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ARTICLE 9

BEHAVIORAL HEALTH

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

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

(1) client outreach,

(2) medication monitoring,

(3) assistance in independent living skills,

(4) development of employability and work-related opportunities,

(5) crisis assistance,

(6) psychosocial rehabilitation,

(7) help in applying for government benefits, and

(8) housing support services.

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

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

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

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

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

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

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ARTICLE 9

MENTAL HEALTH

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

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

(1) client outreach,

(2) medication monitoring,

(3) assistance in independent living skills,

(4) development of employability and work-related opportunities,

(5) crisis assistance,

(6) psychosocial rehabilitation,

(7) help in applying for government benefits, and

(8) housing support services.

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

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

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

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

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

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

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

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

(1) counties;

(2) Indian tribes;

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

(4) mental health service providers.

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

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

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

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

(4) children's mental health crisis services;

(5) child-, youth-, and family-specific mobile response and stabilization services models;

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

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

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

(9) school-linked mental health services under section 245.4901;

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

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

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

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

(1) counties;

(2) Indian tribes;

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

(4) mental health service providers.

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

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

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

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

(4) children's mental health crisis services;

(5) child-, youth-, and family-specific mobile response and stabilization services models;

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

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

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

(9) school-linked mental health services under section 245.4901;

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

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

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(12) mental health first aid training;

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

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

(15) early childhood mental health consultation;

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

(17) psychiatric consultation for primary care practitioners; and

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

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

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

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

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

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

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

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

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(12) mental health first aid training;

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

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

(15) early childhood mental health consultation;

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

(17) psychiatric consultation for primary care practitioners; and

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

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

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

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

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

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

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

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

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

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

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

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

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

(i) the client's mental health symptoms;

(ii) the client's mental health service needs;

(iii) the client's substance use;

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

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

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

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

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

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

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

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

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

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

(i) the client's mental health symptoms;

(ii) the client's mental health service needs;

(iii) the client's substance use;

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

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

(vi) the client's interpersonal functioning, including relationships with the client's family and other natural supports;

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

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

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

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

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

~~(6)~~ (5) complete the client's functional assessment before the client's initial individual treatment plan unless a service specifies otherwise; and

~~(7)~~ (6) update the client's functional assessment with the client's current functioning whenever there is a significant change in the client's functioning or at least every ~~180~~ 365 days, unless a service specifies otherwise.

(b) A license holder may use any available, validated measurement tool, including but not limited to the Daily Living Activities-20, when completing the required elements of a functional assessment under this subdivision.

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

Subdivision 1. **Generally.** (a) If a license holder is licensed as a residential program, stores or administers client medications, or observes clients self-administer medications, the license holder must ensure that a staff person who is a registered nurse or licensed prescriber is responsible for overseeing storage and administration of client medications and observing as a client self-administers medications, including training according to section 245I.05, subdivision 6, and documenting the occurrence according to section 245I.08, subdivision 5.

(b) For purposes of this section, "observed self-administration" means the preparation and administration of a medication by a client to themselves under the direct supervision of a registered nurse or a staff member to whom a registered nurse delegates supervision duty. Observed self-administration does not include a client's use of a medication that they keep in their own possession while participating in a program.

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

Subd. 6. **Medication administration in children's day treatment settings.** (a) For a program providing children's day treatment services under section 256B.0943, the license

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

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

(vi) the client's interpersonal functioning, including relationships with the client's family and other natural supports;

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

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

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

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

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

~~(6)~~ (5) complete the client's functional assessment before the client's initial individual treatment plan unless a service specifies otherwise; and

~~(7)~~ (6) update the client's functional assessment with the client's current functioning whenever there is a significant change in the client's functioning or at least every ~~180~~ 365 days, unless a service specifies otherwise.

(b) A license holder may use any available, validated measurement tool, including but not limited to the Daily Living Activities-20, when completing the required elements of a functional assessment under this subdivision.

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

Subdivision 1. **Generally.** (a) If a license holder is licensed as a residential program, stores or administers client medications, or observes clients self-administer medications, the license holder must ensure that a staff person who is a registered nurse or licensed prescriber is responsible for overseeing storage and administration of client medications and observing as a client self-administers medications, including training according to section 245I.05, subdivision 6, and documenting the occurrence according to section 245I.08, subdivision 5.

(b) For purposes of this section, "observed self-administration" means the preparation and administration of a medication by a client to themselves under the direct supervision of a registered nurse or a staff member to whom a registered nurse delegates supervision duty. Observed self-administration does not include a client's use of a medication that they keep in their own possession while participating in a program.

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

Subd. 6. **Medication administration in children's day treatment settings.** (a) For a program providing children's day treatment services under section 256B.0943, the license

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

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

(1) an evaluation that the client is capable of holding and administering the medication safely;

(2) an evaluation of whether the medication is prone to diversion, misuse, or self-injury; and

(3) any conditions under which the license holder should no longer allow the client to maintain the medication in their own possession.

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

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

(b) The treatment team must include:

(1) a physician qualified as a mental health professional according to section 245I.04, subdivision 2, clause (4), or a nurse qualified as a mental health professional according to section 245I.04, subdivision 2, clause (1); and

(2) a psychologist qualified as a mental health professional according to section 245I.04, subdivision 2, clause (3).

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

(1) eight hours every two weeks if the mental health clinic has over 25.0 full-time equivalent treatment team members;

(2) eight hours each month if the mental health clinic has 15.1 to 25.0 full-time equivalent treatment team members;

(3) four hours each month if the mental health clinic has 5.1 to 15.0 full-time equivalent treatment team members; or

(4) two hours each month if the mental health clinic has 2.0 to 5.0 full-time equivalent treatment team members or only provides in-home services to clients.

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

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

(1) an evaluation that the client is capable of holding and administering the medication safely;

(2) an evaluation of whether the medication is prone to diversion, misuse, or self-injury; and

(3) any conditions under which the license holder should no longer allow the client to maintain the medication in their own possession.

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

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

(b) The treatment team must include:

(1) a physician qualified as a mental health professional according to section 245I.04, subdivision 2, clause (4), or a nurse qualified as a mental health professional according to section 245I.04, subdivision 2, clause (1); and

(2) a psychologist qualified as a mental health professional according to section 245I.04, subdivision 2, clause (3).

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

(1) eight hours every two weeks if the mental health clinic has over 25.0 full-time equivalent treatment team members;

(2) eight hours each month if the mental health clinic has 15.1 to 25.0 full-time equivalent treatment team members;

(3) four hours each month if the mental health clinic has 5.1 to 15.0 full-time equivalent treatment team members; or

(4) two hours each month if the mental health clinic has 2.0 to 5.0 full-time equivalent treatment team members or only provides in-home services to clients.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(1) children's intensive behavioral health services under section 256B.0946; and

(2) intensive nonresidential rehabilitative mental health services under section 256B.0947.

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

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

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

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

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

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

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

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

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

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

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

(1) children's intensive behavioral health services under section 256B.0946; and

(2) intensive nonresidential rehabilitative mental health services under section 256B.0947.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(iii) significant difficulty maintaining a safe living situation;

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

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

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

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

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

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

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

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

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

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

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

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

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

(iii) significant difficulty maintaining a safe living situation;

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

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

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

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

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

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

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

(vii) significant difficulty meeting basic survival needs;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(vii) significant difficulty meeting basic survival needs;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(1) have capacity to recruit, hire, manage, and train required ACT team members;

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

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

(4) keep all necessary records required by law;

(5) be an enrolled Medicaid provider; and

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

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

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

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

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

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

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

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

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

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

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

(1) have capacity to recruit, hire, manage, and train required ACT team members;

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

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

(4) keep all necessary records required by law;

(5) be an enrolled Medicaid provider; and

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

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

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

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

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(1) the team leader:

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

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

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

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

(2) the psychiatric care provider:

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

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

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

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

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

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(1) the team leader:

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

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

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

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

(2) the psychiatric care provider:

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

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

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

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

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

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

(3) the nursing staff:

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

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

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

(4) the co-occurring disorder specialist:

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

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

(5) the vocational specialist:

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

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

(3) the nursing staff:

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

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

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

(4) the co-occurring disorder specialist:

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

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

(5) the vocational specialist:

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

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

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

(6) the mental health certified peer specialist:

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

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

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

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

(8) additional staff:

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

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

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

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

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

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

(6) the mental health certified peer specialist:

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

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

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

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

(8) additional staff:

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

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

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

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

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

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

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

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

~~(1) a small ACT team must:~~

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

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

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

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

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

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

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

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

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

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

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

~~(1) a small ACT team must:~~

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

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

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

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

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

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

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

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

~~(2) a midsize ACT team shall:~~

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

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

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

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

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

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

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

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

~~(3) a large ACT team must:~~

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

~~(2) a midsize ACT team shall:~~

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

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

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

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

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

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

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

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

~~(3) a large ACT team must:~~

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(2) programming the information systems.

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

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

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

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

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

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

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

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

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

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

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

(2) programming the information systems.

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

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

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

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

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

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

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

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

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

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

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

(1) support the development of psychosocial skills that are medically necessary to rehabilitate 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

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

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

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

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

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

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

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

(1) support the development of psychosocial skills that are medically necessary to support 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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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(iii) prevention or education programs provided to the community; and

(iv) treatment for clients with primary diagnoses of alcohol or other drug abuse.

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

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

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

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

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

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

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

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

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

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

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

(i) additional mental health professionals;

(ii) a vocational specialist;

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

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(iii) prevention or education programs provided to the community; and

(iv) treatment for clients with primary diagnoses of alcohol or other drug abuse.

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

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

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

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

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

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

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

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

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

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

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

(i) additional mental health professionals;

(ii) a vocational specialist;

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

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

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

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

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

(viii) a housing access specialist; and

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(viii) a housing access specialist; and

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

256B.761 REIMBURSEMENT FOR MENTAL HEALTH SERVICES.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(3) crisis planning and intervention;

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

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

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

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

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

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

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

(c) An eligible recipient is an individual who:

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

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

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

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

(1) an overview of the recommended benefit;

(2) eligibility requirements;

(3) program standards;

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

(5) performance evaluation criteria for programs; and

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

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

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

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

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

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

(3) qualify for federal financial participation; and

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

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

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

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

(3) qualify for federal financial participation; and

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

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

(ii) individualized care to address immediate needs and restore the child to a precrisis level of functioning;

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

(iv) supportive counseling and clinical services;

(v) skills training and positive support services, as identified in the child's individual crisis stabilization plan;

(vi) referrals to other service providers in the community as needed and to support the child's transition from residential crisis stabilization services;

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

(viii) assistance to access and store medication.

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

(c) The commissioner must consult with or contract with rate-setting experts to develop a prospective data-based rate methodology for the children's residential mental health crisis stabilization benefit.

(d) No later than October 1, 2025, the commissioner must submit to the chairs and ranking minority members of the legislative committees with jurisdiction over human services policy and finance a report detailing the children's residential mental health crisis stabilization benefit and must include:

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

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

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

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

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

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

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

(ii) individualized care to address immediate needs and restore the child to a precrisis level of functioning;

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

(iv) supportive counseling and clinical services;

(v) skills training and positive support services, as identified in the child's individual crisis stabilization plan;

(vi) referrals to other service providers in the community as needed and to support the child's transition from residential crisis stabilization services;

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

(viii) assistance to access and store medication.

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

(c) The commissioner must consult with or contract with rate-setting experts to develop a prospective data-based rate methodology for the children's residential mental health crisis stabilization benefit.

(d) No later than January 15, 2025, the commissioner must submit to the chairs and ranking minority members of the legislative committees with jurisdiction over human services policy and finance a report detailing for the children's residential mental health crisis stabilization benefit the proposed:

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

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

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

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

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

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

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

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

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

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

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

(3) qualify for federal financial participation; and

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

(i) assessment;

(ii) individual treatment planning;

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

(iv) supportive counseling and clinical services; and

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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Sec. 31. **REVISOR INSTRUCTION.**

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

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

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

Sec. 32. **REVISOR INSTRUCTION.**

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