabilization;

(8) supported employment;

(9) assertive community treatment (ACT);

(10) housing subsidies;

(11) basic living, social skills, and community intervention;

(12) emergency response services;

(13) adult outpatient psychotherapy;

(14) adult outpatient medication management;

ARTICLE 3

CHEMICAL AND MENTAL HEALTH

Section 1. Minnesota Statutes 2018, section 13.851, is amended by adding a subdivision to read:

Subd. 11. **Mental health data sharing.** Section 641.15, subdivision 3a, governs the sharing of data on prisoners who may have a mental illness or need services with county social service agencies or welfare system personnel.

(15) adult mobile crisis services;

(16) adult day treatment;

(17) partial hospitalization;

(18) adult residential treatment;

(19) adult mental health targeted case management;

(20) intensive community rehabilitative services (ICRS); and

(21) transportation.

Sec. 2. **[245.4663] OFFICER-INVOLVED COMMUNITY-BASED CARE COORDINATION GRANT PROGRAM.**

Subdivision 1. **Establishment and authority.** (a) The commissioner shall award grants to programs that provide officer-involved community-based care coordination services under section 256B.0625, subdivision 56a. The commissioner shall balance awarding grants to counties outside the metropolitan area and counties inside the metropolitan area.

(b) The commissioner shall provide outreach, technical assistance, and program development support to increase capacity of new and existing officer-involved community-based care coordination programs, particularly in areas where officer-involved community-based care coordination programs have not been established, especially in greater Minnesota.

(c) Funds appropriated for this section must be expended on activities described under subdivision 3, technical assistance, and capacity building, including the capacity to maximize revenue by billing services to available third-party reimbursement sources, in order to meet the greatest need on a statewide basis.

Subd. 2. **Eligibility.** An eligible applicant for an officer-involved community-based care coordination grant under subdivision 1, paragraph (a), is a county or tribe that operates or is prepared to implement an officer-involved community-based care coordination program.

Subd. 3. **Allowable grant activities.** Grant recipients may use grant funds for the costs of providing officer-involved community-based care coordination services that are not otherwise covered under section 256B.0625, subdivision 56a, and for the cost of services for individuals not eligible for medical assistance.

Subd. 4. **Reporting.** (a) The commissioner shall report annually on the use of officer-involved community-based care coordination grants to the legislative committees with jurisdiction over human services by December 31, beginning in 2020. Each report shall include the name and location of the grant recipients, the amount of each grant, the services provided or planning activities conducted, and the number of individuals receiving services.

Sec. 3. Minnesota Statutes 2018, section 245.4889, subdivision 1, is amended to read:

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

(1) counties;

(2) Indian tribes;

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

(4) mental health service providers.

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

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

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

(3) respite care services for children with severe emotional disturbances who are at risk of out-of-home placement;

(4) children's mental health crisis services;

(5) mental health services for people from cultural and ethnic minorities;

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

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

(8) school-linked mental health services~~, including transportation for children receiving school-linked mental health services when school is not in session~~ under section 245.4901;

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

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

(11) mental health first aid training;

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

The commissioner shall determine the form required for the reports and may specify additional reporting requirements.

(b) The reporting requirements under this subdivision are in addition to the reporting requirements under section 256B.0625, subdivision 56a, paragraph (e).

Sec. 3. Minnesota Statutes 2018, section 245.4889, subdivision 1, is amended to read:

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

(1) counties;

(2) Indian tribes;

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

(4) mental health service providers.

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

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

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

(3) respite care services for children with severe emotional disturbances who are at risk of out-of-home placement, whether or not the child is receiving case management services;

(4) children's mental health crisis services;

(5) mental health services for people from cultural and ethnic minorities;

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

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

(8) school-linked mental health services, including transportation for children receiving school-linked mental health services when school is not in session;

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

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

(11) mental health first aid training;

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

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

(14) early childhood mental health consultation;

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

(16) psychiatric consultation for primary care practitioners; and

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

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

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

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

Sec. 4. **[245.4901] SCHOOL-LINKED MENTAL HEALTH GRANTS.**

Subdivision 1. **Establishment.** The commissioner of human services shall establish a school-linked mental health grant program to provide early identification and intervention for students with mental health needs and to build the capacity of schools to support students with mental health needs in the classroom.

Subd. 2. **Eligible applicants.** An eligible applicant for school-linked mental health grants is an entity that is:

(1) certified under Minnesota Rules, parts 9520.0750 to 9520.0870;

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

(3) an Indian health service facility or a facility owned and operated by a tribe or tribal organization operating under United States Code, title 25, section 5321;

(4) a provider of children's therapeutic services and supports as defined in section 256B.0943; or

(5) enrolled in medical assistance as a mental health or substance use disorder provider agency and employs at least two full-time equivalent mental health professionals qualified

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

(14) early childhood mental health consultation;

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

(16) psychiatric consultation for primary care practitioners; ~~and~~

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

(18) promoting and developing a provider's capacity to deliver multigenerational mental health treatment and services.

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

FOR SENATE LANGUAGE SEE S0007-2, ARTICLE 5, SECTION 7

according to section 245I.16, subdivision 2, or two alcohol and drug counselors licensed or exempt from licensure under chapter 148F who are qualified to provide clinical services to children and families.

Subd. 3. **Allowable grant activities and related expenses.** (a) Allowable grant activities and related expenses may include but are not limited to:

(1) identifying and diagnosing mental health conditions of students;

(2) delivering mental health treatment and services to students and their families, including via telemedicine consistent with section 256B.0625, subdivision 3b;

(3) supporting families in meeting their child's needs, including navigating health care, social service, and juvenile justice systems;

(4) providing transportation for students receiving school-linked mental health services when school is not in session;

(5) building the capacity of schools to meet the needs of students with mental health concerns, including school staff development activities for licensed and nonlicensed staff; and

(6) purchasing equipment, connection charges, on-site coordination, set-up fees, and site fees in order to deliver school-linked mental health services via telemedicine.

(b) Grantees shall obtain all available third-party reimbursement sources as a condition of receiving a grant. For purposes of this grant program, a third-party reimbursement source excludes a public school as defined in section 120A.20, subdivision 1. Grantees shall serve students regardless of health coverage status or ability to pay.

Subd. 4. **Data collection and outcome measurement.** Grantees shall provide data to the commissioner for the purpose of evaluating the effectiveness of the school-linked mental health grant program.

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

Sec. 5. Minnesota Statutes 2018, section 245.735, subdivision 3, is amended to read:

Subd. 3. **Certified community behavioral health clinics.** (a) The commissioner shall establish a state certification process for certified community behavioral health clinics (CCBHCs) ~~to be eligible for the prospective payment system in paragraph (f)~~. Entities that choose to be CCBHCs must:

(1) comply with the CCBHC criteria published by the United States Department of Health and Human Services;

(2) employ or contract for clinic staff who have backgrounds in diverse disciplines, including licensed mental health professionals and licensed alcohol and drug counselors,

and staff who are culturally and linguistically trained to ~~serve~~ meet the needs of the ~~clinic's patient~~ population the clinic serves;

(3) ensure that clinic services are available and accessible to ~~patients~~ individuals and families of all ages and genders and that crisis management services are available 24 hours per day;

(4) establish fees for clinic services for ~~nonmedical assistance patients~~ individuals who are not enrolled in medical assistance using a sliding fee scale that ensures that services to patients are not denied or limited due to ~~a patient's~~ an individual's inability to pay for services;

(5) comply with quality assurance reporting requirements and other reporting requirements, including any required reporting of encounter data, clinical outcomes data, and quality data;

(6) provide crisis mental health and substance use services, withdrawal management services, emergency crisis intervention services, and stabilization services; screening, assessment, and diagnosis services, including risk assessments and level of care determinations; ~~patient-centered~~ person- and family-centered treatment planning; outpatient mental health and substance use services; targeted case management; psychiatric rehabilitation services; peer support and counselor services and family support services; and intensive community-based mental health services, including mental health services for members of the armed forces and veterans;

(7) provide coordination of care across settings and providers to ensure seamless transitions for ~~patients~~ individuals being served across the full spectrum of health services, including acute, chronic, and behavioral needs. Care coordination may be accomplished through partnerships or formal contracts with:

(i) counties, health plans, pharmacists, pharmacies, rural health clinics, federally qualified health centers, inpatient psychiatric facilities, substance use and detoxification facilities, or community-based mental health providers; and

(ii) other community services, supports, and providers, including schools, child welfare agencies, juvenile and criminal justice agencies, Indian health services clinics, tribally licensed health care and mental health facilities, urban Indian health clinics, Department of Veterans Affairs medical centers, outpatient clinics, drop-in centers, acute care hospitals, and hospital outpatient clinics;

(8) be certified as mental health clinics under section 245.69, subdivision 2;

~~(9) be certified to provide integrated treatment for co-occurring mental illness and substance use disorders in adults or children under Minnesota Rules, chapter 9533, effective July 1, 2017;~~

~~(10)~~ (9) comply with standards relating to mental health services in ~~Minnesota Rules, parts 9505.0370 to 9505.0372~~ chapter 245I and section 256B.0671;

~~(11)~~ (10) be licensed to provide ~~chemical dependency~~ substance use disorder treatment under chapter 245G;

~~(12)~~ (11) be certified to provide children's therapeutic services and supports under section 256B.0943;

~~(13)~~ (12) be certified to provide adult rehabilitative mental health services under section 256B.0623;

~~(14)~~ (13) be enrolled to provide mental health crisis response services under ~~section~~ sections 256B.0624 and 256B.0944;

~~(15)~~ (14) be enrolled to provide mental health targeted case management under section 256B.0625, subdivision 20;

~~(16)~~ (15) comply with standards relating to mental health case management in Minnesota Rules, parts 9520.0900 to 9520.0926; ~~and~~

~~(17)~~ (16) provide services that comply with the evidence-based practices described in paragraph (e)~~.~~; and

(17) comply with standards relating to peer services under sections 256B.0615, 256B.0616, and 245G.07, subdivision 1, paragraph (a), clause (5), as applicable when peer services are provided.

(b) If an entity is unable to provide one or more of the services listed in paragraph (a), clauses (6) to (17), the commissioner may certify the entity as a CCBHC, if the entity has a current contract with another entity that has the required authority to provide that service and that meets federal CCBHC criteria as a designated collaborating organization, or, to the extent allowed by the federal CCBHC criteria, the commissioner may approve a referral arrangement. The CCBHC must meet federal requirements regarding the type and scope of services to be provided directly by the CCBHC.

(c) Notwithstanding any other law that requires a county contract or other form of county approval for certain services listed in paragraph (a), clause (6), a clinic that otherwise meets CCBHC requirements may receive the prospective payment under ~~paragraph (f)~~ section 256B.0625, subdivision 5m, for those services without a county contract or county approval. There is no county share when medical assistance pays the CCBHC prospective payment. As part of the certification process in paragraph (a), the commissioner shall require a letter of support from the CCBHC's host county confirming that the CCBHC and the county or counties it serves have an ongoing relationship to facilitate access and continuity of care, especially for individuals who are uninsured or who may go on and off medical assistance.

(d) When the standards listed in paragraph (a) or other applicable standards conflict or address similar issues in duplicative or incompatible ways, the commissioner may grant variances to state requirements if the variances do not conflict with federal requirements. If standards overlap, the commissioner may substitute all or a part of a licensure or certification that is substantially the same as another licensure or certification. The

commissioner shall consult with stakeholders, as described in subdivision 4, before granting variances under this provision. For the CCBHC that is certified but not approved for prospective payment under section 256B.0625, subdivision 5m, the commissioner may grant a variance under this paragraph if the variance does not increase the state share of costs.

(e) The commissioner shall issue a list of required evidence-based practices to be delivered by CCBHCs, and may also provide a list of recommended evidence-based practices. The commissioner may update the list to reflect advances in outcomes research and medical services for persons living with mental illnesses or substance use disorders. The commissioner shall take into consideration the adequacy of evidence to support the efficacy of the practice, the quality of workforce available, and the current availability of the practice in the state. At least 30 days before issuing the initial list and any revisions, the commissioner shall provide stakeholders with an opportunity to comment.

~~(f) The commissioner shall establish standards and methodologies for a prospective payment system for medical assistance payments for services delivered by certified community behavioral health clinics, in accordance with guidance issued by the Centers for Medicare and Medicaid Services. During the operation of the demonstration project, payments shall comply with federal requirements for an enhanced federal medical assistance percentage. The commissioner may include quality bonus payment in the prospective payment system based on federal criteria and on a clinic's provision of the evidence-based practices in paragraph (e). The prospective payment system does not apply to MinnesotaCare. Implementation of the prospective payment system is effective July 1, 2017, or upon federal approval, whichever is later.~~

~~(g) The commissioner shall seek federal approval to continue federal financial participation in payment for CCBHC services after the federal demonstration period ends for clinics that were certified as CCBHCs during the demonstration period and that continue to meet the CCBHC certification standards in paragraph (a). Payment for CCBHC services shall cease effective July 1, 2019, if continued federal financial participation for the payment of CCBHC services cannot be obtained.~~

~~(h) The commissioner may certify at least one CCBHC located in an urban area and at least one CCBHC located in a rural area, as defined by federal criteria. To the extent allowed by federal law, the commissioner may limit the number of certified clinics so that the projected claims for certified clinics will not exceed the funds budgeted for this purpose. The commissioner shall give preference to clinics that:~~

~~(1) provide a comprehensive range of services and evidence-based practices for all age groups, with services being fully coordinated and integrated; and~~

~~(2) enhance the state's ability to meet the federal priorities to be selected as a CCBHC demonstration state.~~

~~(i)~~ (f) The commissioner shall recertify CCBHCs at least every three years. The commissioner shall establish a process for decertification and shall require corrective action, medical assistance repayment, or decertification of a CCBHC that no longer meets the requirements in this section or that fails to meet the standards provided by the commissioner in the application and certification process.

EFFECTIVE DATE. This section is effective July 1, 2019, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 6. Minnesota Statutes 2018, section 245F.05, subdivision 2, is amended to read:

Subd. 2. **Admission criteria.** For an individual to be admitted to a withdrawal management program, the program must make a determination that the program services are appropriate to the needs of the individual. A program may only admit individuals ~~who meet the admission criteria and~~ who, at the time of admission~~:~~, meet the criteria for admission as determined by current American Society of Addiction Medicine standards for appropriate level of withdrawal management.

~~(1) are impaired as the result of intoxication;~~

~~(2) are experiencing physical, mental, or emotional problems due to intoxication or withdrawal from alcohol or other drugs;~~

~~(3) are being held under apprehend and hold orders under section 253B.07, subdivision 2b;~~

~~(4) have been committed under chapter 253B and need temporary placement;~~

~~(5) are held under emergency holds or peace and health officer holds under section 253B.05, subdivision 1 or 2; or~~

~~(6) need to stay temporarily in a protective environment because of a crisis related to substance use disorder. Individuals satisfying this clause may be admitted only at the request of the county of fiscal responsibility, as determined according to section 256G.02, subdivision 4. Individuals admitted according to this clause must not be restricted to the facility.~~

Sec. 7. Minnesota Statutes 2018, section 254A.03, subdivision 3, is amended to read:

Subd. 3. **Rules for substance use disorder care.** (a) The commissioner of human services shall establish by rule criteria to be used in determining the appropriate level of chemical dependency care for each recipient of public assistance seeking treatment for substance misuse or substance use disorder. Upon federal approval of a comprehensive assessment as a Medicaid benefit, or on July 1, 2018, whichever is later, and notwithstanding the criteria in Minnesota Rules, parts 9530.6600 to 9530.6655, an eligible vendor of comprehensive assessments under section 254B.05 may determine and approve the appropriate level of substance use disorder treatment for a recipient of public assistance. The process for determining an individual's financial eligibility for the consolidated chemical

Sec. 4. Minnesota Statutes 2018, section 254A.03, subdivision 3, is amended to read:

Subd. 3. **Rules for substance use disorder care.** (a) The commissioner of human services shall establish by rule criteria to be used in determining the appropriate level of chemical dependency care for each recipient of public assistance seeking treatment for substance misuse or substance use disorder. Upon federal approval of a comprehensive assessment as a Medicaid benefit, or on July 1, 2018, whichever is later, and notwithstanding the criteria in Minnesota Rules, parts 9530.6600 to 9530.6655, an eligible vendor of comprehensive assessments under section 254B.05 may determine and approve the appropriate level of substance use disorder treatment for a recipient of public assistance. The process for determining an individual's financial eligibility for the consolidated chemical

dependency treatment fund or determining an individual's enrollment in or eligibility for a publicly subsidized health plan is not affected by the individual's choice to access a comprehensive assessment for placement.

(b) The commissioner shall develop and implement a utilization review process for publicly funded treatment placements to monitor and review the clinical appropriateness and timeliness of all publicly funded placements in treatment.

(c) If a screen result is positive for alcohol or substance misuse, a brief screening for alcohol or substance use disorder that is provided to a recipient of public assistance within a primary care clinic, hospital, or other medical setting or school setting establishes medical necessity and approval for an initial set of substance use disorder services identified in section 254B.05, subdivision 5. The initial set of services approved for a recipient whose screen result is positive may include any combination of up to four hours of individual or group substance use disorder treatment, two hours of substance use disorder treatment coordination, or two hours of substance use disorder peer support services provided by a qualified individual according to chapter 245G. A recipient must obtain an assessment pursuant to paragraph (a) to be approved for additional treatment services.

EFFECTIVE DATE. Contingent upon federal approval, this section is effective July 1, 2019. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained or denied.

dependency treatment fund or determining an individual's enrollment in or eligibility for a publicly subsidized health plan is not affected by the individual's choice to access a comprehensive assessment for placement.

(b) The commissioner shall develop and implement a utilization review process for publicly funded treatment placements to monitor and review the clinical appropriateness and timeliness of all publicly funded placements in treatment.

(c) If a screen result is positive for alcohol or substance misuse, a brief screening for alcohol or substance use disorder that is provided to a recipient of public assistance within a primary care clinic, hospital, or other medical setting or school setting establishes medical necessity and approval for an initial set of substance use disorder services identified in section 254B.05, subdivision 5. The initial set of services approved for a recipient whose screen result is positive may include four hours of individual or group substance use disorder treatment, two hours of substance use disorder treatment coordination, or two hours of substance use disorder peer support services provided by a qualified individual according to chapter 245G. A recipient must obtain an assessment pursuant to paragraph (a) to be approved for additional treatment services.

EFFECTIVE DATE. Contingent upon federal approval, this section is effective July 1, 2019. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained or denied.

Sec. 5. Minnesota Statutes 2018, section 254A.19, is amended by adding a subdivision to read:

Subd. 5. **Assessment via telemedicine.** Notwithstanding Minnesota Rules, part 9530.6615, subpart 3, item A, a chemical use assessment may be conducted via telemedicine.

Sec. 8. Minnesota Statutes 2018, section 254B.02, subdivision 1, is amended to read:

Subdivision 1. **Chemical dependency treatment allocation.** The chemical dependency treatment appropriation shall be placed in a special revenue account. ~~The commissioner shall annually transfer funds from the chemical dependency fund to pay for operation of the drug and alcohol abuse normative evaluation system and to pay for all costs incurred by adding two positions for licensing of chemical dependency treatment and rehabilitation programs located in hospitals for which funds are not otherwise appropriated.~~ The ~~remainder of the~~ money in the special revenue account must be used according to the requirements in this chapter.

EFFECTIVE DATE. This section is effective July 1, 2019.

Sec. 6. Minnesota Statutes 2018, section 254B.02, subdivision 1, is amended to read:

Subdivision 1. **Chemical dependency treatment allocation.** The chemical dependency treatment appropriation shall be placed in a special revenue account. ~~The commissioner shall annually transfer funds from the chemical dependency fund to pay for operation of the drug and alcohol abuse normative evaluation system and to pay for all costs incurred by adding two positions for licensing of chemical dependency treatment and rehabilitation programs located in hospitals for which funds are not otherwise appropriated.~~ The ~~remainder of the~~ money in the special revenue account must be used according to the requirements in this chapter.

EFFECTIVE DATE. This section is effective July 1, 2019.

Sec. 9. Minnesota Statutes 2018, section 254B.03, subdivision 2, is amended to read:

Subd. 2. **Chemical dependency fund payment.** (a) Payment from the chemical dependency fund is limited to payments for services other than detoxification licensed under Minnesota Rules, parts 9530.6510 to 9530.6590, that, if located outside of federally recognized tribal lands, would be required to be licensed by the commissioner as a chemical

Sec. 7. Minnesota Statutes 2018, section 254B.03, subdivision 2, is amended to read:

Subd. 2. **Chemical dependency fund payment.** (a) Payment from the chemical dependency fund is limited to payments for services other than detoxification licensed under Minnesota Rules, parts 9530.6510 to 9530.6590, that, if located outside of federally recognized tribal lands, would be required to be licensed by the commissioner as a chemical

dependency treatment or rehabilitation program under sections 245A.01 to 245A.16, and services other than detoxification provided in another state that would be required to be licensed as a chemical dependency program if the program were in the state. Out of state vendors must also provide the commissioner with assurances that the program complies substantially with state licensing requirements and possesses all licenses and certifications required by the host state to provide chemical dependency treatment. Vendors receiving payments from the chemical dependency fund must not require co-payment from a recipient of benefits for services provided under this subdivision. The vendor is prohibited from using the client's public benefits to offset the cost of services paid under this section. The vendor shall not require the client to use public benefits for room or board costs. This includes but is not limited to cash assistance benefits under chapters 119B, 256D, and 256J, or SNAP benefits. Retention of SNAP benefits is a right of a client receiving services through the consolidated chemical dependency treatment fund or through state contracted managed care entities. Payment from the chemical dependency fund shall be made for necessary room and board costs provided by vendors ~~certified according to~~ meeting the criteria under section 254B.05, subdivision 1a, or in a community hospital licensed by the commissioner of health according to sections 144.50 to 144.56 to a client who is:

(1) determined to meet the criteria for placement in a residential chemical dependency treatment program according to rules adopted under section 254A.03, subdivision 3; and

(2) concurrently receiving a chemical dependency treatment service in a program licensed by the commissioner and reimbursed by the chemical dependency fund.

(b) A county may, from its own resources, provide chemical dependency services for which state payments are not made. A county may elect to use the same invoice procedures and obtain the same state payment services as are used for chemical dependency services for which state payments are made under this section if county payments are made to the state in advance of state payments to vendors. When a county uses the state system for payment, the commissioner shall make monthly billings to the county using the most recent available information to determine the anticipated services for which payments will be made in the coming month. Adjustment of any overestimate or underestimate based on actual expenditures shall be made by the state agency by adjusting the estimate for any succeeding month.

(c) The commissioner shall coordinate chemical dependency services and determine whether there is a need for any proposed expansion of chemical dependency treatment services. The commissioner shall deny vendor certification to any provider that has not received prior approval from the commissioner for the creation of new programs or the expansion of existing program capacity. The commissioner shall consider the provider's capacity to obtain clients from outside the state based on plans, agreements, and previous utilization history, when determining the need for new treatment services.

dependency treatment or rehabilitation program under sections 245A.01 to 245A.16, and services other than detoxification provided in another state that would be required to be licensed as a chemical dependency program if the program were in the state. Out of state vendors must also provide the commissioner with assurances that the program complies substantially with state licensing requirements and possesses all licenses and certifications required by the host state to provide chemical dependency treatment. Vendors receiving payments from the chemical dependency fund must not require co-payment from a recipient of benefits for services provided under this subdivision. The vendor is prohibited from using the client's public benefits to offset the cost of services paid under this section. The vendor shall not require the client to use public benefits for room or board costs. This includes but is not limited to cash assistance benefits under chapters 119B, 256D, and 256J, or SNAP benefits. Retention of SNAP benefits is a right of a client receiving services through the consolidated chemical dependency treatment fund or through state contracted managed care entities. Payment from the chemical dependency fund shall be made for necessary room and board costs provided by vendors ~~certified according to~~ meeting the criteria under section 254B.05, subdivision 1a, or in a community hospital licensed by the commissioner of health according to sections 144.50 to 144.56 to a client who is:

(1) determined to meet the criteria for placement in a residential chemical dependency treatment program according to rules adopted under section 254A.03, subdivision 3; and

(2) concurrently receiving a chemical dependency treatment service in a program licensed by the commissioner and reimbursed by the chemical dependency fund.

(b) A county may, from its own resources, provide chemical dependency services for which state payments are not made. A county may elect to use the same invoice procedures and obtain the same state payment services as are used for chemical dependency services for which state payments are made under this section if county payments are made to the state in advance of state payments to vendors. When a county uses the state system for payment, the commissioner shall make monthly billings to the county using the most recent available information to determine the anticipated services for which payments will be made in the coming month. Adjustment of any overestimate or underestimate based on actual expenditures shall be made by the state agency by adjusting the estimate for any succeeding month.

(c) The commissioner shall coordinate chemical dependency services and determine whether there is a need for any proposed expansion of chemical dependency treatment services. ~~The commissioner shall deny vendor certification to any provider that has not received prior approval from the commissioner for the creation of new programs or the expansion of existing program capacity. The commissioner shall consider the provider's capacity to obtain clients from outside the state based on plans, agreements, and previous utilization history, when determining the need for new treatment services~~ The commissioner may deny vendor certification to a provider if the commissioner determines that the services currently available in the local area are sufficient to meet local need and that the addition of new services would be detrimental to individuals seeking these services.

EFFECTIVE DATE. This section is effective July 1, 2019.

Sec. 10. Minnesota Statutes 2018, section 254B.03, subdivision 4, is amended to read:

Subd. 4. **Division of costs.** (a) Except for services provided by a county under section 254B.09, subdivision 1, or services provided under section 256B.69, the county shall, out of local money, pay the state for 22.95 percent of the cost of chemical dependency services, ~~including~~ except for those services provided to persons ~~eligible for~~ enrolled in medical assistance under chapter 256B and room and board services under section 254B.05, subdivision 5, paragraph (b), clause (12). Counties may use the indigent hospitalization levy for treatment and hospital payments made under this section.

(b) 22.95 percent of any state collections from private or third-party pay, less 15 percent for the cost of payment and collections, must be distributed to the county that paid for a portion of the treatment under this section.

~~(c) For fiscal year 2017 only, the 22.95 percentages under paragraphs (a) and (b) are equal to 20.2 percent.~~

EFFECTIVE DATE. This section is effective July 1, 2019.

Sec. 11. Minnesota Statutes 2018, section 254B.04, subdivision 1, is amended to read:

Subdivision 1. **Eligibility.** (a) Persons eligible for benefits under Code of Federal Regulations, title 25, part 20, ~~and persons eligible for medical assistance benefits under sections 256B.055, 256B.056, and 256B.057, subdivisions 1, 5, and 6, or~~ who meet the income standards of section 256B.056, subdivision 4, and are not enrolled in medical assistance, are entitled to chemical dependency fund services. State money appropriated for this paragraph must be placed in a separate account established for this purpose.

(b) Persons with dependent children who are determined to be in need of chemical dependency treatment pursuant to an assessment under section 626.556, subdivision 10, or a case plan under section 260C.201, subdivision 6, or 260C.212, shall be assisted by the local agency to access needed treatment services. Treatment services must be appropriate for the individual or family, which may include long-term care treatment or treatment in a facility that allows the dependent children to stay in the treatment facility. The county shall pay for out-of-home placement costs, if applicable.

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

EFFECTIVE DATE. This section is effective September 1, 2019.

EFFECTIVE DATE. This section is effective July 1, 2019.

Sec. 8. Minnesota Statutes 2018, section 254B.03, subdivision 4, is amended to read:

Subd. 4. **Division of costs.** (a) Except for services provided by a county under section 254B.09, subdivision 1, or services provided under section 256B.69, the county shall, out of local money, pay the state for 22.95 percent of the cost of chemical dependency services, ~~including~~ those except that the county shall pay the state for ten percent of the nonfederal share of the cost of chemical dependency services provided to persons ~~eligible for~~ enrolled in medical assistance under chapter 256B, and ten percent of the cost of room and board services under section 254B.05, subdivision 5, paragraph (b), clause (12). Counties may use the indigent hospitalization levy for treatment and hospital payments made under this section.

(b) 22.95 percent of any state collections from private or third-party pay, less 15 percent for the cost of payment and collections, must be distributed to the county that paid for a portion of the treatment under this section.

~~(c) For fiscal year 2017 only, the 22.95 percentages under paragraphs (a) and (b) are equal to 20.2 percent.~~

EFFECTIVE DATE. This section is effective July 1, 2019.

Sec. 9. Minnesota Statutes 2018, section 254B.04, subdivision 1, is amended to read:

Subdivision 1. **Eligibility.** (a) Persons eligible for benefits under Code of Federal Regulations, title 25, part 20, ~~and persons eligible for medical assistance benefits under sections 256B.055, 256B.056, and 256B.057, subdivisions 1, 5, and 6, or~~ who meet the income standards of section 256B.056, subdivision 4, and are not enrolled in medical assistance, are entitled to chemical dependency fund services. State money appropriated for this paragraph must be placed in a separate account established for this purpose.

(b) Persons with dependent children who are determined to be in need of chemical dependency treatment pursuant to an assessment under section 626.556, subdivision 10, or a case plan under section 260C.201, subdivision 6, or 260C.212, shall be assisted by the local agency to access needed treatment services. Treatment services must be appropriate for the individual or family, which may include long-term care treatment or treatment in a facility that allows the dependent children to stay in the treatment facility. The county shall pay for out-of-home placement costs, if applicable.

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

EFFECTIVE DATE. This section is effective September 1, 2019.

Sec. 12. Minnesota Statutes 2018, section 254B.05, subdivision 1a, is amended to read:

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

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

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

(3) is not a jail or prison;

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

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

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

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

(8) has staff who are at least 18 years of age and meet the requirements of section 245G.11, subdivision 1, paragraph (b);

(9) has emergency behavioral procedures that meet the requirements of section 245G.16;

(10) meets the requirements of section 245G.08, subdivision 5, if administering medications to clients;

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

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

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

(14) has a grievance procedure that meets the requirements of section 245G.15, subdivision 2; and

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

(b) Programs licensed according to Minnesota Rules, chapter 2960, are exempt from paragraph (a), clauses (5) to (15).

(c) Licensed programs providing intensive residential treatment services or residential crisis stabilization services pursuant to section 256B.0622 or 256B.0624 are eligible vendors of room and board and are exempt from paragraph (a), clauses (6) to (15).

Sec. 10. Minnesota Statutes 2018, section 254B.05, subdivision 1a, is amended to read:

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

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

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

(3) is not a jail or prison;

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

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

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

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

(8) has staff who are at least 18 years of age and meet the requirements of section 245G.11, subdivision 1, paragraph (b);

(9) has emergency behavioral procedures that meet the requirements of section 245G.16;

(10) meets the requirements of section 245G.08, subdivision 5, if administering medications to clients;

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

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

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

(14) has a grievance procedure that meets the requirements of section 245G.15, subdivision 2; and

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

(b) Programs licensed according to Minnesota Rules, chapter 2960, are exempt from paragraph (a), clauses (5) to (15).

(c) Licensed programs providing intensive residential treatment services or residential crisis stabilization services pursuant to section 256B.0622 or 256B.0624 are eligible vendors of room and board and are exempt from paragraph (a), clauses (6) to (15).

EFFECTIVE DATE. This section is effective September 1, 2019.

Sec. 13. Minnesota Statutes 2018, section 254B.06, subdivision 1, is amended to read:

Subdivision 1. **State collections.** The commissioner is responsible for all collections from persons determined to be partially responsible for the cost of care of an eligible person receiving services under Laws 1986, chapter 394, sections 8 to 20. The commissioner may initiate, or request the attorney general to initiate, necessary civil action to recover the unpaid cost of care. The commissioner may collect all third-party payments for chemical dependency services provided under Laws 1986, chapter 394, sections 8 to 20, including private insurance and federal Medicaid and Medicare financial participation. ~~The commissioner shall deposit in a dedicated account a percentage of collections to pay for the cost of operating the chemical dependency consolidated treatment fund invoice processing and vendor payment system, billing, and collections.~~ The remaining receipts must be deposited in the chemical dependency fund.

EFFECTIVE DATE. This section is effective July 1, 2019.

Sec. 14. Minnesota Statutes 2018, section 254B.06, subdivision 2, is amended to read:

Subd. 2. **Allocation of collections.** ~~(a) The commissioner shall allocate all federal financial participation collections to a special revenue account.~~ The commissioner shall allocate 77.05 percent of patient payments and third-party payments to the special revenue account and 22.95 percent to the county financially responsible for the patient.

~~(b) For fiscal year 2017 only, the commissioner's allocation to the special revenue account shall be increased from 77.05 percent to 79.8 percent and the county financial responsibility shall be reduced from 22.95 percent to 20.2 percent.~~

EFFECTIVE DATE. This section is effective July 1, 2019.

Sec. 15. Minnesota Statutes 2018, section 256.478, is amended to read:

256.478 ~~HOME AND COMMUNITY-BASED SERVICES TRANSITIONS GRANTS~~ TRANSITION TO COMMUNITY INITIATIVE.

Subdivision 1. **Eligibility.** (a) An individual is eligible for the transition to community initiative if the individual meets the following criteria:

(1) without the additional resources available through the transitions to community initiative the individual would otherwise remain at the Anoka-Metro Regional Treatment Center, a state-operated community behavioral health hospital, or the Minnesota Security Hospital;

(2) the individual's discharge would be significantly delayed without the additional resources available through the transitions to community initiative; and

EFFECTIVE DATE. This section is effective September 1, 2019.

Sec. 11. Minnesota Statutes 2018, section 254B.06, subdivision 1, is amended to read:

Subdivision 1. **State collections.** The commissioner is responsible for all collections from persons determined to be partially responsible for the cost of care of an eligible person receiving services under Laws 1986, chapter 394, sections 8 to 20. The commissioner may initiate, or request the attorney general to initiate, necessary civil action to recover the unpaid cost of care. The commissioner may collect all third-party payments for chemical dependency services provided under Laws 1986, chapter 394, sections 8 to 20, including private insurance and federal Medicaid and Medicare financial participation. ~~The commissioner shall deposit in a dedicated account a percentage of collections to pay for the cost of operating the chemical dependency consolidated treatment fund invoice processing and vendor payment system, billing, and collections.~~ The remaining receipts must be deposited in the chemical dependency fund.

EFFECTIVE DATE. This section is effective July 1, 2019.

Sec. 12. Minnesota Statutes 2018, section 254B.06, subdivision 2, is amended to read:

Subd. 2. **Allocation of collections.** ~~(a) The commissioner shall allocate all federal financial participation collections to a special revenue account.~~ The commissioner shall allocate 77.05 percent of patient payments and third-party payments to the special revenue account and 22.95 percent to the county financially responsible for the patient.

~~(b) For fiscal year 2017 only, the commissioner's allocation to the special revenue account shall be increased from 77.05 percent to 79.8 percent and the county financial responsibility shall be reduced from 22.95 percent to 20.2 percent.~~

EFFECTIVE DATE. This section is effective July 1, 2019.

(3) the individual met treatment objectives and no longer needs hospital-level care or a secure treatment setting.

(b) An individual who is in a community hospital and on the waiting list for the Anoka-Metro Regional Treatment Center, but for whom alternative community placement would be appropriate is eligible for the transition to community initiative upon the commissioner's approval.

Subd. 2. **Transition grants.** The commissioner shall make available ~~home and community-based services~~ transition to community grants to ~~serve~~ assist individuals ~~who do not meet eligibility criteria for the medical assistance program under section 256B.056 or 256B.057, but who otherwise meet the criteria under section 256B.092, subdivision 13, or 256B.49, subdivision 24~~ who met the criteria under subdivision 1.

EFFECTIVE DATE. This section is effective July 1, 2019.

Sec. 16. Minnesota Statutes 2018, section 256B.0625, is amended by adding a subdivision to read:

Subd. 5m. **Certified community behavioral health clinic services.** (a) Medical assistance covers certified community behavioral health clinic (CCBHC) services that meet the requirements of section 245.735, subdivision 3.

(b) The commissioner shall establish standards and methodologies for a prospective payment system for medical assistance payments for services delivered by a CCBHC, in accordance with guidance issued by the Centers for Medicare and Medicaid Services. The commissioner shall include a quality bonus payment in the prospective payment system based on federal criteria.

(c) To the extent allowed by federal law, the commissioner may limit the number of CCBHCs for the prospective payment system in paragraph (b) to ensure that the projected claims do not exceed the money appropriated for this purpose. The commissioner shall apply the following priorities, in the order listed, to give preference to clinics that:

(1) provide a comprehensive range of services and evidence-based practices for all age groups, with services being fully coordinated and integrated;

(2) are certified as CCBHCs during the federal CCBHC demonstration period;

(3) receive CCBHC grants from the United States Department of Health and Human Services; or

(4) focus on serving individuals in tribal areas and other underserved communities.

(d) Unless otherwise indicated in applicable federal requirements, the prospective payment system must continue to be based on the federal instructions issued for the federal CCBHC demonstration, except:

(1) the commissioner shall rebase CCBHC rates at least every three years;

(2) the commissioner shall provide for a 60-day appeals process of the rebasing;

(3) the prohibition against inclusion of new facilities in the demonstration does not apply after the demonstration ends;

(4) the prospective payment rate under this section does not apply to services rendered by CCBHCs to individuals who are dually eligible for Medicare and medical assistance when Medicare is the primary payer for the service. An entity that receives a prospective payment system rate that overlaps with the CCBHC rate is not eligible for the CCBHC rate;

(5) payments for CCBHC services to individuals enrolled in managed care shall be coordinated with the state's phase-out of CCBHC wrap payments;

(6) initial prospective payment rates for CCBHCs certified after July 1, 2019, shall be based on rates for comparable CCBHCs. If no comparable provider exists, the commissioner shall compute a CCBHC-specific rate based upon the CCBHC's audited costs adjusted for changes in the scope of services; and

(7) the prospective payment rate for each CCBHC shall be adjusted annually by the Medicare Economic Index as defined for the CCBHC federal demonstration.

EFFECTIVE DATE. Contingent upon federal approval, this section is effective July 1, 2019. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained or denied.

Sec. 17. Minnesota Statutes 2018, section 256B.0625, is amended by adding a subdivision to read:

Subd. 20c. **Integrated care model; mental health case management services by Center for Victims of Torture.** (a) The commissioner of human services, in collaboration with the Center for Victims of Torture, shall develop a pilot project to support the continued testing of an integrated care model for the delivery of mental health targeted case management at one designated service site. For purposes of this subdivision, "center" means the Center for Victims of Torture.

(b) The commissioner of human services shall contract directly with the center for the provision of the services described in paragraph (c). The services shall be paid at $695 per member per month and shall be funded using 100 percent state funding.

(c) Individuals who are eligible to receive medical assistance under this chapter, who are eligible to receive mental health targeted case management as described under section 245.4711, and who are being served by the center shall be served using the integrated care model and must be evaluated using the center's social functioning tool.

(d) The commissioner of human services, in collaboration with the center, shall also evaluate whether the center's social functioning tool can be adapted for use with the general

medical assistance population. Beginning July 1, 2020, and annually thereafter until the evaluation is complete, the commissioner of human services shall report on the results of the evaluation to the legislative committees with jurisdiction over human services.

Sec. 18. Minnesota Statutes 2018, section 256B.0625, subdivision 24, is amended to read:

Subd. 24. **Other medical or remedial care.** Medical assistance covers any other medical or remedial care licensed and recognized under state law unless otherwise prohibited by law~~, except licensed chemical dependency treatment programs or primary treatment or extended care treatment units in hospitals that are covered under chapter 254B. The commissioner shall include chemical dependency services in the state medical assistance plan for federal reporting purposes, but payment must be made under chapter 254B~~. The commissioner shall publish in the State Register a list of elective surgeries that require a second medical opinion before medical assistance reimbursement, and the criteria and standards for deciding whether an elective surgery should require a second medical opinion. The list and criteria and standards are not subject to the requirements of sections 14.01 to 14.69.

EFFECTIVE DATE. This section is effective July 1, 2019.

Sec. 19. Minnesota Statutes 2018, section 256B.0625, is amended by adding a subdivision to read:

Subd. 24a. **Substance use disorder services.** Medical assistance covers substance use disorder treatment services according to section 254B.05, subdivision 5, except for room and board.

EFFECTIVE DATE. This section is effective July 1, 2019.

Sec. 13. Minnesota Statutes 2018, section 256B.0625, subdivision 24, is amended to read:

Subd. 24. **Other medical or remedial care.** Medical assistance covers any other medical or remedial care licensed and recognized under state law unless otherwise prohibited by law~~, except licensed chemical dependency treatment programs or primary treatment or extended care treatment units in hospitals that are covered under chapter 254B. The commissioner shall include chemical dependency services in the state medical assistance plan for federal reporting purposes, but payment must be made under chapter 254B~~. The commissioner shall publish in the State Register a list of elective surgeries that require a second medical opinion before medical assistance reimbursement, and the criteria and standards for deciding whether an elective surgery should require a second medical opinion. The list and criteria and standards are not subject to the requirements of sections 14.01 to 14.69.

EFFECTIVE DATE. This section is effective July 1, 2019.

Sec. 14. Minnesota Statutes 2018, section 256B.0625, is amended by adding a subdivision to read:

Subd. 24a. **Substance use disorder services.** Medical assistance covers substance use disorder treatment services according to section 254B.05, subdivision 5, except for room and board.

EFFECTIVE DATE. This section is effective July 1, 2019.

UEH2414-1 ARTICLE 1

Sec. 32. Minnesota Statutes 2018, section 256B.0625, subdivision 43, is amended to read:

Subd. 43. **Mental health provider travel time.** (a) Medical assistance covers provider travel time if a ~~recipient's individual treatment plan~~ recipient requires the provision of mental health services outside of the provider's ~~normal~~ usual place of business. ~~This does not include any travel time which is included in other billable services, and is only covered when the mental health service being provided to a recipient is covered under medical assistance.~~

(b) Medical assistance covers under this subdivision the time a provider is in transit to provide a covered mental health service to a recipient at a location that is not the provider's usual place of business. A provider must travel the most direct route available. Mental health provider travel time does not include time for scheduled or unscheduled stops, meal breaks, or vehicle maintenance or repair, including refueling or vehicle emergencies. Recipient transportation is not covered under this subdivision.

(c) Mental health provider travel time under this subdivision is only covered when the mental health service being provided is covered under medical assistance and only when

the covered mental health service is delivered and billed. Mental health provider travel time is not covered when the mental health service being provided otherwise includes provider travel time or when the service is site based.

(d) A provider must document each trip for which the provider seeks reimbursement under this subdivision in a compiled travel record. Required documentation may be collected and maintained electronically or in paper form but must be made available and produced upon request by the commissioner. The travel record must be written in English and must be legible according to the standard of a reasonable person. The recipient's individual identification number must be on each page of the record. The reason the provider must travel to provide services must be included in the record, if not otherwise documented in the recipient's individual treatment plan. Each entry in the record must document:

(1) start and stop time (with a.m. and p.m. notations);

(2) printed name of the recipient;

(3) date the entry is made;

(4) date the service is provided;

(5) origination site and destination site;

(6) who provided the service;

(7) the electronic source used to calculate driving directions and distance between locations; and

(8) the medically necessary mental health service delivered.

(e) Mental health providers identified by the commissioner to have submitted a fraudulent report may be excluded from participation in Minnesota health care programs.

UEH2414-1 ARTICLE 3

Sec. 15. 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 supervision of a mental health professional; ~~or~~

(3) a certified peer specialist under section 256B.0615, working under the clinical supervision of a mental health professional~~.~~;

(4) an individual qualified as an alcohol and drug counselor under section 245G.11, subdivision 5; or

(5) 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. 20. Minnesota Statutes 2018, section 256B.0625, subdivision 45a, is amended to read:

Subd. 45a. **Psychiatric residential treatment facility services for persons younger than 21 years of age.** (a) Medical assistance covers psychiatric residential treatment facility services, according to section 256B.0941, for persons younger than 21 years of age. Individuals who reach age 21 at the time they are receiving services are eligible to continue receiving services until they no longer require services or until they reach age 22, whichever occurs first.

(b) For purposes of this subdivision, "psychiatric residential treatment facility" means a facility other than a hospital that provides psychiatric services, as described in Code of Federal Regulations, title 42, sections 441.151 to 441.182, to individuals under age 21 in an inpatient setting.

(c) The commissioner shall enroll up to 150 certified psychiatric residential treatment facility services beds ~~at up to six sites~~. The commissioner may enroll an additional 80 certified psychiatric residential treatment facility services beds beginning July 1, 2020, and an additional 70 certified psychiatric residential treatment facility services beds beginning July 1, 2023. The commissioner shall select psychiatric residential treatment facility services providers through a request for proposals process. Providers of state-operated services may respond to the request for proposals. The commissioner shall prioritize programs that demonstrate the capacity to serve children and youth with aggressive and risky behaviors toward themselves or others, multiple diagnoses, neurodevelopmental disorders, or complex trauma related issues.

(d) Notwithstanding the limit on the number of certified psychiatric residential treatment facility services beds under paragraph (c), providers of children's residential treatment under section 256B.0945, who are enrolled to provide services as of July 1, 2019, may submit a letter of intent to develop a psychiatric residential treatment facility program in a format developed by the commissioner. Each letter of intent must demonstrate the need for psychiatric residential treatment facility services, the proposed bed capacity for the program, and the capacity of the organization to develop and deliver psychiatric residential treatment facility services. The letter of intent must also include a description of the proposed services and physical site as well as specific information about the population that the program plans to serve. The commissioner shall respond to the letter of intent within 60 days of receiving all requested information with a determination of whether the program is approved, or with specific recommended actions required to obtain approval. Programs that receive an approved letter of intent must initiate the processes required by the commissioner to enroll as a provider of psychiatric residential treatment facility services within 30 days of receiving notice of approval. The commissioner shall process letters of intent in the order received. A program approved under this paragraph may not increase bed capacity when converting to provide psychiatric residential treatment facility services.

EFFECTIVE DATE. This section is effective July 1, 2019.

Sec. 21. Minnesota Statutes 2018, section 256B.0625, subdivision 57, is amended to read:

Subd. 57. **Payment for Part B Medicare crossover claims.** (a) Effective for services provided on or after January 1, 2012, medical assistance payment for an enrollee's cost-sharing associated with Medicare Part B is limited to an amount up to the medical assistance total allowed, when the medical assistance rate exceeds the amount paid by Medicare.

(b) Excluded from this limitation are payments for mental health services and payments for dialysis services provided to end-stage renal disease patients. The exclusion for mental health services does not apply to payments for physician services provided by psychiatrists and advanced practice nurses with a specialty in mental health.

(c) Excluded from this limitation are payments to federally qualified health centers ~~and~~, rural health clinics, and CCBHCs subject to the prospective payment system under subdivision 5m.

EFFECTIVE DATE. Contingent upon federal approval, this section is effective July 1, 2019. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained or denied.

Sec. 22. Minnesota Statutes 2018, section 256B.0757, subdivision 2, is amended to read:

Subd. 2. **Eligible individual.** (a) The commissioner may develop health home models in accordance with United States Code, title 42, section 1396w-4(h)(1).

(b) 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;~~

Sec. 16. Minnesota Statutes 2018, section 256B.0757, subdivision 1, is amended to read:

Subdivision 1. **Provision of coverage.** (a) The commissioner shall provide medical assistance coverage of health home services for eligible individuals with chronic conditions who select a designated provider as the individual's health home.

(b) The commissioner shall implement this section in compliance with the requirements of the state option to provide health homes for enrollees with chronic conditions, as provided under the Patient Protection and Affordable Care Act, Public Law 111-148, sections 2703 and 3502. Terms used in this section have the meaning provided in that act.

(c) The commissioner shall establish health homes to serve populations with serious mental illness who meet the eligibility requirements described under subdivision 2~~, clause (4)~~. The health home services provided by health homes shall focus on both the behavioral and the physical health of these populations.

Sec. 17. Minnesota Statutes 2018, section 256B.0757, subdivision 2, is amended to read:

Subd. 2. **Eligible individual.** (a) The commissioner may elect to develop health home models in accordance with United States Code, title 42, section 1396w-4.

(b) 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)~~ has a condition that meets the definition of serious mental illness as described in section 245.462, subdivision 20, paragraph (a), or emotional disturbance as defined in section 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, 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.

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

Sec. 23. Minnesota Statutes 2018, section 256B.0757, is amended by adding a subdivision to read:

Subd. 2a. **Discharge criteria.** (a) An individual may be discharged from behavioral health home services if:

(1) the behavioral health home services provider is unable to locate, contact, and engage the individual for a period of greater than three months after persistent efforts by the behavioral health home services provider; or

(2) the individual is unwilling to participate in behavioral health home services as demonstrated by the individual's refusal to meet with the behavioral health home services provider, or refusal to identify the individual's health and wellness goals or the activities or support necessary to achieve these goals.

(b) Before discharge from behavioral health home services, the behavioral health home services provider must offer a face-to-face meeting with the individual and the individual's identified supports, to discuss options available to the individual, including maintaining behavioral health home services.

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

Sec. 24. Minnesota Statutes 2018, section 256B.0757, subdivision 4, is amended to read:

Subd. 4. **Designated provider.** ~~(a)~~ Health home services are voluntary and an eligible individual may choose any designated provider. The commissioner shall establish designated providers to serve as health homes and provide the services described in subdivision 3 to individuals eligible under subdivision 2. The commissioner shall apply for grants as provided under section 3502 of the Patient Protection and Affordable Care Act to establish health homes and provide capitated payments to designated providers. For purposes of this section, "designated provider" means a provider, clinical practice or clinical group practice, rural clinic, community health center, community mental health center, or any other entity that is determined by the commissioner to be qualified to be a health home for eligible individuals.

~~(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 of mental illness as described in section 245.462, subdivision 20, paragraph (a), or emotional disturbance as defined in section 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, 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. 19. Minnesota Statutes 2018, section 256B.0757, is amended by adding a subdivision to read:

Subd. 9. **Discharge criteria.** (a) An individual may be discharged from behavioral health home services if:

(1) the behavioral health home services provider is unable to locate, contact, and engage the individual for a period of greater than three months after persistent efforts by the behavioral health home services provider; or

(2) the individual is unwilling to participate in behavioral health home services as demonstrated by the individual's refusal to meet with the behavioral health home services provider, or refusal to identify the individual's goals or the activities or support necessary to achieve the individual's health and wellness goals.

(b) Before discharge from behavioral health home services, the behavioral health home services provider must offer a face-to-face meeting with the individual, the individual's identified supports, and the behavioral health home services provider to discuss options available to the individual, including maintaining behavioral health home services.

Sec. 18. Minnesota Statutes 2018, section 256B.0757, subdivision 4, is amended to read:

Subd. 4. **Designated provider.** ~~(a)~~ Health home services are voluntary and an eligible individual may choose any designated provider. The commissioner shall establish designated providers to serve as health homes and provide the services described in subdivision 3 to individuals eligible under subdivision 2. The commissioner shall apply for grants as provided under section 3502 of the Patient Protection and Affordable Care Act to establish health homes and provide capitated payments to designated providers. For purposes of this section, "designated provider" means a provider, clinical practice or clinical group practice, rural clinic, community health center, community mental health center, or any other entity that is determined by the commissioner to be qualified to be a health home for eligible individuals.

This determination must be based on documentation evidencing that the designated provider has the systems and infrastructure in place to provide health home services and satisfies the qualification standards established by the commissioner in consultation with stakeholders and approved by the Centers for Medicare and Medicaid Services.

~~(b) The commissioner shall develop and implement certification standards for designated providers under this subdivision.~~

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

Sec. 25. Minnesota Statutes 2018, section 256B.0757, is amended by adding a subdivision to read:

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

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

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

(3) utilize an electronic health record;

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

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

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

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

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

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

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

This determination must be based on documentation evidencing that the designated provider has the systems and infrastructure in place to provide health home services and satisfies the qualification standards established by the commissioner in consultation with stakeholders and approved by the Centers for Medicare and Medicaid Services.

~~(b) The commissioner shall develop and implement certification standards for designated providers under this subdivision.~~

Sec. 20. Minnesota Statutes 2018, section 256B.0757, is amended by adding a subdivision to read:

Subd. 10. **Behavioral health home services provider requirements.** A behavioral health home services provider must:

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

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

(3) utilize an electronic health record;

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

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

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

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

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

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

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

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

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

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

Sec. 26. Minnesota Statutes 2018, section 256B.0757, is amended by adding a subdivision to read:

Subd. 4b. **Behavioral health home provider training and practice transformation requirements.** (a) The behavioral health home services provider must ensure that all staff delivering behavioral health home services receive adequate preservice and ongoing training, including:

(1) training approved by the commissioner that describes the goals and principles of behavioral health home services; and

(2) training on evidence-based practices to promote an individual's ability to successfully engage with medical, behavioral health, and social services to achieve the individual's health and wellness goals.

(b) The behavioral health home services provider must ensure that staff are capable of implementing culturally responsive services, as determined by the individual's culture, beliefs, values, and language as identified in the individual's health wellness assessment.

(c) The behavioral health home services provider must participate in the department's practice transformation activities to support continued skill and competency development in the provision of integrated medical, behavioral health, and social services.

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

Sec. 27. Minnesota Statutes 2018, section 256B.0757, is amended by adding a subdivision to read:

Subd. 4c. **Behavioral health home staff qualifications.** (a) A behavioral health home services provider must maintain staff with required professional qualifications appropriate to the setting.

(b) If behavioral health home services are offered in a mental health setting, the integration specialist must be a registered nurse licensed under the Minnesota Nurse Practice Act, sections 148.171 to 148.285.

(c) If behavioral health home services are offered in a primary care setting, the integration specialist must be 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).

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

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

Sec. 21. Minnesota Statutes 2018, section 256B.0757, is amended by adding a subdivision to read:

Subd. 11. **Provider training and practice transformation requirements.** (a) The behavioral health home services provider must ensure that all staff delivering behavioral health home services receive adequate preservice and ongoing training including:

(1) training approved by the commissioner that describes the goals and principles of behavioral health home services; and

(2) training on evidence-based practices to promote an individual's ability to successfully engage with medical, behavioral health, and social services to reach the individual's health and wellness goals.

(b) The behavioral health home services provider must ensure that staff are capable of implementing culturally responsive services as determined by the individual's culture, beliefs, values, and language as identified in the individual's health wellness assessment.

(c) The behavioral health home services provider must participate in the department's practice transformation activities to support continued skill and competency development in the provision of integrated medical, behavioral health, and social services.

Sec. 22. Minnesota Statutes 2018, section 256B.0757, is amended by adding a subdivision to read:

Subd. 12. **Staff qualifications.** (a) A behavioral health home services provider must maintain staff with required professional qualifications appropriate to the setting.

(b) If behavioral health home services are offered in a mental health setting, the integration specialist must be a registered nurse licensed under the Minnesota Nurse Practice Act, sections 148.171 to 148.285.

(c) If behavioral health home services are offered in a primary care setting, the integration specialist must be 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).

(d) If behavioral health home services are offered in either a primary care setting or mental health setting, the systems navigator must be a mental health practitioner as defined in section 245.462, subdivision 17, or a community health worker as defined in section 256B.0625, subdivision 49.

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

(1) a peer support specialist as defined in section 256B.0615;

(2) a family peer support specialist as defined in section 256B.0616;

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

(4) a mental health rehabilitation worker as defined in section 256B.0623, subdivision 5, clause (4);

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

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

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

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

Sec. 28. Minnesota Statutes 2018, section 256B.0757, is amended by adding a subdivision to read:

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

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

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

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

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

(d) If behavioral health home services are offered in either a primary care setting or mental health setting, the systems navigator must be a mental health practitioner as defined in section 245.462, subdivision 17, or a community health worker as defined in section 256B.0625, subdivision 49.

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

(1) a peer support specialist as defined in section 256B.0615;

(2) a family peer support specialist as defined in section 256B.0616;

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

(4) a mental health rehabilitation worker as defined in section 256B.0623, subdivision 5, clause (4);

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

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

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

Sec. 23. Minnesota Statutes 2018, section 256B.0757, is amended by adding a subdivision to read:

Subd. 13. **Service delivery standards.** (a) A behavioral health home services provider must meet the following service delivery standards:

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

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

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

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

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

(6) utilize the Department of Human Services Partner Portal to identify past and current treatment or services and identify potential gaps in care;

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

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

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

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

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

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

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

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

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

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

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

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

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

(6) utilize Department of Human Services Partner Portal to identify past and current treatment or services and to identify potential gaps in care;

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

(8) ensure that all individuals receiving behavioral health home services have a diagnostic assessment completed within six months of when the individual begins receiving behavioral health home services;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Sec. 29. Minnesota Statutes 2018, section 256B.0757, is amended by adding a subdivision to read:

Subd. 4e. **Behavioral health home provider variances.** (a) The commissioner may grant a variance to specific requirements under subdivisions 4a, 4b, 4c, or 4d for a behavioral health home services provider according to this subdivision.

(b) The commissioner may grant a variance if the commissioner finds that:

(1) failure to grant the variance would result in hardship or injustice to the applicant;

(2) the variance would be consistent with the public interest; and

(3) the variance would not reduce the level of services provided to individuals served by the organization.

(c) The commissioner may grant a variance from one or more requirements to permit an applicant to offer behavioral health home services of a type or in a manner that is innovative, if the commissioner finds that the variance does not impede the achievement of

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

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

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

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

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

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

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

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

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

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

Sec. 24. Minnesota Statutes 2018, section 256B.0757, is amended by adding a subdivision to read:

Subd. 14. **Provider variances.** (a) The commissioner may grant a variance to specific requirements under subdivision 10, 11, 12, or 13 for a behavioral health home services provider according to this subdivision.

(b) The commissioner may grant a variance if the commissioner finds that (1) failure to grant the variance would result in hardship or injustice to the applicant, (2) the variance would be consistent with the public interest, and (3) the variance would not reduce the level of services provided to individuals served by the organization.

(c) The commissioner may grant a variance from one or more requirements to permit an applicant to offer behavioral health home services of a type or in a manner that is innovative if the commissioner finds that the variance does not impede the achievement of

the criteria in subdivisions 4a, 4b, 4c, or 4d and may improve the behavioral health home services provided by the applicant.

(d) The commissioner's decision to grant or deny a variance request is final and not subject to appeal.

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

Sec. 30. Minnesota Statutes 2018, section 256B.0757, subdivision 8, is amended to read:

Subd. 8. **Evaluation and continued development.** (a) For continued certification under this section, behavioral health homes must meet process, outcome, and quality standards developed and specified by the commissioner. The commissioner shall collect data from health homes as necessary to monitor compliance with certification standards.

(b) The commissioner may contract with a private entity to evaluate patient and family experiences, health care utilization, and costs.

(c) The commissioner shall utilize findings from the implementation of ~~behavioral~~ health homes to determine populations to serve under subsequent health home models for individuals with chronic conditions.

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

Sec. 31. **[256B.0759] SUBSTANCE USE DISORDER DEMONSTRATION PROJECT.**

Subdivision 1. **Establishment.** The commissioner shall develop and implement a medical assistance demonstration project to test reforms of Minnesota's substance use disorder treatment system to ensure individuals with substance use disorders have access to a full continuum of high quality care.

Subd. 2. **Provider participation.** Substance use disorder treatment providers may elect to participate in the demonstration project and meet the requirements of subdivision 3. To participate, a provider must notify the commissioner of the provider's intent to participate in a format required by the commissioner and enroll as a demonstration project provider.

Subd. 3. **Provider standards.** (a) The commissioner shall establish requirements for participating providers that are consistent with the federal requirements of the demonstration project.

(b) A participating residential provider must obtain applicable licensure under chapters 245F and 245G or other applicable standards for the services provided and must:

(1) deliver services in accordance with American Society of Addiction Medicine (ASAM) standards;

(2) maintain formal patient referral arrangements with providers delivering step-up or step-down levels of care in accordance with ASAM standards; and

the criteria in subdivision 10, 11, 12, or 13 and may improve the behavioral health home services provided by the applicant.

(d) The commissioner's decision to grant or deny a variance request is final and not subject to appeal.

Sec. 25. **[256B.0759] SUBSTANCE USE DISORDER DEMONSTRATION PROJECT.**

Subdivision 1. **Establishment.** The commissioner shall develop and implement a medical assistance demonstration project to test reforms of Minnesota's substance use disorder treatment system to ensure individuals with substance use disorders have access to a full continuum of high quality care.

Subd. 2. **Provider participation.** Substance use disorder treatment providers may elect to participate in the demonstration project and fulfill the requirements under subdivision 3. To participate, a provider must notify the commissioner of the provider's intent to participate in a format required by the commissioner and enroll as a demonstration project provider.

Subd. 3. **Provider standards.** (a) The commissioner shall establish requirements for participating providers that are consistent with the federal requirements of the demonstration project.

(b) Participating residential providers must obtain applicable licensure under chapters 245F, 245G, or other applicable standards for the services provided and must:

(1) deliver services in accordance with American Society of Addiction Medicine (ASAM) standards;

(2) maintain formal patient referral arrangements with providers delivering step-up or step-down levels of care in accordance with ASAM standards; and

(3) provide or arrange for medication-assisted treatment services if requested by a client for whom an effective medication exists.

(c) A participating outpatient provider must obtain applicable licensure under chapter 245G or other applicable standards for the services provided and must:

(1) deliver services in accordance with ASAM standards; and

(2) maintain formal patient referral arrangements with providers delivering step-up or step-down levels of care in accordance with ASAM standards.

(d) If the provider standards under chapter 245G or other applicable standards conflict or are duplicative, the commissioner may grant variances to the standards if the variances do not conflict with federal requirements. The commissioner shall publish service components, service standards, and staffing requirements for participating providers that are consistent with ASAM standards and federal requirements.

Subd. 4. **Provider payment rates.** (a) Payment rates for participating providers must be increased for services provided to medical assistance enrollees.

(b) For substance use disorder services under section 254B.05, subdivision 5, paragraph (b), clause (8), payment rates must be increased by 15 percent over the rates in effect on January 1, 2020.

(c) For substance use disorder services under section 254B.05, subdivision 5, paragraph (b), clauses (1), (6), (7), and (10), payment rates must be increased by ten percent over the rates in effect on January 1, 2021.

Subd. 5. **Federal approval.** The commissioner shall seek federal approval to implement the demonstration project under this section and to receive federal financial participation.

Sec. 32. Minnesota Statutes 2018, section 256B.0915, subdivision 3b, is amended to read:

Subd. 3b. **Cost limits for elderly waiver applicants who reside in a nursing facility or another eligible facility.** (a) For a person who is a nursing facility resident at the time of requesting a determination of eligibility for elderly waivered services, a monthly conversion budget limit for the cost of elderly waivered services may be requested. The monthly conversion budget limit for the cost of elderly waiver services shall be ~~the resident class assigned under Minnesota Rules, parts 9549.0050 to 9549.0059, for that resident in the nursing facility where the resident currently resides until July 1 of the state fiscal year in which the resident assessment system as described in section 256B.438 for nursing home rate determination is implemented. Effective on July 1 of the state fiscal year in which the resident assessment system as described in section 256B.438 for nursing home rate determination is implemented, the monthly conversion budget limit for the cost of elderly waiver services shall be~~ based on the per diem nursing facility rate as determined by the resident assessment system as described in section ~~256B.438~~ 256R.17 for residents in the nursing facility where the elderly waiver applicant currently resides. The monthly conversion budget limit shall be calculated by multiplying the per diem by 365, divided by 12, and

(3) provide or arrange for medication-assisted treatment services if requested by a client for whom an effective medication exists.

(c) Participating outpatient providers must be licensed and must:

(1) deliver services in accordance with ASAM standards; and

(2) maintain formal patient referral arrangements with providers delivering step-up or step-down levels of care in accordance with ASAM standards.

(d) If the provider standards under chapter 245G or other applicable standards conflict or are duplicative, the commissioner may grant variances to the standards if the variances do not conflict with federal requirements. The commissioner shall publish service components, service standards, and staffing requirements for participating providers that are consistent with ASAM standards and federal requirements.

Subd. 4. **Provider payment rates.** (a) Payment rates for participating providers must be increased for services provided to medical assistance enrollees.

(b) For substance use disorder services under section 254B.05, subdivision 5, paragraph (b), clause (8), payment rates must be increased by 15 percent over the rates in effect on January 1, 2020.

(c) For substance use disorder services under section 254B.05, subdivision 5, paragraph (b), clauses (1), (6), (7), and (10), payment rates must be increased by ten percent over the rates in effect on January 1, 2021.

Subd. 5. **Federal approval.** The commissioner shall seek federal approval to implement the demonstration project under this section and to receive federal financial participation.

reduced by the recipient's maintenance needs allowance as described in subdivision 1d. The initially approved monthly conversion budget limit shall be adjusted annually as described in subdivision 3a, paragraph (a). The limit under this ~~subdivision~~ paragraph only applies to persons discharged from a nursing facility after a minimum 30-day stay and found eligible for waivered services on or after July 1, 1997. For conversions from the nursing home to the elderly waiver with consumer directed community support services, the nursing facility per diem used to calculate the monthly conversion budget limit must be reduced by a percentage equal to the percentage difference between the consumer directed services budget limit that would be assigned according to the federally approved waiver plan and the corresponding community case mix cap, but not to exceed 50 percent.

(b) A person who meets elderly waiver eligibility criteria and the eligibility criteria under section 256.478, subdivision 1, is eligible for a special monthly budget limit for the cost of elderly waivered services up to $21,610 per month. The special monthly budget limit must be adjusted annually as described in subdivision 3a, paragraphs (a) and (e). For a person using a special monthly budget limit under the elderly waiver with consumer-directed community support services, the special monthly budget limit must be reduced as described in paragraph (a).

(c) The commissioner may provide an additional payment for documented costs between a threshold determined by the commissioner and the special monthly budget limit to a managed care plan for elderly waiver services provided to a person who is: (1) eligible for a special monthly budget limit under paragraph (b); and (2) enrolled in a managed care plan that provides elderly waiver services under section 256B.69.

(d) For monthly conversion budget limits under paragraph (a) and special monthly budget limits under paragraph (b), the service rate limits for adult foster care under subdivision 3d and for customized living under subdivision 3e may be exceeded if necessary for the provider to meet identified needs and provide services as approved in the coordinated service and support plan, if the total cost of all services does not exceed the monthly conversion or special monthly budget limit. Service rates must be established using tools provided by the commissioner.

(e) The following costs must be included in determining the total monthly costs for the waiver client:

(1) cost of all waivered services, including specialized supplies and equipment and environmental accessibility adaptations; and

(2) cost of skilled nursing, home health aide, and personal care services reimbursable by medical assistance.

EFFECTIVE DATE. This section is effective upon federal approval. The commissioner of human services shall notify the revisor of statutes once federal approval is obtained.

Sec. 33. Minnesota Statutes 2018, section 256B.092, subdivision 13, is amended to read:

Subd. 13. **Waiver allocations for transition populations.** (a) The commissioner shall make available additional waiver allocations and additional necessary resources ~~to assure timely discharges from the Anoka-Metro Regional Treatment Center and the Minnesota Security Hospital in St. Peter~~ for individuals who meet the ~~following~~ eligibility criteria~~:~~ established under section 256.478, subdivision 1.

~~(1) are otherwise eligible for the developmental disabilities waiver under this section;~~

~~(2) who would otherwise remain at the Anoka-Metro Regional Treatment Center or the Minnesota Security Hospital;~~

~~(3) whose discharge would be significantly delayed without the available waiver allocation; and~~

~~(4) who have met treatment objectives and no longer meet hospital level of care.~~

(b) Additional waiver allocations under this subdivision must meet cost-effectiveness requirements of the federal approved waiver plan.

(c) Any corporate foster care home developed under this subdivision must be considered an exception under section 245A.03, subdivision 7, paragraph (a).

EFFECTIVE DATE. This section is effective July 1, 2019.

Sec. 34. Minnesota Statutes 2018, section 256B.0941, subdivision 3, is amended to read:

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

(b) The following are included in the rate:

(1) costs necessary for licensure and accreditation, meeting all staffing standards for participation, meeting all service standards for participation, meeting all requirements for active treatment, maintaining medical records, conducting utilization review, meeting inspection of care, and discharge planning. The direct services costs must be determined using the actual cost of salaries, benefits, payroll taxes, and training of direct services staff and service-related transportation; and

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

(c) A facility may submit a claim for payment outside of the per diem for professional services arranged by and provided at the facility by an appropriately licensed professional who is enrolled as a provider with Minnesota health care programs. Arranged services must be billed by the facility on a separate claim, and the facility shall be responsible for payment to the provider. These services must be included in the individual plan of care and are subject to prior authorization by the state's medical review agent.

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

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

(1) educational services;

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

(3) dental services; and

(4) pharmacy drug costs.

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

Sec. 35. Minnesota Statutes 2018, section 256B.49, subdivision 24, is amended to read:

Subd. 24. **Waiver allocations for transition populations.** (a) The commissioner shall make available additional waiver allocations and additional necessary resources ~~to assure timely discharges from the Anoka-Metro Regional Treatment Center and the Minnesota Security Hospital in St. Peter~~ for individuals who meet the ~~following~~ eligibility criteria~~:~~ established under section 256.478, subdivision 1.

~~(1) are otherwise eligible for the brain injury, community access for disability inclusion, or community alternative care waivers under this section;~~

~~(2) who would otherwise remain at the Anoka-Metro Regional Treatment Center or the Minnesota Security Hospital;~~

~~(3) whose discharge would be significantly delayed without the available waiver allocation; and~~

~~(4) who have met treatment objectives and no longer meet hospital level of care.~~

(b) Additional waiver allocations under this subdivision must meet cost-effectiveness requirements of the federal approved waiver plan.

(c) Any corporate foster care home developed under this subdivision must be considered an exception under section 245A.03, subdivision 7, paragraph (a).

EFFECTIVE DATE. This section is effective July 1, 2019.

Sec. 36. Minnesota Statutes 2018, section 256I.04, subdivision 1, is amended to read:

Subdivision 1. **Individual eligibility requirements.** An individual is eligible for and entitled to a housing support payment to be made on the individual's behalf if the agency has approved the setting where the individual will receive housing support and the individual meets the requirements in paragraph (a), (b), or (c).

(a) The individual is aged, blind, or is over 18 years of age with a disability as determined under the criteria used by the title II program of the Social Security Act, and meets the resource restrictions and standards of section 256P.02, and the individual's countable income after deducting the (1) exclusions and disregards of the SSI program, (2) the medical assistance personal needs allowance under section 256B.35, and (3) an amount equal to the income actually made available to a community spouse by an elderly waiver participant under the provisions of sections 256B.0575, paragraph (a), clause (4), and 256B.058, subdivision 2, is less than the monthly rate specified in the agency's agreement with the provider of housing support in which the individual resides.

(b) The individual meets a category of eligibility under section 256D.05, subdivision 1, paragraph (a), clauses (1), (3), (4) to (8), and (13), and paragraph (b), if applicable, and the individual's resources are less than the standards specified by section 256P.02, and the individual's countable income as determined under section 256P.06, less the medical assistance personal needs allowance under section 256B.35 is less than the monthly rate specified in the agency's agreement with the provider of housing support in which the individual resides.

(c) The individual ~~receives licensed residential crisis stabilization services under section 256B.0624, subdivision 7, and is receiving medical assistance. The individual may receive concurrent housing support payments if receiving licensed residential crisis stabilization services under section 256B.0624, subdivision 7.~~ lacks a fixed, adequate, nighttime residence upon discharge from a residential behavioral health treatment program, as determined by treatment staff from the residential behavioral health treatment program. An individual is eligible under this paragraph for up to three months, including a full or partial month from the individual's move-in date at a setting approved for housing support following discharge from treatment, plus two full months.

EFFECTIVE DATE. This section is effective September 1, 2019.

Sec. 26. Minnesota Statutes 2018, section 256I.04, subdivision 1, is amended to read:

Subdivision 1. **Individual eligibility requirements.** An individual is eligible for and entitled to a housing support payment to be made on the individual's behalf if the agency has approved the setting where the individual will receive housing support and the individual meets the requirements in paragraph (a), (b), or (c).

(a) The individual is aged, blind, or is over 18 years of age with a disability as determined under the criteria used by the title II program of the Social Security Act, and meets the resource restrictions and standards of section 256P.02, and the individual's countable income after deducting the (1) exclusions and disregards of the SSI program, (2) the medical assistance personal needs allowance under section 256B.35, and (3) an amount equal to the income actually made available to a community spouse by an elderly waiver participant under the provisions of sections 256B.0575, paragraph (a), clause (4), and 256B.058, subdivision 2, is less than the monthly rate specified in the agency's agreement with the provider of housing support in which the individual resides.

(b) The individual meets a category of eligibility under section 256D.05, subdivision 1, paragraph (a), clauses (1), (3), (4) to (8), and (13), and paragraph (b), if applicable, and the individual's resources are less than the standards specified by section 256P.02, and the individual's countable income as determined under section 256P.06, less the medical assistance personal needs allowance under section 256B.35 is less than the monthly rate specified in the agency's agreement with the provider of housing support in which the individual resides.

(c) The individual ~~receives licensed residential crisis stabilization services under section 256B.0624, subdivision 7, and is receiving medical assistance. The individual may receive concurrent housing support payments if receiving licensed residential crisis stabilization services under section 256B.0624, subdivision 7.~~ lacks a fixed, adequate, nighttime residence upon discharge from a residential behavioral health treatment program, as determined by treatment staff from the residential behavioral health treatment program. An individual is eligible under this paragraph for up to three months, including a full or partial month from the individual's move-in date at a setting approved for housing support following discharge from treatment, plus two full months.

EFFECTIVE DATE. This section is effective September 1, 2019.

Sec. 37. Minnesota Statutes 2018, section 256I.04, subdivision 2f, is amended to read:

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

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

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

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

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

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

EFFECTIVE DATE. This section is effective September 1, 2019.

Sec. 38. Minnesota Statutes 2018, section 256I.06, subdivision 8, is amended to read:

Subd. 8. **Amount of housing support payment.** (a) The amount of a room and board payment to be made on behalf of an eligible individual is determined by subtracting the individual's countable income under section 256I.04, subdivision 1, for a whole calendar month from the room and board rate for that same month. The housing support payment is determined by multiplying the housing support rate times the period of time the individual was a resident or temporarily absent under section 256I.05, subdivision 1c, paragraph (d).

(b) For an individual with earned income under paragraph (a), prospective budgeting must be used to determine the amount of the individual's payment for the following six-month period. An increase in income shall not affect an individual's eligibility or payment amount until the month following the reporting month. A decrease in income shall be effective the first day of the month after the month in which the decrease is reported.

(c) For an individual who receives ~~licensed residential crisis stabilization services under section 256B.0624, subdivision 7,~~ housing support payments under section 256I.04, subdivision 1, paragraph (c), the amount of the housing support payment is determined by multiplying the housing support rate times the period of time the individual was a resident.

EFFECTIVE DATE. This section is effective September 1, 2019.

Sec. 27. Minnesota Statutes 2018, section 256I.04, subdivision 2f, is amended to read:

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

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

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

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

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

(b) Providers serving participants described in subdivision 1, paragraph (c), shall assist participants in applying for continuing housing support payments before the end of the eligibility period.

EFFECTIVE DATE. This section is effective September 1, 2019.

Sec. 28. Minnesota Statutes 2018, section 256I.06, subdivision 8, is amended to read:

Subd. 8. **Amount of housing support payment.** (a) The amount of a room and board payment to be made on behalf of an eligible individual is determined by subtracting the individual's countable income under section 256I.04, subdivision 1, for a whole calendar month from the room and board rate for that same month. The housing support payment is determined by multiplying the housing support rate times the period of time the individual was a resident or temporarily absent under section 256I.05, subdivision 1c, paragraph (d).

(b) For an individual with earned income under paragraph (a), prospective budgeting must be used to determine the amount of the individual's payment for the following six-month period. An increase in income shall not affect an individual's eligibility or payment amount until the month following the reporting month. A decrease in income shall be effective the first day of the month after the month in which the decrease is reported.

(c) For an individual who receives ~~licensed residential crisis stabilization services under section 256B.0624, subdivision 7,~~ housing support payments under section 256I.04, subdivision 1, paragraph (c), the ~~amount of~~ housing support payment amount is determined by multiplying the housing support rate times the period of time the individual was a resident.

EFFECTIVE DATE. This section is effective September 1, 2019.

Sec. 29. Minnesota Statutes 2018, section 256K.45, subdivision 2, is amended to read:

Subd. 2. **Homeless youth report.** The commissioner shall prepare a biennial report, beginning in February 2015, which provides meaningful information to the legislative committees having jurisdiction over the issue of homeless youth, that includes, but is not limited to: (1) a list of the areas of the state with the greatest need for services and housing

for homeless youth, and the level and nature of the needs identified; (2) details about grants made, including shelter-linked youth mental health grants under section 256K.46; (3) the distribution of funds throughout the state based on population need; (4) follow-up information, if available, on the status of homeless youth and whether they have stable housing two years after services are provided; and (5) any other outcomes for populations served to determine the effectiveness of the programs and use of funding.

Sec. 30. **[256K.46] SHELTER-LINKED YOUTH MENTAL HEALTH GRANT PROGRAM.**

Subdivision 1. **Establishment and authority.** (a) The commissioner shall award grants to provide mental health services to homeless or sexually exploited youth. To be eligible, housing providers must partner with community-based mental health practitioners to provide a continuum of mental health services, including short-term crisis response, support for youth in longer-term housing settings, and ongoing relationships to support youth in other housing arrangements in the community for homeless or sexually exploited youth.

(b) The commissioner shall consult with the commissioner of management and budget to identify evidence-based mental health services for youth and give priority in awarding grants to proposals that include evidence-based mental health services for youth.

(c) The commissioner may make two-year grants under this section.

(d) Money appropriated for this section must be expended on activities described under subdivision 4, technical assistance, and capacity building to meet the greatest need on a statewide basis. The commissioner shall provide outreach, technical assistance, and program development support to increase capacity of new and existing service providers to better meet needs statewide, particularly in areas where shelter-linked youth mental health services have not been established, especially in greater Minnesota.

Subd. 2. **Definitions.** (a) The definitions in this subdivision apply to this section.

(b) "Commissioner" means the commissioner of human services, unless otherwise indicated.

(c) "Housing provider" means a shelter, housing program, or other entity providing services under the Homeless Youth Act in section 256K.45 and the Safe Harbor for Sexually Exploited Youth Act in section 145.4716.

(d) "Mental health practitioner" has the meaning given in section 245.462, subdivision 17.

(e) "Youth" has the meanings given for "homeless youth," "youth at risk for homelessness," and "runaway" in section 256K.45, subdivision 1a, "sexually exploited youth" in section 260C.007, subdivision 31, and "youth eligible for services" in section 145.4716, subdivision 3.

Subd. 3. **Eligibility.** An eligible applicant for shelter-linked youth mental health grants under subdivision 1 is a housing provider that:

(1) demonstrates that the provider received targeted trauma training focused on sexual exploitation and adolescent experiences of homelessness; and

(2) partners with a community-based mental health practitioner who has demonstrated experience or access to training regarding adolescent development and trauma-informed responses.

Subd. 4. **Allowable grant activities.** (a) Grant recipients may conduct the following activities with community-based mental health practitioners:

(1) develop programming to prepare youth to receive mental health services;

(2) provide on-site mental health services, including group skills and therapy sessions. Grant recipients are encouraged to use evidence-based mental health services;

(3) provide mental health case management, as defined in section 256B.0625, subdivision 20; and

(4) consult, train, and educate housing provider staff regarding mental health. Grant recipients are encouraged to provide staff with access to a mental health crisis line 24 hours a day, seven days a week.

(b) Only after promoting and assisting participants with obtaining health insurance coverage for which the participant is eligible, and only after mental health practitioners bill covered services to medical assistance or health plan companies, grant recipients may use grant funds to fill gaps in insurance coverage for mental health services.

(c) Grant funds may be used for purchasing equipment, connection charges, on-site coordination, set-up fees, and site fees to deliver shelter-linked youth mental health services defined in this subdivision via telemedicine consistent with section 256B.0625, subdivision 3b.

Subd. 5. **Reporting.** Grant recipients shall report annually on the use of shelter-linked youth mental health grants to the commissioner by December 31, beginning in 2020. Each report shall include the name and location of the grant recipient, the amount of each grant, the youth mental health services provided, and the number of youth receiving services. The commissioner shall determine the form required for the reports and may specify additional reporting requirements. The commissioner shall include the shelter-linked youth mental health services program in the biennial report required under section 256K.45, subdivision 2.

Sec. 39. Minnesota Statutes 2018, section 641.15, subdivision 3a, is amended to read:

Sec. 31. Minnesota Statutes 2018, section 641.15, subdivision 3a, is amended to read:

Subd. 3a. **Intake procedure; approved mental health screening.** (a) As part of its intake procedure for new ~~prisoners~~ inmates, the sheriff or local corrections shall use a mental

Subd. 3a. **Intake procedure; approved mental health screening; data sharing.** As part of its intake procedure for new prisoners, the sheriff or local corrections shall use a

health screening tool approved by the commissioner of corrections in consultation with the commissioner of human services and local corrections staff to identify persons who may have mental illness.

(b) Names of persons who have screened positive or may have a mental illness may be shared with the local county social services agency. The jail may refer an offender to county personnel of the welfare system, as defined in section 13.46, subdivision 1, paragraph (c), in order to arrange for services upon discharge and may share private data on the offender as necessary to:

(1) provide assistance in filling out an application for medical assistance or MinnesotaCare;

(2) make a referral for case management as provided under section 245.467, subdivision 4;

(3) provide assistance in obtaining a state photo identification;

(4) secure a timely appointment with a psychiatrist or other appropriate community mental health provider;

(5) provide prescriptions for a 30-day supply of all necessary medications; or

(6) coordinate behavioral health services.

(c) Notwithstanding section 138.17, if an offender is referred to a government entity within the welfare system pursuant to paragraph (b), and the offender refuses all services from the entity, the entity must, within 15 days of the refusal, destroy all private data on the offender that it created or received because of the referral.

Sec. 40. Laws 2017, First Special Session chapter 6, article 8, section 71, the effective date, is amended to read:

EFFECTIVE DATE. This section is effective for services provided on July 1, 2017, ~~through April 30, 2019, and expires May 1, 2019~~ and thereafter.

EFFECTIVE DATE. This section is effective April 30, 2019.

Sec. 41. Laws 2017, First Special Session chapter 6, article 8, section 72, the effective date, is amended to read:

EFFECTIVE DATE. This section is effective for services provided on July 1, 2017, ~~through April 30, 2019, and expires May 1, 2019~~ and thereafter.

mental health screening tool approved by the commissioner of corrections, in consultation with the commissioner of human services and local corrections staff, to identify persons who may have a mental illness. Notwithstanding section 13.85, the sheriff or local corrections may share the names of persons who have screened positive for or may have a mental illness with the local county social services agency. The sheriff or local corrections may refer a person to county personnel of the welfare system, as defined in section 13.46, subdivision 1, paragraph (c), in order to arrange for services upon discharge and may share private data on the individual as necessary to:

(1) provide assistance in filling out an application for medical assistance or MinnesotaCare;

(2) make a referral for case management as provided under section 245.467, subdivision 4;

(3) provide assistance in obtaining a state photo identification;

(4) secure a timely appointment with a psychiatrist or other appropriate community mental health provider;

(5) provide prescriptions for a 30-day supply of all necessary medications; or

(6) provide for behavioral health service coordination.

FOR UEH2414-1 ARTICLE 3, SECTIONS 32 AND 33 SEE LAWS 2019, CHAPTER 12

EFFECTIVE DATE. This section is effective April 30, 2019.

Sec. 34. **DIRECTION TO THE COMMISSIONER; SUBSTANCE USE DISORDER TREATMENT PROGRAM SYSTEMS IMPROVEMENT.**

The commissioner of human services, in consultation with counties, tribes, managed care organizations, substance use disorder treatment associations, and other relevant stakeholders, shall develop a plan, proposed timeline, and summary of necessary resources to make systems improvements to minimize the regulatory paperwork for substance use disorder programs licensed under Minnesota Statutes, chapter 245A, and regulated under Minnesota Statutes, chapters 245F and 245G, and Minnesota Rules, parts 2960.0580 to 2960.0700. The plan shall include procedures to ensure that continued input from all stakeholders is considered and that the planned systems improvements maximize client benefits and utility for providers, regulatory agencies, and payers.

Sec. 35. **DIRECTION TO THE COMMISSIONER OF HUMAN SERVICES; PERSON-CENTERED TELEPRESENCE PLATFORM EXPANSION.**

(a) By January 15, 2020, the commissioner of human services shall develop and provide to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services a proposal, including a timeline, a summary of necessary resources, and any necessary legislative changes, to adapt and expand statewide, a common, interoperable, person-centered telepresence platform for delivering behavioral health and other health care services.

(b) In developing the proposal, the commissioner shall consult with the commissioners of management and budget, MN.IT services, corrections, health, and education, and other relevant stakeholders including but not limited to county services agencies in the areas of human services, health, and corrections or law enforcement from counties outside the metropolitan area; public health representatives; behavioral health and primary care service providers, including providers from outside the metropolitan area; representatives of the Minnesota School Boards Association; representatives of the Minnesota Hospital Association, including rural hospital emergency departments; community mental health centers; adolescent treatment centers; child advocacy centers; and the domestic abuse perpetrator program.

(c) In developing the proposal, the commissioner shall:

(1) explore opportunities for improving behavioral health and other health care service delivery through the use of a common interoperable person-centered telepresence platform that provides connectivity and technical support to potential users;

(2) review and coordinate state and local innovation initiatives and investments designed to leverage telepresence connectivity and collaboration;

(3) identify necessary standards and capabilities for a common interoperable telepresence platform;

(4) identify barriers to providing telepresence technology, including limited availability of bandwidth, limitations in providing certain services via telepresence, and broadband infrastructure needs;

(5) make recommendations for governance to ensure the person-centered responsiveness of a common telepresence platform;

(6) develop incentives for ongoing innovation by service providers in Minnesota's health and human services systems;

(7) evaluate the use of vendors to provide a common telepresence platform that meets identified standards and capabilities;

(8) identify sustainable financial support for a common telepresence platform, including infrastructure costs and start-up costs for potential users; and

(9) identify the benefits to the state, political subdivisions, tribal governments, and constituents from using a common person-centered telepresence platform for delivering behavioral health services.

Sec. 37. **OFFICER-INVOLVED COMMUNITY-BASED CARE COORDINATION; PLANNING GRANTS.**

In fiscal year 2020, the commissioner shall award up to ten planning grants of up to $10,000 available to counties and tribes to establish new officer-involved community-based care coordination programs. An eligible applicant for a planning grant under this section is a county or tribe that does not have a fully functioning officer-involved community-based care coordination program and has not yet taken steps to implement an officer-involved community-based care coordination program. Planning grant recipients may use grant funds for the start-up costs of a new officer-involved community-based care coordination program, including data platform design, data collection, and quarterly reporting.

Sec. 38. **COMMUNITY COMPETENCY RESTORATION TASK FORCE.**

Subdivision 1. **Establishment; purpose.** The Community Competency Restoration Task Force is established to evaluate and study community competency restoration programs and develop recommendations to address the needs of individuals deemed incompetent to stand trial.

Subd. 2. **Membership.** (a) The Community Competency Restoration Task Force consists of the following members, appointed as follows:

(1) a representative appointed by the governor's office;

(2) the commissioner of human services or designee;

Sec. 42. **COMMUNITY COMPETENCY RESTORATION TASK FORCE.**

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Subd. 2. **Membership.** (a) The Community Competency Restoration Task Force consists of the following members, appointed as follows:

(1) a representative appointed by the governor's office;

(2) the commissioner of human services or designee;

(3) the commissioner of corrections or designee;

(4) a representative from direct care and treatment services with experience in competency evaluations, appointed by the commissioner of human services;

(5) a representative appointed by the designated State Protection and Advocacy system;

(6) the ombudsman for mental health and developmental disabilities;

(7) a representative appointed by the Minnesota Hospital Association;

(8) a representative appointed by the Association of Minnesota Counties;

(9) three representatives appointed by the Minnesota Association of County Social Service Administrators: one from the seven-county metropolitan area, as defined under Minnesota Statutes, section 473.121, subdivision 2, and two from outside the seven-county metropolitan area;

(10) a representative appointed by the Minnesota Board of Public Defense;

(11) two representatives appointed by the Minnesota County Attorneys Association;

(12) a representative appointed by the Minnesota Chiefs of Police Association;

(13) a representative appointed by the Minnesota Psychiatric Society;

(14) a representative appointed by the Minnesota Psychological Association;

(15) a representative appointed by the State Court Administrator;

(16) a representative appointed by the Minnesota Association of Community Mental Health Programs;

(17) a representative appointed by the Minnesota Sheriffs' Association;

(18) a representative appointed by the Minnesota Sentencing Guidelines Commission;

(19) a jail administrator appointed by the Minnesota Sheriffs' Association;

(20) a representative from an organization providing reentry services appointed by the commissioner of corrections;

(21) a representative from a mental health advocacy organization appointed by the commissioner of human services;

(22) a person with direct experience with competency restoration appointed by the commissioner of human services;

(23) representatives from organizations representing racial and ethnic groups overrepresented in the justice system appointed by the commissioner of corrections;

(3) the commissioner of corrections or designee;

(4) a representative from direct care and treatment services with experience in competency evaluations, appointed by the commissioner of human services;

(5) a representative appointed by the designated State Protection and Advocacy system;

(6) the ombudsman for mental health and developmental disabilities;

(7) a representative appointed by the Minnesota Hospital Association;

(8) a representative appointed by the Association of Minnesota Counties;

(9) two representatives appointed by the Minnesota Association of County Social Service Administrators: one from the seven-county metropolitan area, as defined under Minnesota Statutes, section 473.121, subdivision 2, and one from outside the seven-county metropolitan area;

(10) a representative appointed by the Board of Public Defense;

(11) a representative appointed by the Minnesota County Attorney Association;

(12) a representative appointed by the Chiefs of Police;

(13) a representative appointed by the Minnesota Psychiatric Society;

(14) a representative appointed by the Minnesota Psychological Association;

(15) a representative appointed by the State Court Administrator;

(16) a representative appointed by the Minnesota Association of Community Mental Health Programs;

(17) a representative appointed by the Minnesota Sheriff's Association;

(18) a representative appointed by the Sentencing Commission;

(19) a jail administrator appointed by the commissioner of corrections;

(20) a representative from an organization providing reentry services appointed by the commissioner of corrections;

(21) a representative from a mental health advocacy organization appointed by the commissioner of human services;

(22) a person with direct experience with competency restoration appointed by the commissioner of human services;

(23) representatives from organizations representing racial and ethnic groups overrepresented in the justice system appointed by the commissioner of corrections; and

(24) a representative appointed by the Minnesota Assistance Council for Veterans; and

(25) a crime victim appointed by the commissioner of corrections.

(b) Appointments to the task force must be made no later than July 15, 2019, and members of the task force may be compensated as provided under Minnesota Statutes, section 15.059, subdivision 3.

Subd. 3. **Duties.** The task force must:

(1) identify current services and resources available for individuals in the criminal justice system who have been found incompetent to stand trial;

(2) analyze current trends of competency referrals by county and the impact of any diversion projects or stepping-up initiatives;

(3) analyze selected case reviews and other data to identify risk levels of those individuals, service usage, housing status, and health insurance status prior to being jailed;

(4) research how other states address this issue, including funding and structure of community competency restoration programs, and jail-based programs; and

(5) develop recommendations to address the growing number of individuals deemed incompetent to stand trial including increasing prevention and diversion efforts, providing a timely process for reducing the amount of time individuals remain in the criminal justice system, determining how to provide and fund competency restoration services in the community, and defining the role of the counties and state in providing competency restoration.

Subd. 4. **Officers; meetings.** (a) The commissioner of human services shall convene the first meeting of the task force no later than August 1, 2019.

(b) The task force must elect a chair and vice-chair from among its members and may elect other officers as necessary.

(c) The task force is subject to the Minnesota Open Meeting Law under Minnesota Statutes, chapter 13D.

Subd. 5. **Staff.** (a) The commissioner of human services must provide staff assistance to support the task force's work.

(b) The task force may utilize the expertise of the Council of State Governments Justice Center.

Subd. 6. **Report required.** (a) By February 1, 2020, the task force shall submit a report on its progress and findings to the chairs and ranking minority members of the legislative committees with jurisdiction over mental health and corrections.

(b) By February 1, 2021, the task force must submit a written report including recommendations to address the growing number of individuals deemed incompetent to

(24) a crime victim appointed by the commissioner of corrections.

(b) Appointments to the task force must be made no later than July 15, 2019, and members of the task force may be compensated as provided under Minnesota Statutes, section 15.059, subdivision 3.

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(1) identify current services and resources available for individuals in the criminal justice system who have been found incompetent to stand trial;

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(3) analyze selected case reviews and other data to identify risk levels of those individuals, service usage, housing status, and health insurance status prior to being jailed;

(4) research how other states address this issue, including funding and structure of community competency restoration programs, and jail-based programs; and

(5) develop recommendations to address the growing number of individuals deemed incompetent to stand trial including increasing prevention and diversion efforts, providing a timely process for reducing the amount of time individuals remain in the criminal justice system, determining how to provide and fund competency restoration services in the community, and defining the role of the counties and state in providing competency restoration.

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(b) The task force may utilize the expertise of the Council of State Governments Justice Center.

Subd. 6. **Report required.** (a) By February 1, 2020, the task force shall submit a report on its progress and findings to the chairs and ranking minority members of the legislative committees with jurisdiction over mental health and corrections.

(b) By February 1, 2021, the task force must submit a written report including recommendations to address the growing number of individuals deemed incompetent to

stand trial to the chairs and ranking minority members of the legislative committees with jurisdiction over mental health and corrections.

Subd. 7. **Expiration.** The task force expires upon submission of the report in subdivision 6, paragraph (b), or February 1, 2021, whichever is later.

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

Sec. 43. **DIRECTION TO COMMISSIONER; IMPROVING SCHOOL-LINKED MENTAL HEALTH GRANT PROGRAM.**

(a) The commissioner of human services, in collaboration with the commissioner of education, representatives from the education community, mental health providers, and advocates, shall assess the school-linked mental health grant program under Minnesota Statutes, section 245.4901, and develop recommendations for improvements. The assessment must include but is not limited to the following:

(1) promoting stability among current grantees and school partners;

(2) assessing the minimum number of full-time equivalents needed per school site to effectively carry out the program;

(3) developing a funding formula that promotes sustainability and consistency across grant cycles;

(4) reviewing current data collection and evaluation; and

(5) analyzing the impact on outcomes when a school has a school-linked mental health program, a multi-tier system of supports, and sufficient school support personnel to meet the needs of students.

(b) The commissioner shall provide a report of the findings of the assessment and recommendations, including any necessary statutory changes, to the legislative committees with jurisdiction over mental health and education by January 15, 2020.

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

Sec. 44. **DIRECTION TO COMMISSIONER; CCBHC RATE METHODOLOGY.**

(a) The commissioner of human services shall develop recommendations for a rate methodology that reflects each CCBHC's reasonable cost of providing the services described in Minnesota Statutes, section 245.735, subdivision 3, consistent with applicable federal requirements. In developing the rate methodology, the commissioner shall consider guidance issued by the Centers for Medicare and Medicaid Services for the Section 223 Demonstration Program for CCBHC and costs associated with the following:

(1) a new CCBHC service that is not incorporated in the baseline prospective payment system rate, or a deletion of a CCBHC service that is incorporated in the baseline rate;

stand trial to the chairs and ranking minority members of the legislative committees with jurisdiction over mental health and corrections.

Subd. 7. **Expiration.** The task force expires upon submission of the report in subdivision 6, paragraph (b), or February 1, 2021, whichever is later.

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

Sec. 36. **DIRECTION TO THE COMMISSIONER OF HUMAN SERVICES; IMPROVING SCHOOL-LINKED MENTAL HEALTH GRANT PROGRAM.**

(a) The commissioner of human services, in collaboration with the commissioner of education, representatives from the education community, mental health providers, and advocates, shall assess the school-linked mental health grant program under Minnesota Statutes, section 245.4901, and develop recommendations for improvements. The assessment must include but is not limited to the following:

(1) promoting stability among current grantees and school partners;

(2) assessing the minimum number of full-time equivalents needed per school site to effectively carry out the program;

(3) developing a funding formula that promotes sustainability and consistency across grant cycles;

(4) reviewing current data collection and evaluation; and

(5) analyzing the impact on outcomes when a school has a school-linked mental health program, a multi-tier system of supports, and sufficient school support personnel to meet the needs of students.

(b) The commissioner shall provide a report of the findings of the assessment and recommendations, including any necessary statutory changes, to the legislative committees with jurisdiction over mental health and education by January 15, 2020.

(2) a change in service due to amended regulatory requirements or rules;

(3) a change in types of services due to a change in applicable technology and medical practice utilized by the clinic;

(4) a change in the scope of a project approved by the commissioner; and

(5) a Minnesota-specific quality incentive program for CCBHCs that achieve target performance on select quality measures. The commissioner shall develop the quality incentive program, in consultation with stakeholders, with the following requirements:

(i) the same terms of performance must apply to all CCBHCs;

(ii) quality payments must be in addition to the prospective payment rate and must not exceed an amount equal to five percent of total medical assistance payments for CCBHC services provided during the applicable time period; and

(iii) the quality measures must be consistent with measures used by the commissioner for other health care programs.

(b) By February 15, 2020, the commissioner of human services shall consult with CCBHC providers to develop the rate methodology under paragraph (a). The commissioner shall report to the chairs and ranking minority members of the legislative committees with jurisdiction over mental health services and medical assistance on the recommendations to the CCBHC rate methodology including any necessary statutory updates required for federal approval.

(c) The commissioner shall consult with CCBHCs and other providers receiving a prospective payment system rate to study a rate methodology that eliminates potential duplication of payment for CCBHC providers who also receive a separate prospective payment system rate. By February 15, 2021, the commissioner shall report to the chairs and ranking minority members of the legislative committees with jurisdiction over mental health services and medical assistance on findings and recommendations related to the rate methodology study under this paragraph, including any necessary statutory updates to implement recommendations.

Sec. 45. **DIRECTION TO COMMISSIONER; CONTINUUM OF CARE-BASED RATE METHODOLOGY.**

Subdivision 1. **Rate methodology.** (a) The commissioner of human services shall develop a comprehensive rate methodology for the consolidated chemical dependency treatment fund that reimburses substance use disorder treatment providers for the full continuum of care. The continuum of care-based rate methodology must replace the current rates with a uniform statewide methodology that accurately reflects provider expenses for providing required elements of substance use disorder outpatient and residential services.

(b) The continuum of care-based rate methodology must include:

(1) payment methodologies for substance use disorder treatment services provided under the consolidated chemical dependency treatment fund: (i) by a state-operated vendor and, if the criteria for patient placement is equivalent, by private vendors; or (ii) for persons who have been civilly committed to the commissioner, present the most complex and difficult care needs, and are a potential threat to the community;

(2) compensation to providers who provide culturally competent consultation resources; and

(3) cost-based reimbursement for substance use disorder providers that use sustainable business models that individualize care and retain individuals in ongoing care at the lowest medically appropriate level.

(c) The commissioner of human services may contract with a health care policy consultant or other entity to:

(1) provide stakeholder facilitation and provider outreach services to develop the continuum of care-based rate methodology; and

(2) provide technical services to develop the continuum of care-based rate methodology.

(d) The commissioner of human services must develop comprehensive substance use disorder billing guidance for the continuum of care-based rate methodology.

(e) In developing the continuum of care-based rate methodology, the commissioner of human services must consult with the following stakeholders:

(1) representatives of at least one provider operating residential treatment services, one provider operating out-patient treatment services, one provider operating an opioid treatment program, and one provider operating both residential and out-patient treatment services;

(2) representatives of providers who operate in the seven-county metropolitan area and providers who operate in greater Minnesota; and

(3) representatives of both for-profit and nonprofit providers.

Subd. 2. **Reports.** (a) By November 1, 2020, the commissioner of human services shall report to the legislature on any modifications to the licensure standards necessary to align provider qualifications with the continuum of care-based rate methodology.

(b) The commissioner of human services shall propose legislation for the 2021 legislative session necessary to fully implement the continuum of care-based rate methodology.

Sec. 39. **SPECIALIZED MENTAL HEALTH COMMUNITY SUPERVISION PILOT PROJECT.**

Subdivision 1. **Authorization.** The commissioner of human services shall award a grant to Anoka County to develop and implement a pilot project from July 1, 2019, to June 30,

2021, to evaluate the impact of a coordinated, multidisciplinary service delivery approach for offenders with mental illness who are on probation, parole, supervised release, or pretrial status in Anoka County.

Subd. 2. **Pilot project goals and design.** (a) The pilot project must provide enhanced assessment, case management, treatment services, and community supervision for offenders with mental illness who have symptoms or behavior resulting in heightened risk to harm themselves or others, to recidivate, to commit violations of supervision, or to face incarceration or reincarceration.

(b) The goals of the pilot project are to:

(1) improve mental health service delivery and supervision coordination through establishment of a multidisciplinary caseload management team that must include at least one probation officer and social services professional who share case management responsibilities;

(2) provide expedited assessment, diagnosis, and community-based treatment and programming for acute symptom and behavior management;

(3) enhance community supervision through a specialized caseload and team specifically trained to work with individuals with mental illness;

(4) offer community-based mental health treatment and programming alternatives to incarceration if available and appropriate;

(5) reduce incarceration related to unmanaged mental illness and technical violations;

(6) eliminate or reduce duplication of services between county social services and corrections; and

(7) improve collaboration among, and reduce barriers between, criminal justice system partners, county social services, and community service providers.

Subd. 3. **Target population.** The target population of the pilot project is:

(1) adult offenders on probation, parole, supervised release, or pretrial status in Anoka County who have been assessed with significant or unmanaged mental illness or acute symptoms that pose a risk to harm themselves or others, or increase their risk to recidivate or commit technical violations of supervision;

(2) adult offenders who receive county social service case management for mental illness while under correctional supervision in Anoka County; and

(3) adult offenders incarcerated in jail in Anoka County who have significant or unmanaged mental illness and may be safely treated in a community setting under correctional supervision.

Subd. 4. **Evaluation and report.** By October 1, 2021, Anoka County must report to the commissioner of human services on the impact and outcomes of the project.

Sec. 40. **REPEALER.**

(a) Minnesota Statutes 2018, section 254B.03, subdivision 4a, is repealed.

(b) Minnesota Rules, parts 9530.6800; and 9530.6810, are repealed.

Sec. 46. **REPEALER.**

Minnesota Statutes 2018, section 254B.03, subdivision 4a, is repealed.