

179.19

ARTICLE 6

179.20 **ASSERTIVE COMMUNITY TREATMENT AND INTENSIVE RESIDENTIAL**
179.21 **TREATMENT SERVICES RECODIFICATION**

179.22 Section 1. Minnesota Statutes 2024, section 256B.0622, subdivision 1, is amended to read:

179.23 Subdivision 1. **Scope.** (a) Subject to federal approval, medical assistance covers medically
179.24 necessary, assertive community treatment when the services are provided by an entity
179.25 certified under and meeting the standards in this section.

179.26 ~~(b) Subject to federal approval, medical assistance covers medically necessary, intensive~~
179.27 ~~residential treatment services when the services are provided by an entity licensed under~~
179.28 ~~and meeting the standards in section 245I.23.~~

179.29 ~~(e)~~ (b) The provider entity must make reasonable and good faith efforts to report
179.30 individual client outcomes to the commissioner, using instruments and protocols approved
179.31 by the commissioner.

180.1 Sec. 2. Minnesota Statutes 2024, section 256B.0622, subdivision 8, is amended to read:

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

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

180.13 ~~(c) Payment must not be made based solely on a court order to participate in intensive~~
180.14 ~~residential treatment services. If a client has a court order to participate in the program or~~
180.15 ~~to obtain assessment for treatment and follow treatment recommendations, payment under~~
180.16 ~~this section must only be provided if the client is eligible for the service and the service is~~
180.17 ~~determined to be medically necessary.~~

180.18 (d) The commissioner shall determine ~~one rate for each provider that will bill medical~~
180.19 ~~assistance for residential services under this section and~~ one rate for each assertive community
180.20 ~~treatment provider under this section.~~ If a single entity provides both ~~services~~ intensive
180.21 residential treatment services under section 256B.0632 and assertive community treatment
180.22 under this section, one rate is established for the entity's intensive residential treatment
180.23 services under section 256B.0632 and another rate for the entity's nonresidential assertive
180.24 community treatment services under this section. A provider is not eligible for payment

390.1

ARTICLE 11

390.2 **ASSERTIVE COMMUNITY TREATMENT AND INTENSIVE RESIDENTIAL**
390.3 **TREATMENT SERVICES RECODIFICATION**

390.4 Section 1. Minnesota Statutes 2024, section 256B.0622, subdivision 1, is amended to read:

390.5 Subdivision 1. **Scope.** (a) Subject to federal approval, medical assistance covers medically
390.6 necessary, assertive community treatment when the services are provided by an entity
390.7 certified under and meeting the standards in this section.

390.8 ~~(b) Subject to federal approval, medical assistance covers medically necessary, intensive~~
390.9 ~~residential treatment services when the services are provided by an entity licensed under~~
390.10 ~~and meeting the standards in section 245I.23.~~

390.11 ~~(e)~~ (b) The provider entity must make reasonable and good faith efforts to report
390.12 individual client outcomes to the commissioner, using instruments and protocols approved
390.13 by the commissioner.

390.14 Sec. 2. Minnesota Statutes 2024, section 256B.0622, subdivision 8, is amended to read:

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

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

390.26 ~~(e) Payment must not be made based solely on a court order to participate in intensive~~
390.27 ~~residential treatment services. If a client has a court order to participate in the program or~~
390.28 ~~to obtain assessment for treatment and follow treatment recommendations, payment under~~
390.29 ~~this section must only be provided if the client is eligible for the service and the service is~~
390.30 ~~determined to be medically necessary.~~

390.31 ~~(d)~~ (c) The commissioner shall determine ~~one rate for each provider that will bill medical~~
390.32 ~~assistance for residential services under this section and~~ one rate for each assertive community
390.33 ~~treatment provider under this section.~~ If a single entity provides both ~~services~~ intensive
391.1 residential treatment services under section 256B.0632 and assertive community treatment
391.2 under this section, one rate is established for the entity's intensive residential treatment
391.3 services under section 256B.0632 and another rate for the entity's nonresidential assertive
391.4 community treatment services under this section. A provider is not eligible for payment

180.25 under this section without authorization from the commissioner. The commissioner shall
180.26 develop rates using the following criteria:

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

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

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

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

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

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

181.11 (2) actual ~~cost is~~ costs are defined as costs which are allowable, allocable, and reasonable,
181.12 and consistent with federal reimbursement requirements under Code of Federal Regulations,
181.13 title 48, chapter 1, part 31, relating to for-profit entities, and Office of Management and
181.14 Budget Circular Number A-122 Uniform Guidance under Code of Federal Regulations,
181.15 title 2, section 200, relating to nonprofit entities;

181.16 (3) the number of service units;

181.17 (4) the degree to which clients will receive services other than services under this section,
181.18 or section 256B.0632; and

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

181.20 ~~(e)~~ The rate for ~~intensive residential treatment services and~~ assertive community treatment
181.21 must exclude the medical assistance room and board rate, as defined in section 256B.056,
181.22 subdivision 5d, and services not covered under this section, such as partial hospitalization,
181.23 home care, and inpatient services.

181.24 ~~(f)~~ Physician services that are not separately billed may be included in the rate to the
181.25 extent that a psychiatrist, or other health care professional providing physician services
181.26 within their scope of practice, is a member of the intensive residential treatment services
181.27 treatment team. Physician services, whether billed separately or included in the rate, may

391.5 under this section without authorization from the commissioner. The commissioner shall
391.6 develop rates using the following criteria:

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

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

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

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

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

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

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

391.28 (3) the number of service units;

391.29 (4) the degree to which clients will receive services other than services under this section,
391.30 or section 256B.0632; and

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

392.1 ~~(e)~~ ~~(d)~~ The rate for ~~intensive residential treatment services and~~ assertive community
392.2 treatment must exclude the medical assistance room and board rate, as defined in section
392.3 256B.056, subdivision 5d, and services not covered under this section, such as partial
392.4 hospitalization, home care, and inpatient services.

392.5 ~~(f)~~ Physician services that are not separately billed may be included in the rate to the
392.6 extent that a psychiatrist, or other health care professional providing physician services
392.7 within their scope of practice, is a member of the intensive residential treatment services
392.8 treatment team. Physician services, whether billed separately or included in the rate, may

181.28 be delivered by telehealth. For purposes of this paragraph, "telehealth" has the meaning
181.29 given to "mental health telehealth" in section 256B.0625, subdivision 46, when telehealth
181.30 is used to provide intensive residential treatment services.

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

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

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

182.7 ~~(j)~~ (i) Effective for the rate years beginning on and after January 1, 2024, rates for
182.8 assertive community treatment, adult residential crisis stabilization services, and intensive
182.9 residential treatment services must be annually adjusted for inflation using the Centers for
182.10 Medicare and Medicaid Services Medicare Economic Index, as forecasted in the third quarter
182.11 of the calendar year before the rate year. The inflation adjustment must be based on the
182.12 12-month period from the midpoint of the previous rate year to the midpoint of the rate year
182.13 for which the rate is being determined. This paragraph expires upon federal approval.

182.14 ~~(k)~~ (j) Effective upon the expiration of paragraph (i), and effective for the rate years beginning
182.15 on and after January 1, 2024, rates for assertive community treatment services must be
182.16 annually adjusted for inflation using the Centers for Medicare and Medicaid Services
182.17 Medicare Economic Index, as forecasted in the third quarter of the calendar year before the
182.18 rate year. The inflation adjustment must be based on the 12-month period from the midpoint
182.19 of the previous rate year to the midpoint of the rate year for which the rate is being
182.20 determined.

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

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

392.9 be delivered by telehealth. For purposes of this paragraph, "telehealth" has the meaning
392.10 given to "mental health telehealth" in section 256B.0625, subdivision 46, when telehealth
392.11 is used to provide intensive residential treatment services.

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

392.14 ~~(h)~~ (f) The rate for a provider must not exceed the rate charged by that provider for the
392.15 same service to other payors.

392.16 ~~(i)~~ (g) The rates for existing programs must be established prospectively based upon the
392.17 expenditures and utilization over a prior 12-month period using the criteria established in
392.18 paragraph ~~(d)~~ (c). The rates for new programs must be established based upon estimated
392.19 expenditures and estimated utilization using the criteria established in paragraph ~~(d)~~ (c).

392.20 ~~(j)~~ (h) Effective for the rate years beginning on and after January 1, 2024, rates for
392.21 assertive community treatment, adult residential crisis stabilization services, and intensive
392.22 residential treatment services must be annually adjusted for inflation using the Centers for
392.23 Medicare and Medicaid Services Medicare Economic Index, as forecasted in the third quarter
392.24 of the calendar year before the rate year. The inflation adjustment must be based on the
392.25 12-month period from the midpoint of the previous rate year to the midpoint of the rate year
392.26 for which the rate is being determined. This paragraph expires upon federal approval.

392.27 ~~(k)~~ (i) Effective upon the expiration of paragraph (h), and effective for the rate years
392.28 beginning on and after January 1, 2024, rates for assertive community treatment services
392.29 must be annually adjusted for inflation using the Centers for Medicare and Medicaid Services
392.30 Medicare Economic Index, as forecasted in the third quarter of the calendar year before the
392.31 rate year. The inflation adjustment must be based on the 12-month period from the midpoint
392.32 of the previous rate year to the midpoint of the rate year for which the rate is being
392.33 determined.

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

393.10 ~~(m)~~ (k) A provider may request of the commissioner a review of any rate-setting decision
393.11 made under this subdivision.

183.1 Sec. 3. Minnesota Statutes 2024, section 256B.0622, subdivision 11, is amended to read:

183.2 Subd. 11. **Sustainability grants.** The commissioner may disburse grant funds directly

183.3 to ~~intensive residential treatment services providers and~~ assertive community treatment

183.4 providers to maintain access to these services.

183.5 Sec. 4. Minnesota Statutes 2024, section 256B.0622, subdivision 12, is amended to read:

183.6 Subd. 12. **Start-up grants.** The commissioner may, within available appropriations,

183.7 disburse grant funding to counties, Indian tribes, or mental health service providers to

183.8 establish additional assertive community treatment teams, ~~intensive residential treatment~~

183.9 ~~services, or crisis residential services.~~

183.10 Sec. 5. **[256B.0632] INTENSIVE RESIDENTIAL TREATMENT SERVICES.**

183.11 Subdivision 1. **Scope.** (a) Subject to federal approval, medical assistance covers medically

183.12 necessary, intensive residential treatment services when the services are provided by an

183.13 entity licensed under and meeting the standards in section 245I.23.

183.14 (b) The provider entity must make reasonable and good faith efforts to report individual

183.15 client outcomes to the commissioner, using instruments and protocols approved by the

183.16 commissioner.

183.17 Subd. 2. **Provider entity licensure and contract requirements for intensive residential**

183.18 **treatment services.** (a) The commissioner shall develop procedures for counties and

183.19 providers to submit other documentation as needed to allow the commissioner to determine

183.20 whether the standards in this section are met.

183.21 (b) A provider entity must specify in the provider entity's application what geographic

183.22 area and populations will be served by the proposed program. A provider entity must

183.23 document that the capacity or program specialties of existing programs are not sufficient

183.24 to meet the service needs of the target population. A provider entity must submit evidence

183.25 of ongoing relationships with other providers and levels of care to facilitate referrals to and

183.26 from the proposed program.

183.27 (c) A provider entity must submit documentation that the provider entity requested a

183.28 statement of need from each county board and Tribal authority that serves as a local mental

183.29 health authority in the proposed service area. The statement of need must specify if the local

183.30 mental health authority supports or does not support the need for the proposed program and

183.31 the basis for this determination. If a local mental health authority does not respond within

184.1 60 days of the receipt of the request, the commissioner shall determine the need for the

184.2 program based on the documentation submitted by the provider entity.

184.3 Subd. 3. **Medical assistance payment for intensive residential treatment services.** (a)

184.4 Payment for intensive residential treatment services in this section shall be based on one

184.5 daily rate per provider inclusive of the following services received by an eligible client in

184.6 a given calendar day: all rehabilitative services under this section, staff travel time to provide

393.12 Sec. 3. Minnesota Statutes 2024, section 256B.0622, subdivision 11, is amended to read:

393.13 Subd. 11. **Sustainability grants.** The commissioner may disburse grant funds directly

393.14 to ~~intensive residential treatment services providers and~~ assertive community treatment

393.15 providers to maintain access to these services.

393.16 Sec. 4. Minnesota Statutes 2024, section 256B.0622, subdivision 12, is amended to read:

393.17 Subd. 12. **Start-up grants.** The commissioner may, within available appropriations,

393.18 disburse grant funding to counties, Indian tribes, or mental health service providers to

393.19 establish additional assertive community treatment teams, ~~intensive residential treatment~~

393.20 ~~services, or crisis residential services.~~

393.21 Sec. 5. **[256B.0632] INTENSIVE RESIDENTIAL TREATMENT SERVICES.**

393.22 Subdivision 1. **Scope.** (a) Subject to federal approval, medical assistance covers medically

393.23 necessary, intensive residential treatment services when the services are provided by an

393.24 entity licensed under and meeting the standards in section 245I.23.

393.25 (b) The provider entity must make reasonable and good faith efforts to report individual

393.26 client outcomes to the commissioner, using instruments and protocols approved by the

393.27 commissioner.

393.28 Subd. 2. **Provider entity licensure and contract requirements for intensive residential**

393.29 **treatment services.** (a) The commissioner shall develop procedures for counties and

393.30 providers to submit other documentation as needed to allow the commissioner to determine

393.31 whether the standards in this section are met.

394.1 (b) A provider entity must specify in the provider entity's application what geographic

394.2 area and populations will be served by the proposed program. A provider entity must

394.3 document that the capacity or program specialties of existing programs are not sufficient

394.4 to meet the service needs of the target population. A provider entity must submit evidence

394.5 of ongoing relationships with other providers and levels of care to facilitate referrals to and

394.6 from the proposed program.

394.7 (c) A provider entity must submit documentation that the provider entity requested a

394.8 statement of need from each county board and Tribal authority that serves as a local mental

394.9 health authority in the proposed service area. The statement of need must specify if the local

394.10 mental health authority supports or does not support the need for the proposed program and

394.11 the basis for this determination. If a local mental health authority does not respond within

394.12 60 days of the receipt of the request, the commissioner shall determine the need for the

394.13 program based on the documentation submitted by the provider entity.

394.14 Subd. 3. **Medical assistance payment for intensive residential treatment services.** (a)

394.15 Payment for intensive residential treatment services in this section shall be based on one

394.16 daily rate per provider inclusive of the following services received by an eligible client in

394.17 a given calendar day: all rehabilitative services under this section, staff travel time to provide

184.7 rehabilitative services under this section, and nonresidential crisis stabilization services
184.8 under section 256B.0624.

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

184.13 (c) Payment must not be made based solely on a court order to participate in intensive
184.14 residential treatment services. If a client has a court order to participate in the program or
184.15 to obtain assessment for treatment and follow treatment recommendations, payment under
184.16 this section must only be provided if the client is eligible for the service and the service is
184.17 determined to be medically necessary.

184.18 (d) The commissioner shall determine one rate for each provider that will bill medical
184.19 assistance for intensive residential treatment services under this section. If a single entity
184.20 provides both intensive residential treatment services under this section and assertive
184.21 community treatment under section 256B.0622, one rate is established for the entity's
184.22 intensive residential treatment services under this section and another rate for the entity's
184.23 assertive community treatment services under section 256B.0622. A provider is not eligible
184.24 for payment under this section without authorization from the commissioner. The
184.25 commissioner shall develop rates using the following criteria:

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

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

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

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

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

185.7 (2) actual costs are defined as costs which are allowable, allocable, and reasonable, and
185.8 consistent with federal reimbursement requirements under Code of Federal Regulations,

394.18 rehabilitative services under this section, and nonresidential crisis stabilization services
394.19 under section 256B.0624.

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

394.24 (c) Payment must not be made based solely on a court order to participate in intensive
394.25 residential treatment services. If a client has a court order to participate in the program or
394.26 to obtain assessment for treatment and follow treatment recommendations, payment under
394.27 this section must only be provided if the client is eligible for the service and the service is
394.28 determined to be medically necessary.

394.29 (d) The commissioner shall determine one rate for each provider that will bill medical
394.30 assistance for intensive residential treatment services under this section. If a single entity
394.31 provides both intensive residential treatment services under this section and assertive
394.32 community treatment under section 256B.0622, one rate is established for the entity's
394.33 intensive residential treatment services under this section and another rate for the entity's
394.34 assertive community treatment services under section 256B.0622. A provider is not eligible
395.1 for payment under this section without authorization from the commissioner. The
395.2 commissioner shall develop rates using the following criteria:

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

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

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

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

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

395.18 (2) actual costs are defined as costs which are allowable, allocable, and reasonable, and
395.19 consistent with federal reimbursement requirements under Code of Federal Regulations,

185.9 title 48, chapter 1, part 31, relating to for-profit entities, and Office of Management and
185.10 Budget Uniform Guidance under Code of Federal Regulations, title 2, section 200, relating
185.11 to nonprofit entities;

185.12 (3) the number of services units;

185.13 (4) the degree to which clients will receive services other than services under this section
185.14 or section 256B.0622; and

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

185.16 (e) The rate for intensive residential treatment services must exclude the medical
185.17 assistance room and board rate, as defined in section 256B.056, subdivision 5d, and services
185.18 not covered under this section, such as partial hospitalization, home care, and inpatient
185.19 services.

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

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

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

186.1 (i) Effective upon the expiration of section 256B.0622, subdivision 8, paragraph (h),
186.2 and effective for rate years beginning on and after January 1, 2024, rates for intensive
186.3 residential treatment services and adult residential crisis stabilization services must be
186.4 annually adjusted for inflation using the Centers for Medicare and Medicaid Services
186.5 Medicare Economic Index, as forecasted in the third quarter of the calendar year before the
186.6 rate year. The inflation adjustment must be based on the 12-month period from the midpoint
186.7 of the previous rate year to the midpoint of the rate year for which the rate is being
186.8 determined.

186.9 (j) Entities who discontinue providing services must be subject to a settle-up process
186.10 whereby actual costs and reimbursement for the previous 12 months are compared. In the
186.11 event that the entity was paid more than the entity's actual costs plus any applicable
186.12 performance-related funding due the provider, the excess payment must be reimbursed to
186.13 the department. If a provider's revenue is less than actual allowed costs due to lower
186.14 utilization than projected, the commissioner may reimburse the provider to recover its actual

395.20 title 48, chapter 1, part 31, relating to for-profit entities, and Office of Management and
395.21 Budget Circular Number A-122, relating to nonprofit entities;

395.22 (3) the number of services units;

395.23 (4) the degree to which clients will receive services other than services under this section
395.24 or section 256B.0622; and

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

395.26 (e) The rate for intensive residential treatment services must exclude the medical
395.27 assistance room and board rate, as defined in section 256B.056, subdivision 5d, and services
395.28 not covered under this section, such as partial hospitalization, home care, and inpatient
395.29 services.

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

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

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

396.11 (i) Effective upon the expiration of section 256B.0622, subdivision 8, paragraph (h),
396.12 and effective for rate years beginning on and after January 1, 2024, rates for intensive
396.13 residential treatment services and adult residential crisis stabilization services must be
396.14 annually adjusted for inflation using the Centers for Medicare and Medicaid Services
396.15 Medicare Economic Index, as forecasted in the third quarter of the calendar year before the
396.16 rate year. The inflation adjustment must be based on the 12-month period from the midpoint
396.17 of the previous rate year to the midpoint of the rate year for which the rate is being
396.18 determined.

396.19 (j) Entities who discontinue providing services must be subject to a settle-up process
396.20 whereby actual costs and reimbursement for the previous 12 months are compared. In the
396.21 event that the entity was paid more than the entity's actual costs plus any applicable
396.22 performance-related funding due the provider, the excess payment must be reimbursed to
396.23 the department. If a provider's revenue is less than actual allowed costs due to lower
396.24 utilization than projected, the commissioner may reimburse the provider to recover its actual

186.15 allowable costs. The resulting adjustments by the commissioner must be proportional to the
186.16 percent of total units of service reimbursed by the commissioner and must reflect a difference
186.17 of greater than five percent.

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

186.20 **Subd. 4. Provider enrollment; rate setting for county-operated entities.** Counties
186.21 that employ their own staff to provide services under this section shall apply directly to the
186.22 commissioner for enrollment and rate setting. In this case, a county contract is not required.

186.23 **Subd. 5. Provider enrollment; rate setting for specialized program.** A county contract
186.24 is not required for a provider proposing to serve a subpopulation of eligible clients under
186.25 the following circumstances:

186.26 (1) the provider demonstrates that the subpopulation to be served requires a specialized
186.27 program which is not available from county-approved entities; and

186.28 (2) the subpopulation to be served is of such a low incidence that it is not feasible to
186.29 develop a program serving a single county or regional group of counties.

186.30 **Subd. 6. Sustainability grants.** The commissioner may disburse grant funds directly to
186.31 intensive residential treatment services providers to maintain access to these services.

187.1 **Subd. 7. Start-up grants.** The commissioner may, within available appropriations,
187.2 disburse grant funding to counties, Indian Tribes, or mental health service providers to
187.3 establish additional intensive residential treatment services and residential crisis services.

187.4 **Sec. 6. REPEALER.**

187.5 Minnesota Statutes 2024, section 256B.0622, subdivision 4, is repealed.

396.25 allowable costs. The resulting adjustments by the commissioner must be proportional to the
396.26 percent of total units of service reimbursed by the commissioner and must reflect a difference
396.27 of greater than five percent.

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

396.30 **Subd. 4. Provider enrollment; rate setting for county-operated entities.** Counties
396.31 that employ their own staff to provide services under this section shall apply directly to the
396.32 commissioner for enrollment and rate setting. In this case, a county contract is not required.

397.1 **Subd. 5. Provider enrollment; rate setting for specialized program.** A county contract
397.2 is not required for a provider proposing to serve a subpopulation of eligible clients under
397.3 the following circumstances:

397.4 (1) the provider demonstrates that the subpopulation to be served requires a specialized
397.5 program which is not available from county-approved entities; and

397.6 (2) the subpopulation to be served is of such a low incidence that it is not feasible to
397.7 develop a program serving a single county or regional group of counties.

397.8 **Subd. 6. Sustainability grants.** The commissioner may disburse grant funds directly to
397.9 intensive residential treatment services providers to maintain access to these services.

397.10 **Subd. 7. Start-up grants.** The commissioner may, within available appropriations,
397.11 disburse grant funding to counties, Indian Tribes, or mental health service providers to
397.12 establish additional intensive residential treatment services and residential crisis services.

397.13 **Sec. 6. REPEALER.**

397.14 Minnesota Statutes 2024, section 256B.0622, subdivision 4, is repealed.