

231.7

ARTICLE 9

231.8

BEHAVIORAL HEALTH

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

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

- 231.15 (1) client outreach,
- 231.16 (2) medication monitoring,
- 231.17 (3) assistance in independent living skills,
- 231.18 (4) development of employability and work-related opportunities,
- 231.19 (5) crisis assistance,
- 231.20 (6) psychosocial rehabilitation,
- 231.21 (7) help in applying for government benefits, and
- 231.22 (8) housing support services.

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

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

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

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

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

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

229.11

ARTICLE 9

229.12

MENTAL HEALTH

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

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

- 229.19 (1) client outreach,
- 229.20 (2) medication monitoring,
- 229.21 (3) assistance in independent living skills,
- 229.22 (4) development of employability and work-related opportunities,
- 229.23 (5) crisis assistance,
- 229.24 (6) psychosocial rehabilitation,
- 229.25 (7) help in applying for government benefits, and
- 229.26 (8) housing support services.

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

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

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

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

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

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

232.11 Sec. 3. Minnesota Statutes 2023 Supplement, section 245.4889, subdivision 1, is amended
 232.12 to read:

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

232.15 (1) counties;
 232.16 (2) Indian tribes;
 232.17 (3) children's collaboratives under section 124D.23 or 245.493; or
 232.18 (4) mental health service providers.

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

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

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

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

233.1 (4) children's mental health crisis services;
 233.2 (5) child-, youth-, and family-specific mobile response and stabilization services models;
 233.3 (6) mental health services for people from cultural and ethnic minorities, including
 233.4 supervision of clinical trainees who are Black, indigenous, or people of color;
 233.5 (7) children's mental health screening and follow-up diagnostic assessment and treatment;
 233.6 (8) services to promote and develop the capacity of providers to use evidence-based
 233.7 practices in providing children's mental health services;
 233.8 (9) school-linked mental health services under section 245.4901;
 233.9 (10) building evidence-based mental health intervention capacity for children birth to
 233.10 age five;
 233.11 (11) suicide prevention and counseling services that use text messaging statewide;

230.14 Sec. 3. Minnesota Statutes 2023 Supplement, section 245.4889, subdivision 1, is amended
 230.15 to read:

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

230.18 (1) counties;
 230.19 (2) Indian tribes;
 230.20 (3) children's collaboratives under section 124D.23 or 245.493; or
 230.21 (4) mental health service providers.

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

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

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

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

231.5 (4) children's mental health crisis services;
 231.6 (5) child-, youth-, and family-specific mobile response and stabilization services models;
 231.7 (6) mental health services for people from cultural and ethnic minorities, including
 231.8 supervision of clinical trainees who are Black, indigenous, or people of color;
 231.9 (7) children's mental health screening and follow-up diagnostic assessment and treatment;
 231.10 (8) services to promote and develop the capacity of providers to use evidence-based
 231.11 practices in providing children's mental health services;
 231.12 (9) school-linked mental health services under section 245.4901;
 231.13 (10) building evidence-based mental health intervention capacity for children birth to
 231.14 age five;
 231.15 (11) suicide prevention and counseling services that use text messaging statewide;

233.12 (12) mental health first aid training;

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

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

233.18 (15) early childhood mental health consultation;

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

233.22 (17) psychiatric consultation for primary care practitioners; and

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

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

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

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

234.6 Sec. 4. Minnesota Statutes 2022, section 245I.02, subdivision 17, is amended to read:

234.7 Subd. 17. **Functional assessment.** "Functional assessment" means the assessment of a
234.8 client's current level of functioning relative to functioning that is appropriate for someone
234.9 the client's age. For a client five years of age or younger, a functional assessment is the
234.10 Early Childhood Service Intensity Instrument (ESCHI). For a client six to 17 years of age,
234.11 a functional assessment is the Child and Adolescent Service Intensity Instrument (CASH).
234.12 For a client 18 years of age or older, a functional assessment is the functional assessment
234.13 described in section 245I.10, subdivision 9.

234.14 Sec. 5. Minnesota Statutes 2022, section 245I.02, subdivision 19, is amended to read:

234.15 Subd. 19. **Level of care assessment.** "Level of care assessment" means the level of care
234.16 decision support tool appropriate to the client's age. For a client five years of age or younger,
234.17 a level of care assessment is the Early Childhood Service Intensity Instrument (ESCHI). For

231.16 (12) mental health first aid training;

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

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

231.22 (15) early childhood mental health consultation;

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

231.26 (17) psychiatric consultation for primary care practitioners; and

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

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

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

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

232.10 Sec. 4. Minnesota Statutes 2022, section 245I.02, subdivision 17, is amended to read:

232.11 Subd. 17. **Functional assessment.** "Functional assessment" means the assessment of a
232.12 client's current level of functioning relative to functioning that is appropriate for someone
232.13 the client's age. For a client five years of age or younger, a functional assessment is the
232.14 Early Childhood Service Intensity Instrument (ESCHI). For a client six to 17 years of age,
232.15 a functional assessment is the Child and Adolescent Service Intensity Instrument (CASH).
232.16 For a client 18 years of age or older, a functional assessment is the functional assessment
232.17 described in section 245I.10, subdivision 9.

232.18 Sec. 5. Minnesota Statutes 2022, section 245I.02, subdivision 19, is amended to read:

232.19 Subd. 19. **Level of care assessment.** "Level of care assessment" means the level of care
232.20 decision support tool appropriate to the client's age. For a client five years of age or younger,
232.21 a level of care assessment is the Early Childhood Service Intensity Instrument (ESCHI). For

234.18 a client six to 17 years of age, a level of care assessment is the Child and Adolescent Service
 234.19 Intensity Instrument (CASII). For a client 18 years of age or older, a level of care assessment
 234.20 is the Level of Care Utilization System for Psychiatric and Addiction Services (LOCUS)
 234.21 or another tool authorized by the commissioner.

232.22 a client six to 17 years of age, a level of care assessment is the Child and Adolescent Service
 232.23 Intensity Instrument (CASII). For a client 18 years of age or older, a level of care assessment
 232.24 is the Level of Care Utilization System for Psychiatric and Addiction Services (LOCUS)
 232.25 or another tool authorized by the commissioner.

234.22 Sec. 6. Minnesota Statutes 2022, section 245I.10, subdivision 9, is amended to read:

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

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

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

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

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

- 235.3 (i) the client's mental health symptoms;
- 235.4 (ii) the client's mental health service needs;
- 235.5 (iii) the client's substance use;

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

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

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

233.11 Sec. 7. Minnesota Statutes 2022, section 245I.10, subdivision 9, is amended to read:

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

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

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

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

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

- 233.23 (i) the client's mental health symptoms;
- 233.24 (ii) the client's mental health service needs;
- 233.25 (iii) the client's substance use;

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

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

235.8 (vi) the client's interpersonal functioning, including relationships with the client's family

235.9 and other natural supports;

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

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

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

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

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

235.15 ~~functional impairment;~~

235.16 ~~(6) (5) complete the client's functional assessment before the client's initial individual~~

235.17 treatment plan unless a service specifies otherwise; and

235.18 ~~(7) (6) update the client's functional assessment with the client's current functioning~~

235.19 whenever there is a significant change in the client's functioning or at least every ~~180~~ 365

235.20 days, unless a service specifies otherwise.

235.21 ~~(b) A license holder may use any available, validated measurement tool, including but~~

235.22 ~~not limited to the Daily Living Activities-20, when completing the required elements of a~~

235.23 ~~functional assessment under this subdivision.~~

235.24 Sec. 7. Minnesota Statutes 2022, section 245I.11, subdivision 1, is amended to read:

235.25 Subdivision 1. **Generally.** ~~(a) If a license holder is licensed as a residential program,~~

235.26 stores or administers client medications, or observes clients self-administer medications,

235.27 the license holder must ensure that a staff person who is a registered nurse or licensed

235.28 prescriber is responsible for overseeing storage and administration of client medications

235.29 and observing as a client self-administers medications, including training according to

236.1 section 245I.05, subdivision 6, and documenting the occurrence according to section 245I.08,

236.2 subdivision 5.

236.3 ~~(b) For purposes of this section, "observed self-administration" means the preparation~~

236.4 and administration of a medication by a client to themselves under the direct supervision

236.5 of a registered nurse or a staff member to whom a registered nurse delegates supervision

236.6 duty. Observed self-administration does not include a client's use of a medication that they

236.7 keep in their own possession while participating in a program.

236.8 Sec. 8. Minnesota Statutes 2022, section 245I.11, is amended by adding a subdivision to

236.9 read:

236.10 **Subd. 6. Medication administration in children's day treatment settings.** ~~(a) For a~~

236.11 program providing children's day treatment services under section 256B.0943, the license

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

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

233.28 (vi) the client's interpersonal functioning, including relationships with the client's family

233.29 and other natural supports;

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

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

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

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

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

234.4 ~~functional impairment;~~

234.5 ~~(6) (5) complete the client's functional assessment before the client's initial individual~~

234.6 treatment plan unless a service specifies otherwise; and

234.7 ~~(7) (6) update the client's functional assessment with the client's current functioning~~

234.8 whenever there is a significant change in the client's functioning or at least every ~~180~~ 365

234.9 days, unless a service specifies otherwise.

234.10 ~~(b) A license holder may use any available, validated measurement tool, including but~~

234.11 ~~not limited to the Daily Living Activities-20, when completing the required elements of a~~

234.12 ~~functional assessment under this subdivision.~~

234.13 Sec. 8. Minnesota Statutes 2022, section 245I.11, subdivision 1, is amended to read:

234.14 Subdivision 1. **Generally.** ~~(a) If a license holder is licensed as a residential program,~~

234.15 stores or administers client medications, or observes clients self-administer medications,

234.16 the license holder must ensure that a staff person who is a registered nurse or licensed

234.17 prescriber is responsible for overseeing storage and administration of client medications

234.18 and observing as a client self-administers medications, including training according to

234.19 section 245I.05, subdivision 6, and documenting the occurrence according to section 245I.08,

234.20 subdivision 5.

234.21 ~~(b) For purposes of this section, "observed self-administration" means the preparation~~

234.22 and administration of a medication by a client to themselves under the direct supervision

234.23 of a registered nurse or a staff member to whom a registered nurse delegates supervision

234.24 duty. Observed self-administration does not include a client's use of a medication that they

234.25 keep in their own possession while participating in a program.

234.26 Sec. 9. Minnesota Statutes 2022, section 245I.11, is amended by adding a subdivision to

234.27 read:

234.28 **Subd. 6. Medication administration in children's day treatment settings.** ~~(a) For a~~

234.29 program providing children's day treatment services under section 256B.0943, the license

236.12 holder must maintain policies and procedures that state whether the program will store
 236.13 medication and administer or allow observed self-administration.

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

236.19 (1) an evaluation that the client is capable of holding and administering the medication
 236.20 safely;
 236.21 (2) an evaluation of whether the medication is prone to diversion, misuse, or self-injury;
 236.22 and
 236.23 (3) any conditions under which the license holder should no longer allow the client to
 236.24 maintain the medication in their own possession.

236.25 Sec. 9. Minnesota Statutes 2022, section 245I.20, subdivision 4, is amended to read:

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

236.31 (b) The treatment team must include:

237.1 (1) a physician qualified as a mental health professional according to section 245I.04,
 237.2 subdivision 2, clause (4), or a nurse qualified as a mental health professional according to
 237.3 section 245I.04, subdivision 2, clause (1); and
 237.4 (2) a psychologist qualified as a mental health professional according to section 245I.04,
 237.5 subdivision 2, clause (3).

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

237.8 (1) eight hours every two weeks if the mental health clinic has over 25.0 full-time
 237.9 equivalent treatment team members;
 237.10 (2) eight hours each month if the mental health clinic has 15.1 to 25.0 full-time equivalent
 237.11 treatment team members;
 237.12 (3) four hours each month if the mental health clinic has 5.1 to 15.0 full-time equivalent
 237.13 treatment team members; or
 237.14 (4) two hours each month if the mental health clinic has 2.0 to 5.0 full-time equivalent
 237.15 treatment team members or only provides in-home services to clients.

234.30 holder must maintain policies and procedures that state whether the program will store
 234.31 medication and administer or allow observed self-administration.

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

235.6 (1) an evaluation that the client is capable of holding and administering the medication
 235.7 safely;
 235.8 (2) an evaluation of whether the medication is prone to diversion, misuse, or self-injury;
 235.9 and
 235.10 (3) any conditions under which the license holder should no longer allow the client to
 235.11 maintain the medication in their own possession.

235.12 Sec. 10. Minnesota Statutes 2022, section 245I.20, subdivision 4, is amended to read:

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

235.18 (b) The treatment team must include:

235.19 (1) a physician qualified as a mental health professional according to section 245I.04,
 235.20 subdivision 2, clause (4), or a nurse qualified as a mental health professional according to
 235.21 section 245I.04, subdivision 2, clause (1); and
 235.22 (2) a psychologist qualified as a mental health professional according to section 245I.04,
 235.23 subdivision 2, clause (3).

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

235.26 (1) eight hours every two weeks if the mental health clinic has over 25.0 full-time
 235.27 equivalent treatment team members;
 235.28 (2) eight hours each month if the mental health clinic has 15.1 to 25.0 full-time equivalent
 235.29 treatment team members;
 235.30 (3) four hours each month if the mental health clinic has 5.1 to 15.0 full-time equivalent
 235.31 treatment team members; or
 236.1 (4) two hours each month if the mental health clinic has 2.0 to 5.0 full-time equivalent
 236.2 treatment team members or only provides in-home services to clients.

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

237.18 Sec. 10. Minnesota Statutes 2022, section 245I.23, subdivision 14, is amended to read:

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

237.21 (b) A mental health professional or certified rehabilitation specialist must hold at least
 237.22 one team meeting each calendar week and, The mental health professional or certified
 237.23 rehabilitation specialist must lead and be physically present at the team meeting, except as
 237.24 permitted under paragraph (e). All treatment team members, including treatment team
 237.25 members who work on a part-time or intermittent basis, must participate in a minimum of
 237.26 one team meeting during each calendar week when the treatment team member is working
 237.27 for the license holder. The license holder must document all weekly team meetings, including
 237.28 the names of meeting attendees, and indicate whether the meeting was conducted remotely
 237.29 under paragraph (e).

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

238.7 (d) If a treatment team member working only one shift during a week cannot participate
 238.8 in a weekly team meeting or participate in an ancillary meeting, the treatment team member
 238.9 must read the minutes of the weekly team meeting required to be documented in paragraph
 238.10 (b). The treatment team member must sign to acknowledge receipt of this information, and
 238.11 document pertinent information or questions. The mental health professional or certified
 238.12 rehabilitation specialist must review any documented questions or pertinent information
 238.13 before the next weekly team meeting.

238.14 (e) A license holder may permit a mental health professional or certified rehabilitation
 238.15 specialist to lead the weekly meeting remotely due to medical or weather conditions. If the
 238.16 conditions that do not permit physical presence persist for longer than one week, the license
 238.17 holder must request a variance to conduct additional meetings remotely.

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

236.5 Sec. 11. Minnesota Statutes 2022, section 245I.23, subdivision 14, is amended to read:

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

236.8 (b) A mental health professional or certified rehabilitation specialist must hold at least
 236.9 one team meeting each calendar week and, The mental health professional or certified
 236.10 rehabilitation specialist must lead and be physically present at the team meeting, except as
 236.11 permitted under paragraph (e). All treatment team members, including treatment team
 236.12 members who work on a part-time or intermittent basis, must participate in a minimum of
 236.13 one team meeting during each calendar week when the treatment team member is working
 236.14 for the license holder. The license holder must document all weekly team meetings, including
 236.15 the names of meeting attendees, and indicate whether the meeting was conducted remotely
 236.16 under paragraph (e).

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

236.26 (d) If a treatment team member working only one shift during a week cannot participate
 236.27 in a weekly team meeting or participate in an ancillary meeting, the treatment team member
 236.28 must read the minutes of the weekly team meeting required to be documented in paragraph
 236.29 (b). The treatment team member must sign to acknowledge receipt of this information, and
 236.30 document pertinent information or questions. The mental health professional or certified
 236.31 rehabilitation specialist must review any documented questions or pertinent information
 236.32 before the next weekly team meeting.

237.1 (e) A license holder may permit a mental health professional or certified rehabilitation
 237.2 specialist to lead the weekly meeting remotely due to medical or weather conditions. If the
 237.3 conditions that do not permit physical presence persist for longer than one week, the license
 237.4 holder must request a variance to conduct additional meetings remotely.

THE FOLLOWING LANGUAGE WAS MOVED IN FROM HOUSE ARTICLE
 11, SECTION 3.

238.18 Sec. 11. Minnesota Statutes 2023 Supplement, section 254B.04, subdivision 1a, is amended
 238.19 to read:

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

238.25 (b) Persons with dependent children who are determined to be in need of substance use
 238.26 disorder treatment pursuant to an assessment under section 260E.20, subdivision 1, or in
 238.27 need of chemical dependency treatment pursuant to a case plan under section 260C.201,
 238.28 subdivision 6, or 260C.212, shall be assisted by the local agency to access needed treatment
 238.29 services. Treatment services must be appropriate for the individual or family, which may
 238.30 include long-term care treatment or treatment in a facility that allows the dependent children
 238.31 to stay in the treatment facility. The county shall pay for out-of-home placement costs, if
 238.32 applicable.

239.1 (c) Notwithstanding paragraph (a), persons any person enrolled in medical assistance
 239.2 are or MinnesotaCare is eligible for room and board services under section 254B.05,
 239.3 subdivision 5, paragraph (b), clause (12) (9).

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

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

239.7 (2) is eligible for medical assistance as determined under Minnesota Rules, parts
 239.8 9505.0010 to 9505.0150;

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

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

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

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

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

314.14 Sec. 3. Minnesota Statutes 2023 Supplement, section 254B.04, subdivision 1a, is amended
 314.15 to read:

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

314.21 (b) Persons with dependent children who are determined to be in need of substance use
 314.22 disorder treatment pursuant to an assessment under section 260E.20, subdivision 1, or in
 314.23 need of chemical dependency treatment pursuant to a case plan under section 260C.201,
 314.24 subdivision 6, or 260C.212, shall be assisted by the local agency to access needed treatment
 314.25 services. Treatment services must be appropriate for the individual or family, which may
 314.26 include long-term care treatment or treatment in a facility that allows the dependent children
 314.27 to stay in the treatment facility. The county shall pay for out-of-home placement costs, if
 314.28 applicable.

314.29 (c) Notwithstanding paragraph (a), persons enrolled in medical assistance are eligible
 314.30 for room and board services under section 254B.05, subdivision 5, paragraph (b), clause
 314.31 (12).

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

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

315.4 (2) is eligible for medical assistance as determined under Minnesota Rules, parts
 315.5 9505.0010 to 9505.0150;

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

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

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

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

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

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

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

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

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

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

240.3 (i) Persons enrolled in MinnesotaCare are eligible for room and board services when
 240.4 provided through intensive residential treatment services and residential crisis services under
 240.5 section 256B.0622.

240.6 **EFFECTIVE DATE.** This section is effective January 1, 2025.

240.7 Sec. 12. **[256B.0617] MENTAL HEALTH SERVICES PROVIDER**
 240.8 **CERTIFICATION.**

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

240.13 (1) children's intensive behavioral health services under section 256B.0946; and
 240.14 (2) intensive nonresidential rehabilitative mental health services under section 256B.0947.

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

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

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

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

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

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

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

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

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

237.5 Sec. 12. **[256B.0617] MENTAL HEALTH SERVICES PROVIDER**
 237.6 **CERTIFICATION.**

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

237.11 (1) children's intensive behavioral health services under section 256B.0946; and
 237.12 (2) intensive nonresidential rehabilitative mental health services under section 256B.0947.

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

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

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

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

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

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

240.29 (3) a formal written communication outlining the process for necessary corrective action
 240.30 and follow-up by the commissioner signed by the commissioner or their designee, if
 240.31 applicable. In the case of corrective action, the commissioner may schedule interim
 240.32 recertification site reviews to confirm certification or decertification.

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

241.3 Sec. 13. Minnesota Statutes 2022, section 256B.0622, subdivision 2a, is amended to read:

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

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

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

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

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

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

241.24 (iii) significant difficulty maintaining a safe living situation;

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

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

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

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

237.27 (3) a formal written communication outlining the process for necessary corrective action
 237.28 and follow-up by the commissioner signed by the commissioner or their designee, if
 237.29 applicable. In the case of corrective action, the commissioner may schedule interim
 237.30 recertification site reviews to confirm certification or decertification.

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

238.1 Sec. 13. Minnesota Statutes 2022, section 256B.0622, subdivision 2a, is amended to read:

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

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

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

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

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

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

238.22 (iii) significant difficulty maintaining a safe living situation;

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

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

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

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

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

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

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

242.4 (vii) significant difficulty meeting basic survival needs;

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

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

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

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

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

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

242.14 (5) there are no indications that other available community-based services would be
 242.15 equally or more effective as evidenced by consistent and extensive efforts to treat the
 242.16 individual; and

242.17 (6) in the written opinion of a licensed mental health professional, has the need for mental
 242.18 health services that cannot be met with other available community-based services, or is
 242.19 likely to experience a mental health crisis or require a more restrictive setting if assertive
 242.20 community treatment is not provided.

242.21 (b) An individual meets the criteria for assertive community treatment under this section
 242.22 if they have participated within the last year or are currently in a first episode of psychosis
 242.23 program if the individual:

242.24 (1) meets the eligibility requirements outlined in paragraph (a), clauses (1), (2), (5), and
 242.25 (6);

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

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

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

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

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

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

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

239.3 (vii) significant difficulty meeting basic survival needs;

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

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

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

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

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

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

239.13 (5) there are no indications that other available community-based services would be
 239.14 equally or more effective as evidenced by consistent and extensive efforts to treat the
 239.15 individual; and

239.16 (6) in the written opinion of a licensed mental health professional, has the need for mental
 239.17 health services that cannot be met with other available community-based services, or is
 239.18 likely to experience a mental health crisis or require a more restrictive setting if assertive
 239.19 community treatment is not provided.

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

239.22 (1) meets the eligibility requirements outlined in paragraph (a), clauses (1), (2), (5), and
 239.23 (6);

242.26 (2) is currently participating in a first episode of psychosis program under section
 242.27 245.4905; and

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

243.1 Sec. 14. Minnesota Statutes 2022, section 256B.0622, subdivision 3a, is amended to read:

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

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

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

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

243.13 (1) have capacity to recruit, hire, manage, and train required ACT team members;
 243.14 (2) have adequate administrative ability to ensure availability of services;
 243.15 (3) ensure flexibility in service delivery to respond to the changing and intermittent care
 243.16 needs of a client as identified by the client and the individual treatment plan;
 243.17 (4) keep all necessary records required by law;
 243.18 (5) be an enrolled Medicaid provider; and
 243.19 (6) establish and maintain a quality assurance plan to determine specific service outcomes
 243.20 and the client's satisfaction with services.

243.21 (c) The commissioner may intervene at any time and decertify an ACT team with cause.
 243.22 The commissioner shall establish a process for decertification of an ACT team and shall
 243.23 require corrective action, medical assistance repayment, or decertification of an ACT team
 243.24 that no longer meets the requirements in this section or that fails to meet the clinical quality
 243.25 standards or administrative standards provided by the commissioner in the application and
 243.26 certification process. The decertification is subject to appeal to the state.

243.27 Sec. 15. Minnesota Statutes 2022, section 256B.0622, subdivision 7a, is amended to read:

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

239.24 (2) is currently participating in a first episode of psychosis program under section
 239.25 245.4905; and

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

239.29 Sec. 14. Minnesota Statutes 2022, section 256B.0622, subdivision 3a, is amended to read:

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

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

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

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

240.10 (1) have capacity to recruit, hire, manage, and train required ACT team members;
 240.11 (2) have adequate administrative ability to ensure availability of services;
 240.12 (3) ensure flexibility in service delivery to respond to the changing and intermittent care
 240.13 needs of a client as identified by the client and the individual treatment plan;
 240.14 (4) keep all necessary records required by law;
 240.15 (5) be an enrolled Medicaid provider; and
 240.16 (6) establish and maintain a quality assurance plan to determine specific service outcomes
 240.17 and the client's satisfaction with services.

240.18 (c) The commissioner may intervene at any time and decertify an ACT team with cause.
 240.19 The commissioner shall establish a process for decertification of an ACT team and shall
 240.20 require corrective action, medical assistance repayment, or decertification of an ACT team
 240.21 that no longer meets the requirements in this section or that fails to meet the clinical quality
 240.22 standards or administrative standards provided by the commissioner in the application and
 240.23 certification process. The decertification is subject to appeal to the state.

240.24 Sec. 15. Minnesota Statutes 2022, section 256B.0622, subdivision 7a, is amended to read:

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

243.30 (1) the team leader:

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

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

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

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

244.14 (2) the psychiatric care provider:

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

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

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

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

245.1 (v) shall have a minimum full-time equivalency that is prorated at a rate of 16 hours per
245.2 50 clients. Part-time psychiatric care providers shall have designated hours to work on the
245.3 team, with sufficient blocks of time on consistent days to carry out the provider's clinical,
245.4 supervisory, and administrative responsibilities. No more than two psychiatric care providers
245.5 may share this role; and

240.27 (1) the team leader:

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

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

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

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

241.11 (2) the psychiatric care provider:

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

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

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

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

241.30 (v) shall have a minimum full-time equivalency that is prorated at a rate of 16 hours per
241.31 50 clients. Part-time psychiatric care providers shall have designated hours to work on the
241.32 team, with sufficient blocks of time on consistent days to carry out the provider's clinical,
242.1 supervisory, and administrative responsibilities. No more than two psychiatric care providers
242.2 may share this role; and

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

245.9 (3) the nursing staff:

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

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

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

245.22 (4) the co-occurring disorder specialist:

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

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

246.4 (5) the vocational specialist:

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

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

242.6 (3) the nursing staff:

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

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

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

242.19 (4) the co-occurring disorder specialist:

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

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

242.33 (5) the vocational specialist:

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

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

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

246.15 (6) the mental health certified peer specialist:

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

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

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

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

246.31 (8) additional staff:

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

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

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

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

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

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

243.11 (6) the mental health certified peer specialist:

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

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

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

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

243.27 (8) additional staff:

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

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

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

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

247.14 (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.

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

247.22 Sec. 16. Minnesota Statutes 2023 Supplement, section 256B.0622, subdivision 7b, is amended to read:

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

247.29 (1) a small ACT team must:

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

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

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

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

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

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

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

244.8 (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.

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

244.16 Sec. 16. Minnesota Statutes 2023 Supplement, section 256B.0622, subdivision 7b, is amended to read:

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

244.23 (1) a small ACT team must:

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

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

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

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

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

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

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

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

248.25 (2) a midsize ACT team shall:

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

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

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

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

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

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

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

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

249.20 (3) a large ACT team must:

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

245.19 (2) a midsize ACT team shall:

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

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

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

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

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

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

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

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

246.14 (3) a large ACT team must:

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

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

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

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

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

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

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

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

250.14 Sec. 17. Minnesota Statutes 2022, section 256B.0622, subdivision 7d, is amended to read:

250.15 Subd. 7d. **Assertive community treatment assessment and individual treatment plan.** (a) An initial assessment shall be completed the day of the client's admission to
 250.16 assertive community treatment by the ACT team leader or the psychiatric care provider,
 250.17 with participation by designated ACT team members and the client. The initial assessment
 250.18 must include obtaining or completing a standard diagnostic assessment according to section
 250.19 245I.10, subdivision 6, and completing a 30-day individual treatment plan. The team leader,
 250.20 psychiatric care provider, or other mental health professional designated by the team leader
 250.21 or psychiatric care provider, must update the client's diagnostic assessment at least annually
 250.22 as required under section 245I.10, subdivision 2, paragraphs (f) and (g).

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

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

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

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

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

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

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

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

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

247.8 Sec. 17. Minnesota Statutes 2022, section 256B.0622, subdivision 7d, is amended to read:

247.9 Subd. 7d. **Assertive community treatment assessment and individual treatment plan.** (a) An initial assessment shall be completed the day of the client's admission to
 247.10 assertive community treatment by the ACT team leader or the psychiatric care provider,
 247.11 with participation by designated ACT team members and the client. The initial assessment
 247.12 must include obtaining or completing a standard diagnostic assessment according to section
 247.13 245I.10, subdivision 6, and completing a 30-day individual treatment plan. The team leader,
 247.14 psychiatric care provider, or other mental health professional designated by the team leader
 247.15 or psychiatric care provider, must update the client's diagnostic assessment at least annually
 247.16 as required under section 245I.10, subdivision 2, paragraphs (f) and (g).

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

250.27 (c) Between 30 and 45 days after the client's admission to assertive community treatment,
 250.28 the entire ACT team must hold a comprehensive case conference, where all team members,
 250.29 including the psychiatric provider, present information discovered from the completed
 250.30 assessments and provide treatment recommendations. The conference must serve as the
 250.31 basis for the first individual treatment plan, which must be written by the primary team
 250.32 member.

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

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

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

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

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

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

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

247.21 (c) Between 30 and 45 days after the client's admission to assertive community treatment,
 247.22 the entire ACT team must hold a comprehensive case conference, where all team members,
 247.23 including the psychiatric provider, present information discovered from the completed
 247.24 assessments and provide treatment recommendations. The conference must serve as the
 247.25 basis for the first individual treatment plan, which must be written by the primary team
 247.26 member.

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

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

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

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

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

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

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

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

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

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

252.10 Sec. 18. Minnesota Statutes 2022, section 256B.0623, subdivision 5, is amended to read:

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

252.14 (1) a mental health professional who is qualified according to section 245I.04, subdivision
 252.15 2;

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

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

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

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

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

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

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

252.27 Sec. 19. Minnesota Statutes 2023 Supplement, section 256B.0625, subdivision 5m, is
 252.28 amended to read:

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

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

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

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

HOUSE ARTICLE 9, SECTION 18, WAS MOVED TO MATCH SENATE ARTICLE 2, SECTION 7.

251.19 Sec. 19. Minnesota Statutes 2022, section 256B.0623, subdivision 5, is amended to read:

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

251.23 (1) a mental health professional who is qualified according to section 245I.04, subdivision
 251.24 2;

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

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

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

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

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

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

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

252.4 Sec. 20. Minnesota Statutes 2023 Supplement, section 256B.0625, subdivision 5m, is
 252.5 amended to read:

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

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

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

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

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

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

253.28 (4) the commissioner shall rebase CCBHC rates once every two years following the last
 253.29 rebasing and no less than 12 months following an initial rate or a rate change due to a change
 253.30 in the scope of services. For CCBHCs certified after September 31, 2020, and before January
 253.31 1, 2021, the commissioner shall rebase rates according to this clause beginning for dates of
 253.32 service provided on January 1, 2024;

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

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

254.3 (7) payments for CCBHC services to individuals enrolled in managed care shall be
 254.4 coordinated with the state's phase-out of CCBHC wrap payments. The commissioner shall
 254.5 complete the phase-out of CCBHC wrap payments within 60 days of the implementation

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

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

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

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

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

253.3 (4) the commissioner shall rebase CCBHC rates once every two years following the last
 253.4 rebasing and no less than 12 months following an initial rate or a rate change due to a change
 253.5 in the scope of services. For CCBHCs certified after September 31, 2020, and before January
 253.6 1, 2021, the commissioner shall rebase rates according to this clause for services provided
 253.7 on or after January 1, 2024;

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

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

253.12 (7) payments for CCBHC services to individuals enrolled in managed care shall be
 253.13 coordinated with the state's phase-out of CCBHC wrap payments. The commissioner shall
 253.14 complete the phase-out of CCBHC wrap payments within 60 days of the implementation

254.6 of the CCBHC daily bundled rate system in the Medicaid Management Information System
 254.7 (MMIS), for CCBHCs reimbursed under this chapter, with a final settlement of payments
 254.8 due made payable to CCBHCs no later than 18 months thereafter;

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

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

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

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

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

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

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

255.9 (4) a CCBHC must provide the commissioner with data needed to determine incentive
 255.10 payment eligibility within six months following the measurement year. The commissioner

253.15 of the CCBHC daily bundled rate system in the Medicaid Management Information System
 253.16 (MMIS), for CCBHCs reimbursed under this chapter, with a final settlement of payments
 253.17 due made payable to CCBHCs no later than 18 months thereafter;

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

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

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

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

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

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

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

254.18 (4) a CCBHC must provide the commissioner with data needed to determine incentive
 254.19 payment eligibility within six months following the measurement year. The commissioner

255.11 shall notify CCBHC providers of their performance on the required measures and the
 255.12 incentive payment amount within 12 months following the measurement year.

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

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

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

255.23 If the conditions in this paragraph are met between January 1 and June 30 of a calendar
 255.24 year, claims shall be submitted to and paid by the commissioner beginning on January 1 of
 255.25 the following year. If the conditions in this paragraph are met between July 1 and December
 255.26 31 of a calendar year, claims shall be submitted to and paid by the commissioner beginning
 255.27 on July 1 of the following year.

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

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

256.2 **Subd. 20. Mental health case management.** (a) To the extent authorized by rule of the
 256.3 state agency, medical assistance covers case management services to persons with serious
 256.4 and persistent mental illness and children with severe emotional disturbance. Services
 256.5 provided under this section must meet the relevant standards in sections 245.461 to 245.4887,
 256.6 the Comprehensive Adult and Children's Mental Health Acts, Minnesota Rules, parts
 256.7 9520.0900 to 9520.0926, and 9505.0322, excluding subpart 10.

256.8 (b) Entities meeting program standards set out in rules governing family community
 256.9 support services as defined in section 245.4871, subdivision 17, are eligible for medical
 256.10 assistance reimbursement for case management services for children with severe emotional
 256.11 disturbance when these services meet the program standards in Minnesota Rules, parts
 256.12 9520.0900 to 9520.0926 and 9505.0322, excluding subparts 6 and 10.

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

254.20 shall notify CCBHC providers of their performance on the required measures and the
 254.21 incentive payment amount within 12 months following the measurement year.

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

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

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

254.32 If the conditions in this paragraph are met between January 1 and June 30 of a calendar
 254.33 year, claims shall be submitted to and paid by the commissioner beginning on January 1 of
 255.1 the following year. If the conditions in this paragraph are met between July 1 and December
 255.2 31 of a calendar year, claims shall be submitted to and paid by the commissioner beginning
 255.3 on July 1 of the following year.

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

255.9 Sec. 21. Minnesota Statutes 2022, section 256B.0625, subdivision 20, is amended to read:

255.10 **Subd. 20. Mental health case management.** (a) To the extent authorized by rule of the
 255.11 state agency, medical assistance covers case management services to persons with serious
 255.12 and persistent mental illness and children with severe emotional disturbance. Services
 255.13 provided under this section must meet the relevant standards in sections 245.461 to 245.4887,
 255.14 the Comprehensive Adult and Children's Mental Health Acts, Minnesota Rules, parts
 255.15 9520.0900 to 9520.0926, and 9505.0322, excluding subpart 10.

255.16 (b) Entities meeting program standards set out in rules governing family community
 255.17 support services as defined in section 245.4871, subdivision 17, are eligible for medical
 255.18 assistance reimbursement for case management services for children with severe emotional
 255.19 disturbance when these services meet the program standards in Minnesota Rules, parts
 255.20 9520.0900 to 9520.0926 and 9505.0322, excluding subparts 6 and 10.

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

256.17 the child's legal representative. To receive payment for an eligible adult, the provider must
 256.18 document:

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

256.21 (2) at least a telephone contact or contact via secure electronic message, if preferred by
 256.22 the adult client, with the adult or the adult's legal representative and document a face-to-face
 256.23 contact either in person or by interactive video that meets the requirements of subdivision
 256.24 20b with the adult or the adult's legal representative within the preceding two months.

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

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

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

257.8 (g) If the service is provided by a team which includes contracted vendors, tribal staff,
 257.9 and county or state staff, the costs for county or state staff participation in the team shall be
 257.10 included in the rate for county-provided services. In this case, the contracted vendor, the
 257.11 tribal agency, and the county may each receive separate payment for services provided by
 257.12 each entity in the same month. In order to prevent duplication of services, each entity must
 257.13 document, in the recipient's file, the need for team case management and a description of
 257.14 the roles of the team members.

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

255.25 the child's legal representative. To receive payment for an eligible adult, the provider must
 255.26 document:

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

255.29 (2) at least a telephone contact or contact via secure electronic message, if preferred by
 255.30 the adult client, with the adult or the adult's legal representative and document a face-to-face
 255.31 contact either in person or by interactive video that meets the requirements of subdivision
 255.32 20b with the adult or the adult's legal representative within the preceding two months.

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

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

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

257.17 (g) If the service is provided by a team which includes contracted vendors, tribal staff,
 257.18 and county or state staff, the costs for county or state staff participation in the team shall be
 257.19 included in the rate for county-provided services. In this case, the contracted vendor, the
 257.20 tribal agency, and the county may each receive separate payment for services provided by
 257.21 each entity in the same month. In order to prevent duplication of services, each entity must
 257.22 document, in the recipient's file, the need for team case management and a description of
 257.23 the roles of the team members.

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

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

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

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

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

258.1 (2) programming the information systems.

258.2 (l) Payments to counties and tribal agencies for case management expenditures under
 258.3 this section shall only be made from federal earnings from services provided under this
 258.4 section. When this service is paid by the state without a federal share through fee-for-service,
 258.5 50 percent of the cost shall be provided by the state. Payments to county-contracted vendors
 258.6 shall include the federal earnings, the state share, and the county share.

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

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

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

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

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

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

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

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

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

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

258.10 (2) programming the information systems.

257.11 (l) Payments to counties and tribal agencies for case management expenditures under
 257.12 this section shall only be made from federal earnings from services provided under this
 257.13 section. When this service is paid by the state without a federal share through fee-for-service,
 257.14 50 percent of the cost shall be provided by the state. Payments to county-contracted vendors
 257.15 shall include the federal earnings, the state share, and the county share.

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

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

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

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

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

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

258.21 Sec. 21. Minnesota Statutes 2023 Supplement, section 256B.0671, subdivision 5, is
 258.22 amended to read:

258.23 Subd. 5. **Child and family psychoeducation services.** (a) Medical assistance covers
 258.24 child and family psychoeducation services provided to a child up to under age 21 with and
 258.25 the child's family members, when determined to be medically necessary due to a diagnosed
 258.26 mental health condition when or diagnosed mental illness identified in the child's individual
 258.27 treatment plan and provided by a mental health professional who is qualified under section
 258.28 245I.04, subdivision 2, and practicing within the scope of practice under section 245I.04,
 258.29 subdivision 3; a mental health practitioner who is qualified under section 245I.04, subdivision
 258.30 4, and practicing within the scope of practice under section 245I.04, subdivision 5; or a
 258.31 clinical trainee who has determined it medically necessary to involve family members in
 258.32 the child's care is qualified under section 245I.04, subdivision 6, and practicing within the
 258.33 scope of practice under section 245I.04, subdivision 7.

259.1 (b) "Child and family psychoeducation services" means information or demonstration
 259.2 provided to an individual or family as part of an individual, family, multifamily group, or
 259.3 peer group session to explain, educate, and support the child and family in understanding
 259.4 a child's symptoms of mental illness, the impact on the child's development, and needed
 259.5 components of treatment and skill development so that the individual, family, or group can
 259.6 help the child to prevent relapse, prevent the acquisition of comorbid disorders, and achieve
 259.7 optimal mental health and long-term resilience.

259.8 (c) Child and family psychoeducation services include individual, family, or group skills
 259.9 development or training to:

259.10 (1) support the development of psychosocial skills that are medically necessary to
 259.11 rehabilitate the child to an age-appropriate developmental trajectory when the child's
 259.12 development was disrupted by a mental health condition or diagnosed mental illness; or

259.13 (2) enable the child to self-monitor, compensate for, cope with, counteract, or replace
 259.14 skills deficits or maladaptive skills acquired over the course of the child's mental health
 259.15 condition or mental illness.

259.16 (d) Skills development or training delivered to a child or the child's family under this
 259.17 subdivision must be targeted to the specific deficits related to the child's mental health
 259.18 condition or mental illness and must be prescribed in the child's individual treatment plan.
 259.19 Group skills training may be provided to multiple recipients who, because of the nature of
 259.20 their emotional, behavioral, or social functional ability, may benefit from interaction in a
 259.21 group setting.

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

258.1 Sec. 22. Minnesota Statutes 2023 Supplement, section 256B.0671, subdivision 5, is
 258.2 amended to read:

258.3 Subd. 5. **Child and family psychoeducation services.** (a) Medical assistance covers
 258.4 child and family psychoeducation services provided to a child up to under age 21 with and
 258.5 the child's family members when determined to be medically necessary due to a diagnosed
 258.6 mental health condition when or diagnosed mental illness identified in the child's individual
 258.7 treatment plan and provided by a mental health professional who is qualified under section
 258.8 245I.04, subdivision 2, and practicing within the scope of practice under section 245I.04,
 258.9 subdivision 3; a mental health practitioner who is qualified under section 245I.04, subdivision
 258.10 4, and practicing within the scope of practice under section 245I.04, subdivision 5; or a
 258.11 clinical trainee who has determined it medically necessary to involve family members in
 258.12 the child's care is qualified under section 245I.04, subdivision 6, and practicing within the
 258.13 scope of practice under section 245I.04, subdivision 7.

258.14 (b) "Child and family psychoeducation services" means information or demonstration
 258.15 provided to an individual or family as part of an individual, family, multifamily group, or
 258.16 peer group session to explain, educate, and support the child and family in understanding
 258.17 a child's symptoms of mental illness, the impact on the child's development, and needed
 258.18 components of treatment and skill development so that the individual, family, or group can
 258.19 help the child to prevent relapse, prevent the acquisition of comorbid disorders, and achieve
 258.20 optimal mental health and long-term resilience.

258.21 (c) Child and family psychoeducation services include individual, family, or group skills
 258.22 development or training to:

258.23 (1) support the development of psychosocial skills that are medically necessary to support
 258.24 the child to an age-appropriate developmental trajectory when the child's development was
 258.25 disrupted by a mental health condition or diagnosed mental illness; or

258.26 (2) enable the child to self-monitor, compensate for, cope with, counteract, or replace
 258.27 skills deficits or maladaptive skills acquired over the course of the child's mental health
 258.28 condition or mental illness.

258.29 (d) Skills development or training delivered to a child or the child's family under this
 258.30 subdivision must be targeted to the specific deficits related to the child's mental health
 258.31 condition or mental illness and must be prescribed in the child's individual treatment plan.
 258.32 Group skills training may be provided to multiple recipients who, because of the nature of
 258.33 their emotional, behavioral, or social functional ability, may benefit from interaction in a
 258.34 group setting.

259.25 Sec. 22. Minnesota Statutes 2022, section 256B.0757, is amended by adding a subdivision
 259.26 to read:

259.27 **Subd. 5a. Payments for behavioral health home services.** The commissioner must
 259.28 implement a single statewide reimbursement rate for behavioral health home services under
 259.29 this section. The rate must be no less than \$335.18 per member per month. The commissioner
 259.30 must adjust the statewide reimbursement rate annually according to the change from the
 259.31 midpoint of the previous rate year to the midpoint of the rate year for which the rate is being
 259.32 determined using the Centers for Medicare and Medicaid Services Medicare Economic
 259.33 Index as forecasted in the fourth quarter of the calendar year before the rate year.

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

260.4 Sec. 23. Minnesota Statutes 2022, section 256B.0943, subdivision 12, is amended to read:

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

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

260.9 (2) treatment by multiple providers within the same agency at the same clock time,
 260.10 unless one service is delivered to the child and the other service is delivered to child's family
 260.11 or treatment team without the child present;

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

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

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

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

260.22 (i) a service that is primarily recreation oriented or that is provided in a setting that is
 260.23 not medically supervised. This includes sports activities, exercise groups, activities such as
 260.24 craft hours, leisure time, social hours, meal or snack time, trips to community activities,
 260.25 and tours;

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

259.1 Sec. 23. Minnesota Statutes 2022, section 256B.0943, subdivision 12, is amended to read:

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

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

259.6 (2) treatment by multiple providers within the same agency at the same clock time,
 259.7 unless one service is delivered to the child and the other service is delivered to the child's
 259.8 family or treatment team without the child present;

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

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

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

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

259.19 (i) a service that is primarily recreation oriented or that is provided in a setting that is
 259.20 not medically supervised. This includes sports activities, exercise groups, activities such as
 259.21 craft hours, leisure time, social hours, meal or snack time, trips to community activities,
 259.22 and tours;

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

260.28 (iii) prevention or education programs provided to the community; and
 260.29 (iv) treatment for clients with primary diagnoses of alcohol or other drug abuse.

261.1 Sec. 24. Minnesota Statutes 2022, section 256B.0947, subdivision 5, is amended to read:

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

261.5 (b) The treatment team must have specialized training in providing services to the specific
 261.6 age group of youth that the team serves. An individual treatment team must serve youth
 261.7 who are: (1) at least eight years of age or older and under 16 years of age, or (2) at least 14
 261.8 years of age or older and under 21 years of age.

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

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

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

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

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

261.23 (iv) (iii) a mental health certified peer specialist who is qualified according to section
 261.24 245I.04, subdivision 10, and is also a former children's mental health consumer; and

261.25 (iv) a co-occurring disorder specialist who meets the requirements under section
 261.26 256B.0622, subdivision 7a, paragraph (a), clause (4), who will provide or facilitate the
 261.27 provision of co-occurring disorder treatment to clients.

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

261.29 (i) additional mental health professionals;

261.30 (ii) a vocational specialist;

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

259.25 (iii) prevention or education programs provided to the community; and
 259.26 (iv) treatment for clients with primary diagnoses of alcohol or other drug abuse.

259.27 Sec. 24. Minnesota Statutes 2022, section 256B.0947, subdivision 5, is amended to read:

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

260.1 (b) The treatment team must have specialized training in providing services to the specific
 260.2 age group of youth that the team serves. An individual treatment team must serve youth
 260.3 who are: (1) at least eight years of age or older and under 16 years of age, or (2) at least 14
 260.4 years of age or older and under 21 years of age.

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

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

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

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

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

260.19 (iv) (iii) a mental health certified peer specialist who is qualified according to section
 260.20 245I.04, subdivision 10, and is also a former children's mental health consumer; and

260.21 (iv) a co-occurring disorder specialist who meets the requirements under section
 260.22 256B.0622, subdivision 7a, paragraph (a), clause (4), who will provide or facilitate the
 260.23 provision of co-occurring disorder treatment to clients.

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

260.25 (i) additional mental health professionals;

260.26 (ii) a vocational specialist;

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

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

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

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

262.7 (vii) a case management service provider, as defined in section 245.4871, subdivision
262.8 4;

262.9 (viii) a housing access specialist; and

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

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

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

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

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

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

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

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

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

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

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

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

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

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

261.2 (vii) a case management service provider, as defined in section 245.4871, subdivision
261.3 4;

261.4 (viii) a housing access specialist; and

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

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

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

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

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

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

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

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

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

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

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

263.8 (g) Nonclinical staff shall have prompt access in person or by telephone to a mental
 263.9 health practitioner, clinical trainee, or mental health professional. The provider shall have
 263.10 the capacity to promptly and appropriately respond to emergent needs and make any
 263.11 necessary staffing adjustments to ensure the health and safety of clients.

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

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

263.17 Sec. 25. Minnesota Statutes 2022, section 256B.76, subdivision 6, is amended to read:

263.18 Subd. 6. **Medicare relative value units.** (a) Effective for services rendered on or after
 263.19 January 1, 2007, the commissioner shall make payments for physician and professional
 263.20 services based on the Medicare relative value units (RVUs). This change shall be budget
 263.21 neutral and the cost of implementing RVUs will be incorporated in the established conversion
 263.22 factor.

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

263.27 (c) The commissioner must revise and implement payment rates for mental health services
 263.28 based on RVUs and rendered on or after January 1, 2025, so that the payment rates are at
 263.29 least equal to 83 percent of the Medicare Physician Fee Schedule.

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

264.1 Sec. 26. Laws 2023, chapter 70, article 1, section 35, is amended to read:

264.2 Sec. 35. Minnesota Statutes 2022, section 256B.761, is amended to read:

264.3 **256B.761 REIMBURSEMENT FOR MENTAL HEALTH SERVICES.**

264.4 (a) Effective for services rendered on or after July 1, 2001, payment for medication
 264.5 management provided to psychiatric patients, outpatient mental health services, day treatment
 264.6 services, home-based mental health services, and family community support services shall
 264.7 be paid at the lower of (1) submitted charges, or (2) 75.6 percent of the 50th percentile of
 264.8 1999 charges.

262.1 (g) Nonclinical staff shall have prompt access in person or by telephone to a mental
 262.2 health practitioner, clinical trainee, or mental health professional. The provider shall have
 262.3 the capacity to promptly and appropriately respond to emergent needs and make any
 262.4 necessary staffing adjustments to ensure the health and safety of clients.

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

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

HOUSE ARTICLE 9, SECTION 25, WAS MOVED TO MATCH SENATE ARTICLE 2, SECTION 13.

263.7 Sec. 26. Minnesota Statutes 2022, section 256B.76, subdivision 6, is amended to read:

263.8 Subd. 6. **Medicare relative value units.** (a) Effective for services rendered on or after
 263.9 January 1, 2007, the commissioner shall make payments for physician and professional
 263.10 services based on the Medicare relative value units (RVUs) (RVUs). This change shall be budget
 263.11 neutral and the cost of implementing RVUs RVUs will be incorporated in the
 263.12 established conversion factor.

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

263.17 (c) The commissioner must revise and implement payment rates for mental health services
 263.18 based on RVUs and rendered on or after January 1, 2025, so that the payment rates are at
 263.19 least equal to 84 percent of the Medicare Physician Fee Schedule.

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

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

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

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

264.27 (e) Effective for services rendered on or after January 1, 2024, payment rates for
264.28 behavioral health services included in the rate analysis required by Laws 2021, First Special
264.29 Session chapter 7, article 17, section 18, except for adult day treatment services under section
264.30 256B.0671, subdivision 3; early intensive developmental and behavioral intervention services
264.31 under section 256B.0949; and substance use disorder services under chapter 254B, must be
264.32 increased by three percent from the rates in effect on December 31, 2023. Effective for
264.33 services rendered on or after January 1, 2025, payment rates for behavioral health services
265.1 included in the rate analysis required by Laws 2021, First Special Session chapter 7, article
265.2 17, section 18, except for adult day treatment services under section 256B.0671, subdivision
265.3 3; early intensive developmental behavioral intervention services under section 256B.0949;
265.4 and substance use disorder services under chapter 254B, must be annually adjusted according
265.5 to the change from the midpoint of the previous rate year to the midpoint of the rate year
265.6 for which the rate is being determined using the Centers for Medicare and Medicaid Services
265.7 Medicare Economic Index as forecasted in the fourth quarter of the calendar year before
265.8 the rate year. For payments made in accordance with this paragraph, if and to the extent
265.9 that the commissioner identifies that the state has received federal financial participation
265.10 for behavioral health services in excess of the amount allowed under United States Code,
265.11 title 42, section 447.321, the state shall repay the excess amount to the Centers for Medicare
265.12 and Medicaid Services with state money and maintain the full payment rate under this
265.13 paragraph. This paragraph does not apply to federally qualified health centers, rural health
265.14 centers, Indian health services, certified community behavioral health clinics, cost-based
265.15 rates, and rates that are negotiated with the county. This paragraph expires upon legislative
265.16 implementation of the new rate methodology resulting from the rate analysis required by
265.17 Laws 2021, First Special Session chapter 7, article 17, section 18.

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

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

266.1 Sec. 27. **FIRST EPISODE PSYCHOSIS COORDINATED SPECIALITY CARE**
266.2 **MEDICAL ASSISTANCE BENEFIT.**

266.3 (a) The commissioner of human services must develop a First Episode Psychosis
266.4 Coordinated Specialty Care (FEP-CSC) medical assistance benefit.

266.5 (b) The benefit must cover medically necessary treatment. Services must include:

266.6 (1) assertive outreach and engagement strategies encouraging individuals' involvement;

266.7 (2) person-centered care, delivered in the home and community, extending beyond
266.8 typical hours of operation, such as evenings and weekends;

266.9 (3) crisis planning and intervention;

266.10 (4) team leadership from a mental health professional who provides ongoing consultation
266.11 to the team members, coordinates admission screening, and leads the weekly team meetings
266.12 to facilitate case review and entry to the program;

266.13 (5) employment and education services that enable individuals to function in workplace
266.14 and educational settings that support individual preferences;

266.15 (6) family education and support that builds on an individual's identified family and
266.16 natural support systems;

266.17 (7) individual and group psychotherapy that include but are not limited to cognitive
266.18 behavioral therapies;

266.19 (8) care coordination services in clinic, community, and home settings to assist individuals
266.20 with practical problem solving, such as securing transportation, addressing housing and

266.21 other basic needs, managing money, obtaining medical care, and coordinating care with
 266.22 other providers; and

266.23 (9) pharmacotherapy, medication management, and primary care coordination provided
 266.24 by a mental health professional who is permitted to prescribe psychiatric medications.

266.25 (c) An eligible recipient is an individual who:

266.26 (1) is between the ages of 15 and 40;

266.27 (2) is experiencing early signs of psychosis with the duration of onset being less than
 266.28 two years; and

266.29 (3) has been on antipsychotic medications for less than a total of 12 months.

267.1 (d) By December 1, 2026, the commissioner must submit a report to the chairs and
 267.2 ranking minority members of the legislative committees with jurisdiction over human
 267.3 services policy and finance. The report must include:

267.4 (1) an overview of the recommended benefit;

267.5 (2) eligibility requirements;

267.6 (3) program standards;

267.7 (4) a reimbursement methodology that covers team-based bundled costs;

267.8 (5) performance evaluation criteria for programs; and

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

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

267.11 Sec. 28. **MEDICAL ASSISTANCE CHILDREN'S RESIDENTIAL MENTAL**
 267.12 **HEALTH CRISIS STABILIZATION.**

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

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

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

267.22 (3) qualify for federal financial participation; and

265.1 Sec. 28. **DIRECTION TO COMMISSIONER OF HUMAN SERVICES; MEDICAL**
 265.2 **ASSISTANCE CHILDREN'S RESIDENTIAL MENTAL HEALTH CRISIS**
 265.3 **STABILIZATION.**

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

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

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

265.13 (3) qualify for federal financial participation; and

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

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

267.25 crisis;

267.26 (ii) individualized care to address immediate needs and restore the child to a precrisis

267.27 level of functioning;

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

267.29 (iv) supportive counseling and clinical services;

268.1 (v) skills training and positive support services, as identified in the child's individual

268.2 crisis stabilization plan;

268.3 (vi) referrals to other service providers in the community as needed and to support the

268.4 child's transition from residential crisis stabilization services;

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

268.6 plan; and

268.7 (viii) assistance to access and store medication.

268.8 (b) When developing the new benefit, the commissioner must make recommendations

268.9 for providers to be reimbursed for room and board.

268.10 (c) The commissioner must consult with or contract with rate-setting experts to develop

268.11 a prospective data-based rate methodology for the children's residential mental health crisis

268.12 stabilization benefit.

268.13 (d) No later than October 1, 2025, the commissioner must submit to the chairs and

268.14 ranking minority members of the legislative committees with jurisdiction over human

268.15 services policy and finance a report detailing the children's residential mental health crisis

268.16 stabilization benefit and must include:

268.17 (1) eligibility criteria, clinical and service requirements, provider standards, licensing

268.18 requirements, and reimbursement rates;

268.19 (2) the process for community engagement, community input, and crisis models studied

268.20 in other states;

268.21 (3) a deadline for the commissioner to submit a state plan amendment to the Centers for

268.22 Medicare and Medicaid Services; and

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

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

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

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

265.16 crisis;

265.17 (ii) individualized care to address immediate needs and restore the child to a precrisis

265.18 level of functioning;

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

265.20 (iv) supportive counseling and clinical services;

265.21 (v) skills training and positive support services, as identified in the child's individual

265.22 crisis stabilization plan;

265.23 (vi) referrals to other service providers in the community as needed and to support the

265.24 child's transition from residential crisis stabilization services;

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

265.26 plan; and

265.27 (viii) assistance to access and store medication.

265.28 (b) When developing the new benefit, the commissioner must make recommendations

265.29 for providers to be reimbursed for room and board.

266.1 (c) The commissioner must consult with or contract with rate-setting experts to develop

266.2 a prospective data-based rate methodology for the children's residential mental health crisis

266.3 stabilization benefit.

266.4 (d) No later than January 15, 2025, the commissioner must submit to the chairs and

266.5 ranking minority members of the legislative committees with jurisdiction over human

266.6 services policy and finance a report detailing for the children's residential mental health

266.7 crisis stabilization benefit the proposed:

266.8 (1) eligibility criteria, clinical and service requirements, provider standards, licensing

266.9 requirements, and reimbursement rates;

266.10 (2) the process for community engagement, community input, and crisis models studied

266.11 in other states;

266.12 (3) a deadline for the commissioner to submit a state plan amendment to the Centers for

266.13 Medicare and Medicaid Services; and

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

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

268.25 Sec. 29. **MEDICAL ASSISTANCE CLUBHOUSE BENEFIT ANALYSIS.**

268.26 The commissioner of human services must conduct an analysis to identify existing or
268.27 pending Medicaid Clubhouse benefits in other states, federal authorities used, populations
268.28 served, service and reimbursement design, and accreditation standards. By December 1,
268.29 2025, the commissioner must submit a report to the chairs and ranking minority members
268.30 of the legislative committees with jurisdiction over health and human services finance and
269.1 policy. The report must include a comparative analysis of Medicaid Clubhouse programs
269.2 and recommendations for designing a medical assistance benefit in Minnesota.

269.3 Sec. 30. **STUDY ON MEDICAL ASSISTANCE CHILDREN'S INTENSIVE
269.4 RESIDENTIAL TREATMENT BENEFIT.**

269.5 (a) The commissioner of human services must consult with providers, advocates, Tribal
269.6 Nations, counties, people with lived experience as or with a child experiencing mental health
269.7 conditions, and other interested community members to develop a medical assistance state
269.8 plan covered benefit to provide intensive residential mental health services for children and
269.9 youth. The benefit must:

269.10 (1) consist of evidence-based promising practices and culturally responsive treatment
269.11 services for children under the age of 21;

269.12 (2) adapt to an integrative care model that supports individuals experiencing mental
269.13 health and co-occurring conditions;

269.14 (3) qualify for federal financial participation; and

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

269.17 (i) assessment;

269.18 (ii) individual treatment planning;

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

269.20 (iv) supportive counseling and clinical services; and

269.21 (v) referrals to other service providers in the community as needed and to support
269.22 transition to the family home or own home.

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

269.25 (c) The commissioner must consult with or contract with rate-setting experts to develop
269.26 a prospective data-based rate methodology for the children's intensive residential mental
269.27 health services.

269.28 (d) No later than August 1, 2026, the commissioner must submit to the chairs and ranking
 269.29 minority members of the legislative committees with jurisdiction over human services policy
 269.30 and finance a report detailing the proposed benefit, including:

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

270.3 (2) the process for community engagement, community input, and residential models
 270.4 studied in other states;

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

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

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

263.23 Sec. 27. **DIRECTION TO COMMISSIONER OF HUMAN SERVICES; CHILDREN'S RESIDENTIAL FACILITY RULEMAKING.**

263.25 (a) The commissioner of human services must use the expedited rulemaking process
 263.26 and comply with all requirements under Minnesota Statutes, section 14.389, to adopt the
 263.27 amendments required under this section. Notwithstanding Laws 1995, chapter 226, article
 263.28 3, sections 50, 51, and 60, or any other law to the contrary, joint rulemaking authority with
 263.29 the commissioner of corrections does not apply to rule amendments applicable only to the
 263.30 commissioner of human services. An amendment to jointly administered rule parts must be
 263.31 related to requirements under this section or to amendments that are necessary for consistency
 263.32 with this section.

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

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

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

264.9 (e) The commissioner of human services must amend Minnesota Rules, parts 2960.0020
 264.10 to 2960.0710, to replace all instances of "physician" with "licensed prescriber." Amendments
 264.11 to rules under this paragraph must apply only to the Department of Human Services.

264.12 (f) The commissioner of human services must amend Minnesota Rules, part 2960.0620,
 264.13 subpart 2, to strike all of the current language and insert the following language: "If a resident
 264.14 is prescribed a psychotropic medication, the license holder must monitor for side effects of

264.15 the medication. Within 24 hours of admission, a registered nurse or licensed prescriber must
 264.16 assess the resident for and document any current side effects and document instructions for
 264.17 how frequently the license holder must monitor for side effects of the psychotropic
 264.18 medications the resident is taking. When a resident begins taking a new psychotropic
 264.19 medication or stops taking a psychotropic medication, the license holder must monitor for
 264.20 side effects according to the instructions of the registered nurse or licensed prescriber. The
 264.21 license holder must monitor for side effects using standardized checklists, rating scales, or
 264.22 other tools according to the instructions of the registered nurse or licensed prescriber. The
 264.23 license holder must provide the results of the checklist, rating scale, or other tool to the
 264.24 licensed prescriber for review."

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

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

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

266.16 Sec. 29. **DIRECTION TO COMMISSIONER OF HUMAN SERVICES; MENTAL**
 266.17 **HEALTH PROCEDURE CODES.**

266.18 The commissioner of human services must develop recommendations, in consultation
 266.19 with external partners and medical coding and compliance experts, on simplifying mental
 266.20 health procedure codes and the feasibility of converting mental health procedure codes to
 266.21 the current procedural terminology (CPT) code structure. By October 1, 2025, the
 266.22 commissioner must submit a report to the chairs and ranking minority members of the
 266.23 legislative committees with jurisdiction over mental health on the recommendations and
 266.24 methodology to simplify and restructure mental health procedure codes with corresponding
 266.25 resource-based relative value scale (RBRVS) values.

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

266.27 Sec. 30. **DIRECTION TO COMMISSIONER OF HUMAN SERVICES; RESPITE**
 266.28 **CARE ACCESS.**

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

270.9 **Sec. 31. REVISOR INSTRUCTION.**

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

267.4 **Sec. 31. MENTAL HEALTH SERVICES FORMULA-BASED ALLOCATION.**

267.5 The commissioner of human services shall consult with the commissioner of management
267.6 and budget, counties, Tribes, mental health providers, and advocacy organizations to develop
267.7 recommendations for moving from the children's and adult mental health grant funding
267.8 structure to a formula-based allocation structure for mental health services. The
267.9 recommendations must consider formula-based allocations for grants for respite care,
267.10 school-linked behavioral health, mobile crisis teams, and first episode of psychosis programs.

267.11 **Sec. 32. REVISOR INSTRUCTION.**

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