

ARTICLE 9

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"
231.11 means services, other than inpatient or residential treatment services, provided or coordinated
231.12 by an identified program and staff under the treatment supervision of a mental health
231.13 professional designed to help adults with serious and persistent mental illness to function
231.14 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
231.24 services specified in section 245.4711. A program that meets the accreditation standards
231.25 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
231.28 health provider must:

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

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

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

ARTICLE 9

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"
229.15 means services, other than inpatient or residential treatment services, provided or coordinated
229.16 by an identified program and staff under the treatment supervision of a mental health
229.17 professional designed to help adults with serious and persistent mental illness to function
229.18 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
229.28 services specified in section 245.4711. A program that meets the accreditation standards
229.29 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
230.3 health provider must:

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

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

- 230.11 (3) provide services to people in a city or township that is not within the seven-county
230.12 metropolitan area as defined in section 473.121, subdivision 2, and is not the city of Duluth,
230.13 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:

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230.24 subdivision 15, and their families;

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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 (ESCH). For a client six to 17 years of age,~~
234.11 ~~a functional assessment is the Child and Adolescent Service Intensity Instrument (CASII).~~
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 (ESCH). 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 (ESCH). For a client six to 17 years of age,~~
232.15 ~~a functional assessment is the Child and Adolescent Service Intensity Instrument (CASII).~~
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 (ESCH). 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 (CASH). 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.~~

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;

232.22 ~~a client six to 17 years of age, a level of care assessment is the Child and Adolescent Service~~
232.23 ~~Intensity Instrument (CASH). 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.~~

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 (c).

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,
242.30 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**
243.3 **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**
239.31 **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,
247.15 experience, and competency to provide a full breadth of rehabilitation services. Each staff
247.16 member shall be proficient in their respective discipline and be able to work collaboratively
247.17 as a member of a multidisciplinary team to deliver the majority of the treatment,
247.18 rehabilitation, and support services clients require to fully benefit from receiving assertive
247.19 community treatment.

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

247.22 Sec. 16. Minnesota Statutes 2023 Supplement, section 256B.0622, subdivision 7b, is
247.23 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,
244.9 experience, and competency to provide a full breadth of rehabilitation services. Each staff
244.10 member shall be proficient in their respective discipline and be able to work collaboratively
244.11 as a member of a multidisciplinary team to deliver the majority of the treatment,
244.12 rehabilitation, and support services clients require to fully benefit from receiving assertive
244.13 community treatment.

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

244.16 Sec. 16. Minnesota Statutes 2023 Supplement, section 256B.0622, subdivision 7b, is
244.17 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**
250.16 **plan.** (a) An initial assessment shall be completed the day of the client's admission to
250.17 assertive community treatment by the ACT team leader or the psychiatric care provider,
250.18 with participation by designated ACT team members and the client. The initial assessment
250.19 must include obtaining or completing a standard diagnostic assessment according to section
250.20 245I.10, subdivision 6, and completing a 30-day individual treatment plan. The team leader,
250.21 psychiatric care provider, or other mental health professional designated by the team leader
250.22 or psychiatric care provider, must update the client's diagnostic assessment ~~at least annually,~~
250.23 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**
247.10 **plan.** (a) An initial assessment shall be completed the day of the client's admission to
247.11 assertive community treatment by the ACT team leader or the psychiatric care provider,
247.12 with participation by designated ACT team members and the client. The initial assessment
247.13 must include obtaining or completing a standard diagnostic assessment according to section
247.14 245I.10, subdivision 6, and completing a 30-day individual treatment plan. The team leader,
247.15 psychiatric care provider, or other mental health professional designated by the team leader
247.16 or psychiatric care provider, must update the client's diagnostic assessment ~~at least annually,~~
247.17 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.

256.17 (g) If the service is provided by a team which includes contracted vendors, tribal staff,
256.18 and county or state staff, the costs for county or state staff participation in the team shall be
256.19 included in the rate for county-provided services. In this case, the contracted vendor, the
256.20 tribal agency, and the county may each receive separate payment for services provided by
256.21 each entity in the same month. In order to prevent duplication of services, each entity must
256.22 document, in the recipient's file, the need for team case management and a description of
256.23 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
257.10 (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
258.24 support
258.25 the child to an age-appropriate developmental trajectory when the child's development was
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
260.10 care. The core team must comprise at least four full-time equivalent direct care staff and
260.11 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 (RVU's). This change shall be budget
263.21 neutral and the cost of implementing RVU's 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 (~~RVU's~~) (RVUs). This change shall be
263.11 budget neutral and the cost of implementing ~~RVU's~~ 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;**
263.24 **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.