Senate Language S2995-3

ARTICLE 9

BEHAVIORAL HEALTH

Section 1. **[245.0961] AFRICAN AMERICAN BEHAVIORAL HEALTH GRANT PROGRAM.**

Subdivision 1. **Establishment.** The commissioner of human services must establish an African American Behavioral Health grant program to offer culturally specific, comprehensive, trauma-informed, practice- and evidence-based, person- and family-centered mental health and substance use disorder treatment services.

Subd. 2. **Eligible applicants.** To be eligible for a grant under this section, applicants must be a nonprofit organization or a nongovernmental organization and must be a culturally specific mental health service provider that is a licensed community mental health center that specializes in services for African American children and families.

Subd. 3. **Application.** An organization seeking a grant under this section must apply to the commissioner at a time and in a manner specified by the commissioner.

Subd. 4. **Grant activities.** Grant money must be used to offer culturally specific, comprehensive, trauma-informed, practice- and evidence-based, person- and family-centered mental health and substance use disorder services. Grant money may also be used for supervision and training, and care coordination regardless of a client's ability to pay or place of residence.

Subd. 5. **Reporting.** (a) The grantee must submit a report to the commissioner in a manner and on a timeline specified by the commissioner. The report must include how many clients were served with the grant money and, if grant money was used for supervision and training, how many providers were supervised or trained using the grant money.

(b) The commissioner must submit a report to the chairs and ranking minority members of the legislative committees with jurisdiction over behavioral health no later than six months after receiving the report under paragraph (a). The report submitted by the commissioner must include the information specified in paragraph (a).

House Language UES2995-2

ARTICLE 7

BEHAVIORAL HEALTH

Section 1. Minnesota Statutes 2022, section 245.4663, subdivision 1, is amended to read:

Subdivision 1. **Grant program established.** The commissioner shall award grants to licensed or certified mental health providers that meet the criteria in subdivision 2 to fund supervision of or preceptorships for students, interns, and clinical trainees who are working toward becoming mental health professionals ~~and~~; to subsidize the costs of licensing applications and examination fees for clinical trainees; and to fund training for workers to become supervisors. For purposes of this section, an intern may include an individual who is working toward an undergraduate degree in the behavioral sciences or related field at an accredited educational institution.

UES2995-2 ARTICLE 7, SECTION 2 WAS REMOVED TO MATCH WITH S2995-3 ARTICLE 5, SECTION 14.

Sec. 2. Minnesota Statutes 2022, section 245.4889, subdivision 1, is amended to read:

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

(1) counties;

(2) Indian Tribes;

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

(4) mental health service providers.

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

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

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

(3) respite care services for children with emotional disturbances or severe emotional disturbances who are at risk of out-of-home placement or already in out-of-home placement in family foster settings as defined in chapter 245A and at risk of change in out-of-home placement or placement in a residential facility or other higher level of care. Allowable activities and expenses for respite care services are defined under subdivision 4. A child is not required to have case management services to receive respite care services;

(4) children's mental health crisis services;

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

(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 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;

(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~~, including start-up grants; and

(18) evidence-informed interventions for youth and young adults who are at risk of developing a mood disorder or are experiencing an emerging mood disorder, including major depression and bipolar disorders, and a public awareness campaign on the signs and symptoms of mood disorders in youth and young adults.

(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 July 1, 2023.

Sec. 3. Minnesota Statutes 2022, section 245.4901, subdivision 4, is amended to read:

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 behavioral health grant program, no more frequently than twice per year. Data provided by grantees shall include the number of clients served, client demographics, payment information, duration and frequency of services and client-related clinic ancillary services including hours of direct client services, and hours of ancillary direct and indirect support services. Qualitative data may also be collected to demonstrate impact from client and school personnel perspectives.

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Sec. 4. Minnesota Statutes 2022, section 245.4901, is amended by adding a subdivision to read:

Subd. 5. **Consultation; grant awards.** In administering the grant program, the commissioner shall consult with school districts that have not received grants under this section but that wish to collaborate with a community mental health provider. The commissioner shall also work with culturally specific providers to allow these providers to serve students from their community in multiple schools. When awarding grants, the commissioner shall consider the need to have consistency of providers over time among schools and students.

THE FOLLOWING SECTION IS FROM UES2995-2 ARTICLE 8.

Sec. 3. **[245.4903] CULTURAL AND ETHNIC MINORITY INFRASTRUCTURE GRANT PROGRAM.**

Subdivision 1. **Establishment.** The commissioner of human services must establish a cultural and ethnic minority infrastructure grant program to ensure that mental health and substance use disorder treatment supports and services are culturally specific and culturally responsive to meet the cultural needs of communities served.

Subd. 2. **Eligible applicants.** An eligible applicant is a licensed entity or provider from a cultural or ethnic minority population who:

(1) provides mental health or substance use disorder treatment services and supports to individuals from cultural and ethnic minority populations, including members of those populations who identify as lesbian, gay, bisexual, transgender, or queer;

(2) provides, or is qualified and has the capacity to provide, clinical supervision and support to members of culturally diverse and ethnic minority communities so they may become qualified mental health and substance use disorder treatment providers; or

(3) has the capacity and experience to provide training for mental health and substance use disorder treatment providers on cultural competency and cultural humility.

Subd. 3. **Allowable grant activities.** (a) Grantees must engage in activities and provide supportive services to ensure and increase equitable access to culturally specific and responsive care and build organizational and professional capacity for licensure and certification for the communities served. Allowable grant activities include but are not limited to:

(1) providing workforce development activities focused on recruiting, supporting, training, and supervising mental health and substance use disorder practitioners and professionals from diverse racial, cultural, and ethnic communities;

(2) helping members of racial and ethnic minority communities become qualified mental health and substance use disorder professionals, practitioners, clinical supervisors, recovery

Sec. 3. **[245.4903] CULTURAL AND ETHNIC MINORITY INFRASTRUCTURE GRANT PROGRAM.**

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Subd. 2. **Eligible applicants.** An eligible applicant is a licensed entity or provider from a cultural or ethnic minority population who:

(1) provides mental health or substance use disorder treatment services and supports to individuals from cultural and ethnic minority populations, including individuals who are lesbian, gay, bisexual, transgender, or queer and from cultural and ethnic minority populations;

(2) provides or is qualified and has the capacity to provide clinical supervision and support to members of culturally diverse and ethnic minority communities to qualify as mental health and substance use disorder treatment providers; or

(3) has the capacity and experience to provide training for mental health and substance use disorder treatment providers on cultural competency and cultural humility.

Subd. 3. **Allowable grant activities.** (a) The cultural and ethnic minority infrastructure grant program grantees must engage in activities and provide supportive services to ensure and increase equitable access to culturally specific and responsive care and to build organizational and professional capacity for licensure and certification for the communities served. Allowable grant activities include but are not limited to:

(1) workforce development activities focused on recruiting, supporting, training, and supervision activities for mental health and substance use disorder practitioners and professionals from diverse racial, cultural, and ethnic communities;

(2) supporting members of culturally diverse and ethnic minority communities to qualify as mental health and substance use disorder professionals, practitioners, clinical supervisors,

peer specialists, mental health certified peer specialists, and mental health certified family peer specialists;

(3) providing culturally specific outreach, early intervention, trauma-informed services, and recovery support in mental health and substance use disorder services;

(4) providing trauma-informed and culturally responsive mental health and substance use disorder supports and services to children and families, youth, or adults who are from cultural and ethnic minority backgrounds and are uninsured or underinsured;

(5) expanding mental health and substance use disorder services, particularly in greater Minnesota;

(6) training mental health and substance use disorder treatment providers on cultural competency and cultural humility; and

(7) providing activities that increase the availability of culturally responsive mental health and substance use disorder services for children and families, youth, or adults, or that increase the availability of substance use disorder services for individuals from cultural and ethnic minorities in the state.

(b) The commissioner must assist grantees with meeting third-party credentialing requirements, and grantees must obtain all available third-party reimbursement sources as a condition of receiving grant money. Grantees must serve individuals from cultural and ethnic minority communities regardless of health coverage status or ability to pay.

Subd. 4. **Program evaluation requirements.** (a) The commissioner must consult with the commissioner of management and budget on program outcomes, evaluation metrics, and progress indicators for the grant program under this section. The commissioner must only implement program outcomes, evaluation metrics, and progress indicators that are determined through and agreed upon during the consultation with the commissioner of management and budget or stated in paragraph (b). The commissioner shall not implement the grant program under this section until the consultation with the commissioner of management and budget is completed. The commissioner must incorporate agreed-upon program outcomes, evaluation metrics, and progress indicators into grant applications, requests for proposals, and any reports to the legislature.

(b) Grantees must provide regular data summaries to the commissioner for purposes of evaluating the effectiveness of the grant program. The commissioner must use identified

recovery peer specialists, mental health certified peer specialists, and mental health certified family peer specialists;

(3) culturally specific outreach, early intervention, trauma-informed services, and recovery support in mental health and substance use disorder services;

(4) provision of trauma-informed, culturally responsive mental health and substance use disorder supports and services for children and families, youth, or adults who are from cultural and ethnic minority backgrounds and are uninsured or underinsured;

(5) mental health and substance use disorder service expansion and infrastructure improvement activities, particularly in greater Minnesota;

(6) training for mental health and substance use disorder treatment providers on cultural competency and cultural humility;

(7) activities to increase the availability of culturally responsive mental health and substance use disorder services for children and families, youth, or adults or to increase the availability of substance use disorder services for individuals from cultural and ethnic minorities in the state;

(8) providing interpreter services at intensive residential treatment facilities, children's residential treatment centers, or psychiatric residential treatment facilities in order for children or adults with limited English proficiency or children or adults who are fluent in another language to be able to access treatment; and

(9) paying for case-specific consultation between a mental health professional and the appropriate diverse mental health professional in order to facilitate the provision of services that are culturally appropriate to a client's needs.

(b) The commissioner must assist grantees with meeting third-party credentialing requirements, and grantees must obtain all available third-party reimbursement sources as a condition of receiving grant funds. Grantees must serve individuals from cultural and ethnic minority communities regardless of health coverage status or ability to pay.

Subd. 4. **Data collection and outcomes.** Grantees must provide regular data summaries to the commissioner for purposes of evaluating the effectiveness of the cultural and ethnic minority infrastructure grant program. The commissioner must use identified culturally appropriate outcome measures instruments to evaluate outcomes and must evaluate program activities by analyzing whether the program:

culturally appropriate outcome measures to evaluate outcomes and must evaluate program activities by analyzing whether the program:

(1) increased access to culturally specific services for individuals from cultural and ethnic minority communities across the state;

(2) increased the number of individuals from cultural and ethnic minority communities served by grantees;

(3) increased the cultural responsiveness and cultural competency of mental health and substance use disorder treatment providers;

(4) increased the number of mental health and substance use disorder treatment providers and clinical supervisors from cultural and ethnic minority communities;

(5) increased the number of mental health and substance use disorder treatment organizations owned, managed, or led by individuals who are Black, Indigenous, or people of color;

(6) reduced health disparities through improved clinical and functional outcomes for those accessing services;

(7) led to an overall increase in culturally specific mental health and substance use disorder service availability; and

(8) led to changes indicated by other measures identified from consultation pursuant to paragraph (a).

Sec. 4. **[245.4904] EMERGING MOOD DISORDER GRANT PROGRAM.**

Subdivision 1. **Creation.** (a) The emerging mood disorder grant program is established in the Department of Human Services to fund:

(1) evidence-informed interventions for youth and young adults who are at risk of developing a mood disorder or are experiencing an emerging mood disorder, including major depression and bipolar disorders; and

(2) a public awareness campaign on the signs and symptoms of mood disorders in youth and young adults.

(b) Emerging mood disorder services are eligible for children's mental health grants as specified in section 245.4889, subdivision 1, paragraph (b), clause (18).

Subd. 2. **Activities.** (a) All emerging mood disorder grant program recipients must:

(1) provide intensive treatment and support to adolescents and young adults experiencing or at risk of experiencing an emerging mood disorder. Intensive treatment and support

(1) increased access to culturally specific services for individuals from cultural and ethnic minority communities across the state;

(2) increased the number of individuals from cultural and ethnic minority communities served by grantees;

(3) increased cultural responsiveness and cultural competency of mental health and substance use disorder treatment providers;

(4) increased the number of mental health and substance use disorder treatment providers and clinical supervisors from cultural and ethnic minority communities;

(5) increased the number of mental health and substance use disorder treatment organizations owned, managed, or led by individuals who are Black, Indigenous, or people of color;

(6) reduced health disparities through improved clinical and functional outcomes for those accessing services; and

(7) led to an overall increase in culturally specific mental health and substance use disorder service availability.

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

includes medication management, psychoeducation for the individual and the individual's family, case management, employment support, education support, cognitive behavioral approaches, social skills training, peer support, crisis planning, and stress management;

(2) conduct outreach and provide training and guidance to mental health and health care professionals, including postsecondary health clinicians, on early symptoms of mood disorders, screening tools, and best practices;

(3) ensure access for individuals to emerging mood disorder services under this section, including ensuring access for individuals who live in rural areas; and

(4) use all available funding streams.

(b) Grant money may also be used to pay for housing or travel expenses for individuals receiving services or to address other barriers preventing individuals and their families from participating in emerging mood disorder services.

(c) Grant money may be used by the grantee to evaluate the efficacy of providing intensive services and supports to people with emerging mood disorders.

Subd. 3. **Eligibility.** Program activities must be provided to youth and young adults with early signs of an emerging mood disorder.

Subd. 4. **Program evaluation requirements.** The commissioner must consult with the commissioner of management and budget on program outcomes, evaluation metrics, and progress indicators for the grant program under this section. The commissioner must only implement program outcomes, evaluation metrics, and progress indicators that are determined through and agreed upon during the consultation with the commissioner of management and budget. The commissioner shall not implement the grant program under this section until the consultation with the commissioner of management and budget is completed. The commissioner must incorporate agreed-upon program outcomes, evaluation metrics, and progress indicators into grant applications, requests for proposals, and any reports to the legislature.

EFFECTIVE DATE. This section is effective July 1, 2023.

Sec. 5. Minnesota Statutes 2022, section 245.735, subdivision 3, is amended to read:

Subd. 3. **Certified community behavioral health clinics.** (a) The commissioner ~~shall~~ must establish a state certification and recertification process for certified community behavioral health clinics (CCBHCs) that satisfy all federal requirements necessary for CCBHCs certified under this section to be eligible for reimbursement under medical assistance, without service area limits based on geographic area or region. The commissioner shall consult with CCBHC stakeholders before establishing and implementing changes in the certification or recertification process and requirements. Any changes to the certification or recertification process or requirements must be consistent with the most recently issued CCBHC criteria published by the Substance Abuse and Mental Health Services Administration (SAMHSA). The commissioner must allow a transition period for CCBHCs

to meet the revised SAMHSA criteria prior to July 1, 2024. The commissioner is authorized to amend Minnesota's Medicaid state plan or the terms of the demonstration to comply with federal requirements. Entities that choose to be CCBHCs must:

(1) comply with state licensing requirements and other requirements issued by the commissioner;

(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 meet the needs of the population the clinic serves;

(3) ensure that clinic services are available and accessible to 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 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 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 through existing mobile crisis services; screening, assessment, and diagnosis services, including risk assessments and level of care determinations; 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. CCBHCs must directly provide the majority of these services to enrollees, but may coordinate some services with another entity through a collaboration or agreement, pursuant to paragraph (b);

(7) provide coordination of care across settings and providers to ensure seamless transitions for 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 a mental health clinic under section 245I.20;

(9) comply with standards established by the commissioner relating to CCBHC screenings, assessments, and evaluations;

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

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

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

(13) be enrolled to provide mental health crisis response services under section 256B.0624;

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

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

(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 2, clause (8), as applicable when peer services are provided.

(b) As part of the state CCBHC certification and recertification process, the commissioner must provide to entities applying for certification or requesting recertification (1) the standard requirements of the community needs assessment, and (2) the staffing plan. The standard requirements and the staffing plan must be consistent with the most recently issued CCBHC criteria published by the SAMHSA.

(c) If a certified CCBHC is unable to provide one or more of the services listed in paragraph (a), clauses (6) to (17), the CCBHC may contract with another entity that has the required authority to provide that service and that meets the following criteria as a designated collaborating organization:

(1) the entity has a formal agreement with the CCBHC to furnish one or more of the services under paragraph (a), clause (6);

(2) the entity provides assurances that it will provide services according to CCBHC service standards and provider requirements;

(3) the entity agrees that the CCBHC is responsible for coordinating care and has clinical and financial responsibility for the services that the entity provides under the agreement; and

(4) the entity meets any additional requirements issued by the commissioner.

~~(c)~~ (d) 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 section 256B.0625, subdivision 5m, for those services without a county contract or county approval. 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)~~ (e) 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 for services reimbursed under medical assistance. 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)~~ (f) 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)~~ (g) 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 upon federal approval. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 6. Minnesota Statutes 2022, section 245.735, subdivision 6, is amended to read:

Subd. 6. **~~Demonstration~~ Section 223 Protecting Access to Medicare Act entities.** (a) The commissioner ~~may operate~~ must request federal approval to participate in the demonstration program established by section 223 of the Protecting Access to Medicare Act and, if approved, must continue to participate in the demonstration program for as long as federal funding for the demonstration program remains available from the United States Department of Health and Human Services. To the extent practicable, the commissioner shall align the requirements of the demonstration program with the requirements under this section for CCBHCs receiving medical assistance reimbursement under the authority of the state's Medicaid state plan. A CCBHC may not apply to participate as a billing provider in both the CCBHC federal demonstration and the benefit for CCBHCs under the medical assistance program.

(b) The commissioner must follow the payment guidance issued by the federal government, including the payment of the CCBHC daily bundled rate for 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 CCBHC daily bundled rate that overlaps with another federal Medicaid methodology is not eligible for the CCBHC rate. Services provided by a CCBHC operating under authority of the state's Medicaid state plan will not receive the prospective payment system rate for services rendered by CCBHCs to individuals who are dually eligible for Medicare and medical assistance when Medicare is the primary payer for the service. Payment for services rendered by CCBHCs to individuals who have commercial insurance as primary and medical assistance as secondary is subject to section 256B.37. Services provided by a CCBHC operating under authority of the 223 demonstration or the state's Medicaid state plan will not receive the prospective payment system rate for services rendered by CCBHCs to individuals who have commercial insurance as primary and medical assistance as secondary.

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

Sec. 7. Minnesota Statutes 2022, section 245.735, is amended by adding a subdivision to read:

Subd. 7. **Addition of CCBHCs to section 223 state demonstration programs.** (a) If the commissioner's request to reenter the demonstration program under subdivision 6 is approved, the commissioner must follow all federal guidance for the addition of CCBHCs to section 223 state demonstration programs.

UES2995-2 ARTICLE 7, SECTIONS 5 TO 18 WERE REMOVED TO MATCH WITH S2995-3 ARTICLE 8.

Sec. 19. Minnesota Statutes 2022, section 245.735, subdivision 6, is amended to read:

Subd. 6. **~~Demonstration~~ Section 223 of the Protecting Access to Medicare Act entities.** (a) The commissioner ~~may operate~~ must request federal approval to participate in the demonstration program established by section 223 of the Protecting Access to Medicare Act and, if approved, to continue to participate in the demonstration program as long as federal funding for the demonstration program remains available from the United States Department of Health and Human Services. To the extent practicable, the commissioner shall align the requirements of the demonstration program with the requirements under this section for CCBHCs receiving medical assistance reimbursement under the authority of the state's Medicaid state plan. A CCBHC may not apply to participate as a billing provider in both the CCBHC federal demonstration and the benefit for CCBHCs under the medical assistance program.

(b) The commissioner must follow federal payment guidance, including payment of the CCBHC daily bundled rate for 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 CCBHC daily bundled rate that overlaps with another federal Medicaid methodology is not eligible for the CCBHC rate. Services provided by a CCBHC operating under the authority of the state's Medicaid state plan will not receive the prospective payment system rate for services rendered by CCBHCs to individuals who are dually eligible for Medicare and medical assistance when Medicare is the primary payer for the service.

(c) Payment for services rendered by CCBHCs to individuals who have commercial insurance as the primary payer and medical assistance as secondary payer is subject to the requirements under section 256B.37. Services provided by a CCBHC operating under the authority of the 223 demonstration or the state's Medicaid state plan will not receive the prospective payment system rate for services rendered by CCBHCs to individuals who have commercial insurance as the primary payer and medical assistance as the secondary payer.

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

Sec. 20. Minnesota Statutes 2022, section 245.735, is amended by adding a subdivision to read:

Subd. 7. **Addition of CCBHCs to section 223 state demonstration programs.** (a) If the commissioner's request under subdivision 6 to reenter the demonstration program established by section 223 of the Protecting Access to Medicare Act is approved, upon reentry the commissioner must follow all federal guidance on the addition of CCBHCs to section 223 state demonstration programs.

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(b) Prior to participating in the demonstration, a clinic must meet the demonstration certification criteria and prospective payment system guidance in effect at that time and be certified as a CCBHC in Minnesota. The SAMHSA attestation process for the CCBHC expansion grants is not sufficient to constitute state certification. CCBHCs newly added to the demonstration must participate in all aspects of the state demonstration program, including but not limited to quality measurement and reporting, evaluation activities, and state CCBHC demonstration program requirements such as use of state-specified evidence-based practices. A newly added CCBHC must report on quality measures before its first full demonstration year if it joined the demonstration program in the 2023 calendar year out of alignment with the state's demonstration year cycle. A CCBHC may provide services in multiple locations and in community-based settings subject to federal rules of the 223 demonstration authority or Medicaid state plan authority. If a facility meets the definition of a satellite facility as defined by the SAMHSA n and was established after April 1, 2014, the facility cannot receive payment as a part of the demonstration program.

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

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(b) Prior to participating in the demonstration, a CCBHC must meet the demonstration certification criteria and prospective payment system guidance in effect at that time and be certified as a CCBHC by the state. The Substance Abuse and Mental Health Services Administration attestation process for CCBHC expansion grants is not sufficient to constitute state certification. CCBHCs newly added to the demonstration must participate in all aspects of the state demonstration program, including but not limited to quality measurement and reporting, evaluation activities, and state CCBHC demonstration program requirements, such as use of state-specified evidence-based practices. A newly added CCBHC must report on quality measures before its first full demonstration year if it joined the demonstration program in calendar year 2023 out of alignment with the state's demonstration year cycle. A CCBHC may provide services in multiple locations and in community-based settings subject to federal rules of the 223 demonstration authority or Medicaid state plan authority.

(c) If a CCBHC meets the definition of a satellite facility, as defined by the Substance Abuse and Mental Health Services Administration, and was established after April 1, 2014, the CCBHC cannot receive payment as a part of the demonstration program.

UES2995-2 ARTICLE 7, SECTION 21 WAS REMOVED TO MATCH WITH S2995-3 ARTICLE 8.

Sec. 22. Minnesota Statutes 2022, section 245I.04, subdivision 14, is amended to read:

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

(1) have a high school diploma or equivalent; ~~and~~

(2) have the training required under section 245I.05, subdivision 3, paragraph (c); and

~~(2)~~ (3) meet one of the following qualification requirements:

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

(ii) have an associate of arts degree;

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

(iv) be a registered nurse;

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

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

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

(b) A mental health rehabilitation worker who is exclusively scheduled as an overnight staff person ~~and works alone~~ is exempt from the additional qualification requirements in paragraph (a), clause ~~(2)~~ (3).

Sec. 23. Minnesota Statutes 2022, section 245I.04, subdivision 16, is amended to read:

Subd. 16. **Mental health behavioral aide qualifications.** (a) A level 1 mental health behavioral aide must have the training required under section 245I.05, subdivision 3, paragraph (c), and: (1) a high school diploma or equivalent; or (2) two years of experience as a primary caregiver to a child with mental illness within the previous ten years.

(b) A level 2 mental health behavioral aide must~~: (1)~~ have the training required under section 245I.05, subdivision 3, paragraph (c), and an associate or bachelor's degree~~; or (2) be certified by a program under section 256B.0943, subdivision 8a~~.

Sec. 24. Minnesota Statutes 2022, section 245I.05, subdivision 3, is amended to read:

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

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

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

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

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

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

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

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

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

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

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

(1) mental illnesses;

(2) client recovery and resiliency;

(3) mental health de-escalation techniques;

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

(5) psychotropic medications and medication side effects.

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

(1) trauma-informed care and secondary trauma;

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

(3) co-occurring substance use disorders; and

(4) culturally responsive treatment practices.

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

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

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

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

(4) culturally responsive treatment practices; and

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

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

Sec. 25. Minnesota Statutes 2022, section 245I.08, subdivision 2, is amended to read:

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

(1) is legible;

(2) identifies the applicable client name on each page of the client file and staff person name on each page of the personnel file; and

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

Sec. 26. Minnesota Statutes 2022, section 245I.08, subdivision 3, is amended to read:

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

Sec. 27. Minnesota Statutes 2022, section 245I.08, subdivision 4, is amended to read:

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

(1) the type of service;

(2) the date of service;

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

(4) the location of the service;

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

(6) the signature and credentials of the staff person who provided the service to the client;

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

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

Sec. 28. Minnesota Statutes 2022, section 245I.10, subdivision 2, is amended to read:

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

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

(1) an explanation of findings;

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

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

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

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

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

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

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

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

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

(1) any combination of psychotherapy sessions, group psychotherapy sessions, family psychotherapy sessions, and family psychoeducation sessions not to exceed ten sessions

within a 12-month period without prior authorization for any new client or for an existing client who the license holder projects will need fewer than ten sessions during the next 12 months; and

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

(f) A license holder must complete a new standard diagnostic assessment of a client or an update to an assessment as permitted under paragraph (g):

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

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

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

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

(5) upon the client's request.

(g) For ~~an existing~~ a client who is already engaged in services and has a prior assessment, the license holder must ~~ensure that a new standard diagnostic assessment includes~~ complete a written update containing all significant new or changed information about the client, removal of outdated or inaccurate information, and an update regarding what information has not significantly changed, including a discussion with the client about changes in the client's life situation, functioning, presenting problems, and progress with achieving treatment goals since the client's last diagnostic assessment was completed.

Sec. 29. Minnesota Statutes 2022, section 245I.10, subdivision 3, is amended to read:

Subd. 3. **Continuity of services.** (a) For any client with a diagnostic assessment completed under Minnesota Rules, parts 9505.0370 to 9505.0372, before July 1, 2022, or upon federal approval, whichever is later, the diagnostic assessment is valid for authorizing the client's treatment and billing for one calendar year after the date that the assessment was completed.

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

(c) This subdivision expires ~~July 1~~ October 17, 2023.

Sec. 30. Minnesota Statutes 2022, section 245I.10, subdivision 5, is amended to read:

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

(b) When conducting a brief diagnostic assessment of a client, the assessor must complete a face-to-face interview with the client and a written evaluation of the client. The assessor must gather and document initial components of the client's standard diagnostic assessment, including the client's:

(1) age;

(2) description of symptoms, including the reason for the client's referral;

(3) history of mental health treatment;

(4) cultural influences on the client; and

(5) mental status examination.

(c) Based on the initial components of the assessment, the assessor must develop a provisional diagnostic formulation about the client. The assessor may use the client's provisional diagnostic formulation to address the client's immediate needs and presenting problems.

(d) A mental health professional or clinical trainee may use treatment sessions with the client authorized by a brief diagnostic assessment to gather additional information about the client to complete the client's standard diagnostic assessment if the number of sessions will exceed the coverage limits in subdivision 2.

Sec. 31. Minnesota Statutes 2022, section 245I.10, subdivision 6, is amended to read:

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

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

(1) the client's age;

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

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

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

(5) the client's current medications;

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

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

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

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

(10) cultural influences on the client.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(1) the client's mental status examination;

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

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

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

(g) Information from other providers and prior assessments may be used to complete the diagnostic assessment if the source of the information is documented in the diagnostic assessment.

Sec. 32. Minnesota Statutes 2022, section 245I.10, subdivision 7, is amended to read:

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

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

(2) when developing a treatment or service plan; and

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

Sec. 33. Minnesota Statutes 2022, section 245I.10, subdivision 8, is amended to read:

Subd. 8. **Individual treatment plan; required elements.** (a) After completing a client's diagnostic assessment or reviewing a client's diagnostic assessment received from a different provider and before providing services to the client beyond those permitted under subdivision 7, the license holder must complete the client's individual treatment plan. The license holder must:

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

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

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

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

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

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

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

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

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

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

the license holder could not obtain the client's approval of the client's individual treatment plan. A license holder may continue to bill for the client's otherwise eligible services when the client re-engages in services.

Sec. 34. Minnesota Statutes 2022, section 245I.11, subdivision 3, is amended to read:

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

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

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

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

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

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

(6) follow a documentation procedure ~~on each shift~~ to account for all ~~scheduled~~ Schedule II to V drugs listed in section 152.02, subdivisions 3 to 6; and

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

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

Sec. 35. Minnesota Statutes 2022, section 245I.11, subdivision 4, is amended to read:

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

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

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

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

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

~~(5)~~ (4) maintain the client's right to privacy and dignity.

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

Sec. 36. Minnesota Statutes 2022, section 245I.20, subdivision 5, is amended to read:

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

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

Sec. 37. Minnesota Statutes 2022, section 245I.20, subdivision 6, is amended to read:

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

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

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

(1) outline the client intake process;

Sec. 8. Minnesota Statutes 2022, section 254B.02, subdivision 5, is amended to read:

Subd. 5. ~~**Administrative adjustment**~~ **Local agency allocation.** The commissioner may make payments to local agencies from money allocated under this section to support ~~administrative activities under sections 254B.03 and 254B.04~~ individuals with substance use disorders. The ~~administrative~~ payment must not ~~exceed the lesser of: (1) five percent of the first $50,000, four percent of the next $50,000, and three percent of the remaining payments for services from the special revenue account according to subdivision 1; or (2)~~ be less than 133 percent of the local agency ~~administrative~~ payment for the fiscal year ending June 30, 2009, adjusted in proportion to the statewide change in the appropriation for this chapter.

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

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

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

(d) Notwithstanding the requirements under section 245I.10, subdivisions 5 to 9, for the required elements of a diagnostic assessment and a treatment plan, psychiatry billed as evaluation and management services must be documented in accordance with the most recent current procedural terminology as published by the American Medical Association.

Sec. 38. Minnesota Statutes 2022, section 254B.02, subdivision 5, is amended to read:

Subd. 5. ~~**Administrative adjustment**~~ **Local agency allocation.** The commissioner may make payments to local agencies from money allocated under this section to support ~~administrative activities under sections 254B.03 and 254B.04~~ individuals with substance use disorders. The ~~administrative~~ payment must not ~~exceed the lesser of: (1) five percent of the first $50,000, four percent of the next $50,000, and three percent of the remaining payments for services from the special revenue account according to subdivision 1; or (2)~~ be less than 133 percent of the local agency ~~administrative~~ payment for the fiscal year ending June 30, 2009, adjusted in proportion to the statewide change in the appropriation for this chapter.

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

Sec. 39. Minnesota Statutes 2022, section 254B.05, subdivision 1, is amended to read:

Subdivision 1. **Licensure required.** (a) Programs licensed by the commissioner are eligible vendors. Hospitals may apply for and receive licenses to be eligible vendors, notwithstanding the provisions of section 245A.03. American Indian programs that provide substance use disorder treatment, extended care, transitional residence, or outpatient treatment services, and are licensed by tribal government are eligible vendors.

(b) A licensed professional in private practice as defined in section 245G.01, subdivision 17, who meets the requirements of section 245G.11, subdivisions 1 and 4, is an eligible vendor of a comprehensive assessment and assessment summary provided according to section 245G.05, and treatment services provided according to sections 245G.06 and 245G.07, subdivision 1, paragraphs (a), clauses (1) to (5), and (b); and subdivision 2, clauses (1) to (6).

(c) A county is an eligible vendor for a comprehensive assessment and assessment summary when provided by an individual who meets the staffing credentials of section 245G.11, subdivisions 1 and 5, and completed according to the requirements of section 245G.05. A county is an eligible vendor of care coordination services when provided by an individual who meets the staffing credentials of section 245G.11, subdivisions 1 and 7, and

provided according to the requirements of section 245G.07, subdivision 1, paragraph (a), clause (5).

(d) A recovery community organization that meets certification requirements identified by the commissioner is an eligible vendor of peer support services.

(e) Detoxification programs licensed under Minnesota Rules, parts 9530.6510 to 9530.6590, are not eligible vendors. Programs that are not licensed as a residential or nonresidential substance use disorder treatment or withdrawal management program by the commissioner or by tribal government or do not meet the requirements of subdivisions 1a and 1b are not eligible vendors.

(f) Hospitals, federally qualified health centers, and rural health clinics are eligible vendors of a comprehensive assessment when the comprehensive assessment is completed according to section 245G.05 and by an individual who meets the criteria of an alcohol and drug counselor according to section 245G.11, subdivision 5. The alcohol and drug counselor must be individually enrolled with the commissioner and reported on the claim as the individual who provided the service.

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

Sec. 40. Minnesota Statutes 2022, 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 behavioral health 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) Programs providing children's mental health crisis admissions and stabilization under section 245.4882, subdivision 6, are eligible vendors of room and board.

(d) Programs providing children's residential services under section 245.4882, except services for individuals who have a placement under chapter 260C or 260D, are eligible vendors of room and board.

~~(d)~~ (e) 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 July 1, 2023.

Sec. 41. Minnesota Statutes 2022, section 256.478, subdivision 1, is amended to read:

Subdivision 1. **Purpose.** (a) The commissioner shall establish the transition to community initiative to award grants to serve ~~individuals~~ children and adults for whom supports and services not covered by medical assistance would allow them to:

(1) live in the least restrictive setting and as independently as possible;

(2) access services that support short- and long-term needs for developmental growth or individualized treatment needs;

~~(2)~~ (3) build or maintain relationships with family and friends; and

~~(3)~~ (4) participate in community life.

(b) Grantees must ensure that ~~individuals~~ the individual or the child and family are engaged in a process that involves person-centered planning and informed choice decision-making. The informed choice decision-making process must provide accessible written information and be experiential whenever possible.

Sec. 42. Minnesota Statutes 2022, section 256.478, subdivision 2, is amended to read:

Subd. 2. **Eligibility.** ~~An individual~~ A child or adult is eligible for the transition to community initiative if the~~ individual does not meet eligibility criteria for the medical assistance program under section 256B.056 or 256B.057, but who~~ child or adult can demonstrate that current services are not capable of meeting individual treatment and service needs that can be met in the community with support, and the child or adult meets at least one of the following criteria:

(1) the person otherwise meets the criteria under section 256B.092, subdivision 13, or 256B.49, subdivision 24;

(2) the person has met treatment objectives and no longer requires a hospital-level care or a secure treatment setting, but the person's discharge from the Anoka Metro Regional Treatment Center, the Minnesota ~~Security Hospital~~ Forensic Mental Health Program, the Child and Adolescent Behavioral Health Hospital program, a psychiatric residential treatment facility under section 256B.0941, intensive residential treatment services under section 256B.0622, children's residential services under section 245.4882, juvenile detention facility, county supervised building, or a ~~community behavioral health~~ hospital would be substantially delayed without additional resources available through the transitions to community initiative;

~~(3) the person is in a community hospital, but alternative community living options would be appropriate for the person, and the person has received approval from the commissioner; or~~

~~(4)(i)~~ (3) the person (i) is receiving customized living services reimbursed under section 256B.4914, 24-hour customized living services reimbursed under section 256B.4914, or community residential services reimbursed under section 256B.4914; (ii) ~~the person~~ expresses a desire to move; and (iii) ~~the person~~ has received approval from the commissioner~~.~~; or

(4) the person can demonstrate that the person's needs are beyond the scope of current service designs and grant funding can support the inclusion of additional supports for the person to access appropriate treatment and services in the least restrictive environment.

EFFECTIVE DATE. This section is effective July 1, 2023.

Sec. 43. Minnesota Statutes 2022, section 256B.0616, subdivision 3, is amended to read:

Subd. 3. **Eligibility.** Family peer support services ~~may~~ shall be provided to recipients ~~of inpatient hospitalization, partial hospitalization, residential treatment, children's intensive behavioral health services, day treatment, children's therapeutic services and supports, or crisis services~~ eligible under medical assistance, upon a determination by a licensed mental health provider.

EFFECTIVE DATE. This section is effective January 1, 2024, or upon federal approval, whichever is later.

Sec. 44. Minnesota Statutes 2022, section 256B.0616, subdivision 4, is amended to read:

Subd. 4. **Peer support specialist program providers.** The commissioner shall develop a process to certify family and youth peer support specialist programs and associated training support, in accordance with the federal guidelines~~,~~ in order for the program to bill for reimbursable services. Family and youth peer support programs must operate within an existing mental health community provider or center.

Sec. 45. Minnesota Statutes 2022, section 256B.0616, subdivision 5, is amended to read:

Subd. 5. **Certified family and youth peer specialist training and certification.** The commissioner shall develop ~~a~~ or approve the use of an existing training and certification process for certified family and youth peer specialists. ~~The~~ Family peer candidates must have raised or be currently raising a child with a mental illness, have had experience navigating the children's mental health system, and ~~must~~ demonstrate leadership and advocacy skills and a strong dedication to family-driven and family-focused services. Youth peer candidates must have demonstrated lived experience in children's mental health or related adverse experiences in adolescence, a high school degree, and leadership and advocacy skills with a focus on supporting client voice. The training curriculum must teach participating family and youth peer specialists specific skills relevant to providing peer support to other parents or to youth in mental health treatment. In addition to initial training and certification, the commissioner shall develop ongoing continuing educational workshops on pertinent issues related to family and youth peer support counseling. Training for family and youth peer support specialists may be delivered by the commissioner or by organizations approved by the commissioner.

EFFECTIVE DATE. This section is effective January 1, 2024, or upon federal approval, whichever is later.

Sec. 46. Minnesota Statutes 2022, section 256B.0622, subdivision 7a, is amended to read:

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

(1) the team leader:

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

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

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

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

(2) the psychiatric care provider:

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

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

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

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

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

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

(3) the nursing staff:

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

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

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

(4) the co-occurring disorder specialist:

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

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

(5) the vocational specialist:

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

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

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

(6) the mental health certified peer specialist:

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

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

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

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

(8) additional staff:

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

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

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

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

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

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

Sec. 47. Minnesota Statutes 2022, section 256B.0622, subdivision 7b, is amended to read:

Subd. 7b. **Assertive community treatment program size and opportunities.** (a) Each ACT team shall maintain an annual average caseload that does not exceed 100 clients. Staff-to-client ratios shall be based on team size as follows:

(1) a small ACT team must:

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

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

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

(iv) schedule ACT team staff ~~for at least eight-hour shift coverage~~ on weekdays and on-call duty to provide crisis services and deliver services after hours when staff are not working;

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

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

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

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

(2) a midsize ACT team shall:

(i) be composed of, at minimum, one full-time team leader, at least 16 hours of psychiatry time for 51 clients, with an additional two hours for every six clients added to the team, 1.5 to two full-time equivalent nursing staff, one full-time co-occurring disorder specialist, one full-time equivalent mental health certified peer specialist, one full-time vocational specialist, one full-time program assistant, and at least 1.5 to two additional full-time equivalent ACT members, with at least one dedicated full-time staff member with mental health professional status. Remaining team members may have mental health professional, certified rehabilitation specialist, clinical trainee, or mental health practitioner status;

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

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

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

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

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

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

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

(3) a large ACT team must:

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

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

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

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

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

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

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

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

Sec. 48. Minnesota Statutes 2022, section 256B.0622, subdivision 7c, is amended to read:

Subd. 7c. **Assertive community treatment program organization and communication requirements.** (a) An ACT team shall provide at least 75 percent of all services in the community in non-office-based or non-facility-based settings.

(b) ACT team members must know all clients receiving services, and interventions must be carried out with consistency and follow empirically supported practice.

(c) Each ACT team client shall be assigned an individual treatment team that is determined by a variety of factors, including team members' expertise and skills, rapport, and other factors specific to the individual's preferences. The majority of clients shall see at least three ACT team members in a given month.

(d) The ACT team shall have the capacity to rapidly increase service intensity to a client when the client's status requires it, regardless of geography, and provide flexible service in an individualized manner~~, and see clients on average three times per week for at least 120 minutes per week~~ at a frequency that meets the client's needs. Services must be available at times that meet client needs.

(e) ACT teams shall make deliberate efforts to assertively engage clients in services. Input of family members, natural supports, and previous and subsequent treatment providers is required in developing engagement strategies. ACT teams shall include the client, identified family, and other support persons in the admission, initial assessment, and planning process as primary stakeholders, meet with the client in the client's environment at times of the day and week that honor the client's preferences, and meet clients at home and in jails or prisons, streets, homeless shelters, or hospitals.

(f) ACT teams shall ensure that a process is in place for identifying individuals in need of more or less assertive engagement. Interventions are monitored to determine the success of these techniques and the need to adapt the techniques or approach accordingly.

(g) ACT teams shall conduct daily team meetings to systematically update clinically relevant information, briefly discuss the status of assertive community treatment clients over the past 24 hours, problem solve emerging issues, plan approaches to address and

prevent crises, and plan the service contacts for the following 24-hour period or weekend. All team members scheduled to work shall attend this meeting.

(h) ACT teams shall maintain a clinical log that succinctly documents important clinical information and develop a daily team schedule for the day's contacts based on a central file of the clients' weekly or monthly schedules, which are derived from interventions specified within the individual treatment plan. The team leader must have a record to ensure that all assigned contacts are completed.

Sec. 49. Minnesota Statutes 2022, section 256B.0622, subdivision 8, is amended to read:

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

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

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

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

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

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

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

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

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

(vi) for assertive community treatment, intensive residential treatment services, and residential crisis services, providers may include in their prospective cost-based rate-setting methodology a line item reflecting estimated additional staffing compensation costs. Estimated additional staffing compensation costs are subject to review by the commissioner; and

(vii) for intensive residential treatment services and residential crisis services, providers may include in their prospective cost-based rate-setting methodology a line item reflecting estimated new capital costs. Estimated new capital costs are subject to review by the commissioner;

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

(3) the number of service units;

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

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

(d) The rate for intensive residential treatment services and assertive community treatment must exclude room and board, as defined in section 256I.03, subdivision 6, and services not covered under this section, such as partial hospitalization, home care, and inpatient services.

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

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

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

(h) The rates for existing programs must be established prospectively based upon the expenditures and utilization over a prior 12-month period using the criteria established in paragraph (c). The rates for new programs must be established based upon estimated expenditures and estimated utilization using the criteria established in paragraph (c).

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

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

Sec. 50. Minnesota Statutes 2022, section 256B.0623, subdivision 4, is amended to read:

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

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

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

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

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

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

(1) have capacity to recruit, hire, manage, and train qualified staff;

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

(3) ensure that staff are skilled in the delivery of the specific adult rehabilitative mental health services provided to the individual eligible recipient;

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

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

(6) ensure that services are coordinated with other recipient mental health services providers and the county mental health authority and the federally recognized American Indian authority and necessary others after obtaining the consent of the recipient. Services must also be coordinated with the recipient's case manager or care coordinator if the recipient is receiving case management or care coordination services;

(7) keep all necessary records required by law;

(8) deliver services as required by section 245.461;

(9) be an enrolled Medicaid provider; and

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

Sec. 51. Minnesota Statutes 2022, section 256B.0624, subdivision 5, is amended to read:

Subd. 5. **Crisis assessment and intervention staff qualifications.** (a) Qualified individual staff of a qualified provider entity must provide crisis assessment and intervention services to a recipient. A staff member providing crisis assessment and intervention services to a recipient must be qualified as a:

(1) mental health professional;

(2) clinical trainee;

(3) mental health practitioner;

(4) mental health certified family peer specialist; or

(5) mental health certified peer specialist.

(b) When crisis assessment and intervention services are provided to a recipient in the community, a mental health professional, clinical trainee, or mental health practitioner must lead the response.

(c) The 30 hours of ongoing training required by section 245I.05, subdivision 4, paragraph (b), must be specific to providing crisis services to children and adults and include training about evidence-based practices identified by the commissioner of health to reduce the recipient's risk of suicide and self-injurious behavior.

(d) At least six hours of the ongoing training under paragraph (c) must be specific to working with families and providing crisis stabilization services to children and include the following topics:

(1) developmental tasks of childhood and adolescence;

(2) family relationships;

(3) child and youth engagement and motivation, including motivational interviewing;

(4) culturally responsive care, including care for lesbian, gay, bisexual, transgender, and queer youth;

(5) positive behavior support;

(6) crisis intervention for youth with developmental disabilities;

(7) child traumatic stress, trauma-informed care, and trauma-focused cognitive behavioral therapy; and

(8) youth substance use.

~~(d)~~ (e) Team members must be experienced in crisis assessment, crisis intervention techniques, treatment engagement strategies, working with families, and clinical decision-making under emergency conditions and have knowledge of local services and resources.

Sec. 52. Minnesota Statutes 2022, section 256B.0624, subdivision 8, is amended to read:

Subd. 8. **Crisis stabilization staff qualifications.** (a) Mental health crisis stabilization services must be provided by qualified individual staff of a qualified provider entity. A staff member providing crisis stabilization services to a recipient must be qualified as a:

(1) mental health professional;

(2) certified rehabilitation specialist;

(3) clinical trainee;

(4) mental health practitioner;

(5) mental health certified family peer specialist;

(6) mental health certified peer specialist; or

(7) mental health rehabilitation worker.

(b) The 30 hours of ongoing training required in section 245I.05, subdivision 4, paragraph (b), must be specific to providing crisis services to children and adults and include training about evidence-based practices identified by the commissioner of health to reduce a recipient's risk of suicide and self-injurious behavior.

(c) For providers who deliver care to children 21 years of age and younger, at least six hours of the ongoing training under this subdivision must be specific to working with families and providing crisis stabilization services to children and include the following topics:

(1) developmental tasks of childhood and adolescence;

(2) family relationships;

(3) child and youth engagement and motivation, including motivational interviewing;

(4) culturally responsive care, including care for lesbian, gay, bisexual, transgender, and queer youth;

(5) positive behavior support;

(6) crisis intervention for youth with developmental disabilities;

(7) child traumatic stress, trauma-informed care, and trauma-focused cognitive behavioral therapy; and

(8) youth substance use.

This paragraph does not apply to adult residential crisis stabilization service providers licensed according to section 245I.23.

Sec. 53. Minnesota Statutes 2022, section 256B.0625, subdivision 5m, is amended to read:

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

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

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

(1) the CCBHC daily bundled rate shall be a provider-specific rate calculated for each CCBHC, based on the daily cost of providing CCBHC services and the total annual allowable CCBHC costs divided by the total annual number of CCBHC visits. For calculating the payment rate, total annual visits include visits covered by medical assistance and visits not covered by medical assistance. Allowable costs include but are not limited to the salaries and benefits of medical assistance providers; the cost of CCBHC services provided under section 245.735, subdivision 3, paragraph (a), clauses (6) and (7); and other costs such as insurance or supplies needed to provide CCBHC services;

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

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

(4) the commissioner shall rebase CCBHC rates once every ~~three~~ two years following the last rebasing and no less than 12 months following an initial rate or a rate change due to a change in the scope of services;

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

(6) ~~the CCBHC daily bundled 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 CCBHC daily bundled rate system that overlaps with the CCBHC rate is not eligible for the CCBHC rate~~ if the commissioner has not reentered the CCBHC demonstration program by July 1, 2023, CCBHCs shall be paid the daily bundled rate under this section for services rendered to individuals who are duly eligible for Medicare and medical assistance;

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

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

(9) a CCBHC may request a rate adjustment for changes in the CCBHC's scope of services when such changes are expected to result in an adjustment to the CCBHC payment rate by 2.5 percent or more. The CCBHC must provide the commissioner with information regarding the changes in the scope of services, including the estimated cost of providing the new or modified services and any projected increase or decrease in the number of visits

resulting from the change. Estimated costs are subject to review by the commissioner. Rate adjustments for changes in scope shall occur no more than once per year in between rebasing periods per CCBHC and are effective on the date of the annual CCBHC rate update.

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

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

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

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

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

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

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

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

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

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

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

EFFECTIVE DATE. This section is effective July 1, 2023, or upon federal approval, whichever is later. The commissioner of human services shall inform the revisor of statutes when federal approval is obtained.

Sec. 54. Minnesota Statutes 2022, section 256B.0757, subdivision 4c, is amended to read:

Subd. 4c. **Behavioral health home services 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~~ licensed nurse ~~licensed under the Minnesota Nurse Practice Act, sections 148.171 to 148.285~~, as defined in section 148.171, subdivision 9.

(c) If behavioral health home services are offered in a primary care setting, the integration specialist must be a mental health professional who is qualified according to section 245I.04, subdivision 2.

(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 who is qualified according to section 245I.04, subdivision 4, 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 mental health certified peer specialist who is qualified according to section 245I.04, subdivision 10;

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

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

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Sec. 9. Minnesota Statutes 2022, section 256B.0941, is amended by adding a subdivision to read:

Subd. 5. **Start-up and capacity-building grants.** (a) The commissioner shall establish start-up and capacity-building grants for psychiatric residential treatment facility sites. Start-up grants to prospective psychiatric residential treatment facility sites may be used for:

(1) administrative expenses;

(2) consulting services;

(3) Health Insurance Portability and Accountability Act of 1996 compliance;

(4) therapeutic resources, including evidence-based, culturally appropriate curriculums and training programs for staff and clients;

(5) allowable physical renovations to the property; and

(6) emergency workforce shortage uses, as determined by the commissioner.

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

(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. 55. Minnesota Statutes 2022, section 256B.0941, subdivision 2a, is amended to read:

Subd. 2a. **Sleeping hours.** During normal sleeping hours, a psychiatric residential treatment facility provider must provide at least one staff person for every six residents present within a living unit. A provider must adjust sleeping-hour staffing levels based on the clinical needs of the residents in the facility. Sleeping hours must include at least one staff trained and certified to provide emergency medical response. During normal sleeping hours, a registered nurse must be available on call to assess a child's needs and must be available within 60 minutes.

Sec. 56. Minnesota Statutes 2022, section 256B.0941, is amended by adding a subdivision to read:

Subd. 2b. **Shared site.** Related services that have a bright-line separation from psychiatric residential treatment facility service operations may be delivered in the same facility, including under the same structural roof. In shared site settings, staff must provide services only to programs they are affiliated to through NETStudy 2.0.

Sec. 57. Minnesota Statutes 2022, section 256B.0941, is amended by adding a subdivision to read:

Subd. 5. **Start-up and capacity-building grants.** (a) The commissioner shall establish start-up and capacity-building grants for psychiatric residential treatment facility sites. Start-up grants to prospective psychiatric residential treatment facility sites may be used for:

(1) administrative expenses;

(2) consulting services;

(3) Health Insurance Portability and Accountability Act of 1996 compliance;

(4) therapeutic resources, including evidence-based, culturally appropriate curriculums and training programs for staff and clients;

(5) allowable physical renovations to the property; and

(6) emergency workforce shortage uses, as determined by the commissioner.

Senate Language S2995-3

(b) Start-up and capacity-building grants to prospective and current psychiatric residential treatment facilities may be used to support providers who treat and accept individuals with complex support needs, including but not limited to:

(1) neurocognitive disorders;

(2) co-occurring intellectual developmental disabilities;

(3) schizophrenia spectrum disorders;

(4) manifested or labeled aggressive behaviors; and

(5) manifested sexually inappropriate behaviors.

EFFECTIVE DATE. This section is effective July 1, 2023.

House Language UES2995-2

(b) Start-up and capacity-building grants to prospective and current psychiatric residential treatment facilities may be used to support providers who treat and accept individuals with complex support needs, including but not limited to:

(1) neurocognitive disorders;

(2) co-occurring intellectual developmental disabilities;

(3) schizophrenia spectrum disorders;

(4) manifested or labeled aggressive behaviors; and

(5) manifested sexually inappropriate behaviors.

EFFECTIVE DATE. This section is effective July 1, 2023.

Sec. 58. Minnesota Statutes 2022, section 256B.0947, is amended by adding a subdivision to read:

Subd. 10. **Young adult continuity of care.** A client who received services under this section or section 256B.0946 and aged out of eligibility may continue to receive services from the same providers under this section until the client is 27 years old.

Sec. 59. Minnesota Statutes 2022, section 256B.69, subdivision 5a, is amended to read:

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

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

(c) The commissioner shall withhold five percent of managed care plan payments under this section and county-based purchasing plan payments under section 256B.692 for the prepaid medical assistance program pending completion of performance targets. Each performance target must be quantifiable, objective, measurable, and reasonably attainable, except in the case of a performance target based on a federal or state law or rule. Criteria for assessment of each performance target must be outlined in writing prior to the contract effective date. Clinical or utilization performance targets and their related criteria must consider evidence-based research and reasonable interventions when available or applicable to the populations served, and must be developed with input from external clinical experts and stakeholders, including managed care plans, county-based purchasing plans, and providers. The managed care or county-based purchasing plan must demonstrate, to the commissioner's satisfaction, that the data submitted regarding attainment of the performance

target is accurate. The commissioner shall periodically change the administrative measures used as performance targets in order to improve plan performance across a broader range of administrative services. The performance targets must include measurement of plan efforts to contain spending on health care services and administrative activities. The commissioner may adopt plan-specific performance targets that take into account factors affecting only one plan, including characteristics of the plan's enrollee population. The withheld funds must be returned no sooner than July of the following year if performance targets in the contract are achieved. The commissioner may exclude special demonstration projects under subdivision 23.

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

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

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

(e) Effective for services rendered on or after January 1, 2012, the commissioner shall include as part of the performance targets described in paragraph (c) a reduction in the health plan's emergency department utilization rate for medical assistance and MinnesotaCare enrollees, as determined by the commissioner. For 2012, the reduction shall be based on the health plan's utilization in 2009. To earn the return of the withhold each subsequent year, the managed care plan or county-based purchasing plan must achieve a qualifying reduction of no less than ten percent of the plan's emergency department utilization rate for medical assistance and MinnesotaCare enrollees, excluding enrollees in programs described in subdivisions 23 and 28, compared to the previous measurement year until the final performance target is reached. When measuring performance, the commissioner must consider the difference in health risk in a managed care or county-based purchasing plan's membership in the baseline year compared to the measurement year, and work with the managed care or county-based purchasing plan to account for differences that they agree are significant.

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

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

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

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

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

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

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

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

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

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

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

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

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

(m) Managed care plans and county-based purchasing plans shall maintain current and fully executed agreements for all subcontractors, including bargaining groups, for administrative services that are expensed to the state's public health care programs. Subcontractor agreements determined to be material, as defined by the commissioner after taking into account state contracting and relevant statutory requirements, must be in the form of a written instrument or electronic document containing the elements of offer,

acceptance, consideration, payment terms, scope, duration of the contract, and how the subcontractor services relate to state public health care programs. Upon request, the commissioner shall have access to all subcontractor documentation under this paragraph. Nothing in this paragraph shall allow release of information that is nonpublic data pursuant to section 13.02.

(n) Effective for services rendered on or after January 1, 2024, the commissioner shall require, as part of a contract, that all managed care plans use timely claim filing timelines of 12 months and use remittance advice and prior authorizations timelines consistent with those used under medical assistance fee-for-service for mental health and substance use disorder treatment services. A managed care plan under this section may not take back funds the managed care plan paid to a mental health and substance use disorder treatment provider once six months have elapsed from the date the funds were paid.

Sec. 60. Minnesota Statutes 2022, section 260C.007, subdivision 26d, is amended to read:

Subd. 26d. **Qualified residential treatment program.** "Qualified residential treatment program" means a children's residential treatment program licensed under chapter 245A or licensed or approved by a tribe that is approved to receive foster care maintenance payments under section 256.82 that:

(1) has a trauma-informed treatment model designed to address the needs of children with serious emotional or behavioral disorders or disturbances;

(2) has registered or licensed nursing staff and other licensed clinical staff who:

(i) provide care within the scope of their practice; and

(ii) are available 24 hours per day and seven days per week;

(3) is accredited by any of the following independent, nonprofit organizations: the Commission on Accreditation of Rehabilitation Facilities (CARF), the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), and the Council on Accreditation (COA), or any other nonprofit accrediting organization approved by the United States Department of Health and Human Services;

(4) if it is in the child's best interests, facilitates participation of the child's family members in the child's treatment programming consistent with the child's out-of-home placement plan under sections 260C.212, subdivision 1, and 260C.708;

(5) facilitates outreach to family members of the child, including siblings;

(6) documents how the facility facilitates outreach to the child's parents and relatives, as well as documents the child's parents' and other relatives' contact information;

(7) documents how the facility includes family members in the child's treatment process, including after the child's discharge, and how the facility maintains the child's sibling connections; and

Senate Language S2995-3

House Language UES2995-2

Sec. 10. **DIRECTION TO COMMISSIONER; CHANGES TO RESIDENTIAL ADULT MENTAL HEALTH PROGRAM LICENSING REQUIREMENTS.**

(a) The commissioner of human services must consult with stakeholders to determine the changes to residential adult mental health program licensing requirements in Minnesota Rules, parts 9520.0500 to 9520.0670, necessary to:

(1) update requirements for category I programs to align with current mental health practices, client rights for similar services, and health and safety needs of clients receiving services;

(2) remove category II classification and requirements; and

(3) add licensing requirements to the rule for the Forensic Mental Health Program.

(b) The commissioner must use existing authority in Minnesota Statutes, chapter 245A, to amend Minnesota Rules, parts 9520.0500 to 9520.0670, based on the stakeholder consultation in paragraph (a) and additional changes as determined by the commissioner.

Sec. 11. **LOCAL AGENCY SUBSTANCE USE DISORDER ALLOCATION.**

The commissioner of human services shall evaluate the ongoing need for local agency substance use disorder allocations under Minnesota Statutes, section 254B.02. The evaluation must include recommendations on whether local agency allocations should continue, and if so, must recommend what the purpose of the allocations should be and propose an updated allocation methodology that aligns with the purpose and person-centered outcomes for people experiencing substance use disorders and behavioral health conditions. The commissioner may contract with a vendor to support this evaluation through research and actuarial analysis.

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

Sec. 12. **MOBILE RESPONSE AND STABILIZATION SERVICES PILOT.**

The commissioner of human services shall establish a pilot to promote access to crisis response services and reduce psychiatric hospitalizations and out-of-home placement services for children, youth, and families. The pilot must incorporate a two-pronged approach to provide an immediate, face-to-face response within 60 minutes of a crisis as well as extended, longer-term supports for the family unit. The pilot must aim to help families respond to children's behavioral health crises while bolstering resiliency and recovery within the family unit. The pilot must include four sites, must include at least one rural site and one urban site, and may include one or more Tribal behavioral health crisis providers. To qualify for the pilot, a grantee must have a current mobile crisis certification in good standing under

(8) provides the child and child's family with discharge planning and family-based aftercare support for at least six months after the child's discharge. Aftercare support may include mental health certified family and youth peer specialist services, as defined under section 256B.0616.

Sec. 61. **LOCAL AGENCY SUBSTANCE USE DISORDER ALLOCATION.**

The commissioner of human services shall evaluate the ongoing need for local agency substance use disorder allocations under Minnesota Statutes, section 254B.02. The evaluation must include recommendations on whether local agency allocations should continue, and if so, the commissioner must recommend what the purpose of the allocations should be and propose an updated allocation methodology that aligns with the purpose and person-centered outcomes for people experiencing substance use disorders and behavioral health conditions. The commissioner may contract with a vendor to support this evaluation through research and actuarial analysis.

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

Minnesota Statutes, section 256B.0624. The commissioner must consult with a qualified expert entity to assist in the formulation of measurable outcomes and explore and position the state to submit a Medicaid state plan amendment to scale the model statewide.

EFFECTIVE DATE. This section is effective July 1, 2023.

Sec. 13. **RATE INCREASE FOR MENTAL HEALTH ADULT DAY TREATMENT.**

The commissioner of human services must increase the reimbursement rate for adult day treatment under Minnesota Statutes, section 256B.0671, subdivision 3, by 50 percent over the reimbursement rate in effect as of June 30, 2023.

EFFECTIVE DATE. This section is effective January 1, 2024, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 62. **RATE INCREASE FOR MENTAL HEALTH ADULT DAY TREATMENT.**

The commissioner of human services must increase the reimbursement rate for adult day treatment under Minnesota Statutes, section 256B.0671, subdivision 3, by 50 percent over the reimbursement rate in effect as of June 30, 2023.

EFFECTIVE DATE. This section is effective January 1, 2024, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 63. **ROOM AND BOARD COSTS IN CHILDREN'S RESIDENTIAL FACILITIES.**

The commissioner of human services must update the behavioral health fund room and board rate schedule to include services provided under Minnesota Statutes, section 245.4882, for individuals who do not have a placement under Minnesota Statutes, chapter 260C or 260D. The commissioner must establish room and board rates commensurate with current room and board rates for adolescent programs licensed under Minnesota Statutes, section 245G.18.

EFFECTIVE DATE. This section is effective July 1, 2023.

Sec. 64. **DIRECTION TO THE COMMISSIONER; EARLY INTERVENTION AND PREVENTION SERVICES.**

The commissioner of human services must make the International Classification of Diseases, Tenth Revision V and Z codes available to medical assistance and MinnesotaCare enrolled professionals to provide early intervention and prevention services. Services must be delivered under the supervision of a mental health professional, as defined in Minnesota Statutes, section 245I.02, subdivision 27, and must only be provided for a period of up to six months after the first contact with a client who is enrolled in medical assistance or MinnesotaCare.