

245I.17 CERTIFIED COMMUNITY BEHAVIORAL HEALTH CLINIC LICENSURE.

Subdivision 1. **Definitions.** (a) For the purposes of this section, the terms in this subdivision have the meanings given.

(b) "Care coordination" means the activities required to coordinate care across settings and providers for an individual served to ensure seamless transitions across the full spectrum of health services. Care coordination includes:

(1) outreach and engagement;

(2) documenting a plan of care for medical, behavioral health, and social services and supports in the integrated treatment plan;

(3) assisting with obtaining appointments;

(4) confirming appointments are kept;

(5) developing a crisis plan;

(6) tracking medication; and

(7) implementing care coordination agreements with external providers. Care coordination may include psychiatric consultation with primary care practitioners and with mental health clinical care practitioners.

(c) "CCBHC client" means an individual who has participated in a preliminary triage and risk assessment and who has received at least one of the nine required services from a CCBHC.

(d) "Certified community behavioral health clinic" or "CCBHC" means a provider of integrated behavioral health services that is licensed under this section and compliant with federal CCBHC requirements.

(e) "Community needs assessment" means an assessment to identify community needs and determine the community behavioral health clinic's capacity to address the needs of the population being served.

(f) "Designated collaborating organization" means an entity that is not under the direct supervision of a CCBHC engaged in a formal relationship with the CCBHC to deliver one or more of the required services or elements of required services.

(g) "Federal CCBHC criteria" means the most recently issued Certified Community Behavioral Health Clinic Certification Criteria published by the Substance Abuse and Mental Health Services Administration.

(h) "Needs assessment" means the community needs assessment described in federal criteria for CCBHCs.

(i) "Preliminary triage and risk assessment" means a mandatory triage and risk assessment that is completed at the time of first contact, whether that contact is in person, by telephone, or using other remote communication.

Subd. 2. **Establishment of licensure.** (a) The certified community behavioral health clinic model is an integrated service delivery model that uses evidence-based behavioral health practices to achieve better outcomes for individuals experiencing behavioral health concerns while achieving sustainable rates through cost-based reimbursement for providers and economic efficiencies for payors.

(b) Beginning January 1, 2028, a CCBHC must be licensed under this section.

(c) A CCBHC must meet the requirements of this section and federal CCBHC criteria. The commissioner may require a CCBHC applicant or license holder to submit documentation of compliance with state licensing requirements and federal CCBHC criteria.

(d) The commissioner may deny a license to a CCBHC applicant or license holder on the basis of geographic area if a license holder does not meet federal criteria for identifying and addressing:

- (1) a community's needs;
- (2) gaps in access to mental health and substance use disorder services; and
- (3) underserved populations to be served by the license holder as outlined in the community needs assessment.

(e) The commissioner shall communicate with licensed CCBHCs, applicants, and community partners before establishing and implementing changes in the licensure requirements.

(f) The commissioner shall update state licensing conditions for CCBHCs to align with changes to the federal CCBHC criteria. The commissioner may select a transition date on which revisions to the federal CCBHC criteria become required as licensing conditions for CCBHCs.

(g) The commissioner shall publish the licensing standards consistent with the most recently issued Certified Community Behavioral Health Clinic Certification Criteria published by the Substance Abuse and Mental Health Services Administration on a publicly available website.

Subd. 3. Compliance with federal CCBHC standards. (a) The commissioner must make the required federal attestation of compliance with state and federal standards to the Centers for Medicare and Medicaid Services (CMS) upon granting a license meeting all requirements of this section.

(b) The commissioner must renew the required attestation to CMS every 36 months if the license holder remains in good standing. If a CCBHC license is revoked during the 36-month term, the commissioner must publicly report the revocation.

(c) A license holder that has operated under an existing attestation to CMS for two years and three months must submit the documentation required under subdivision 2, paragraph (c), to the commissioner.

(d) The commissioner must complete a licensing review that includes an on-site inspection in the six months before the expiration of the federal attestation.

Subd. 4. Required services and scope of licensure. (a) Within a declared service area, the CCBHC must be able to offer:

- (1) mobile crisis services, directly or through a designated collaborating organization under subdivision 4;
- (2) outpatient mental health and substance use disorder treatment services under subdivisions 9 and 10;
- (3) screening, diagnosis, and risk assessment under subdivision 11;
- (4) person- and family-centered treatment planning;
- (5) psychiatric rehabilitation services under subdivision 14;
- (6) community-based mental health care for veterans under subdivision 15;

- (7) outpatient primary care screening and monitoring under subdivision 16;
- (8) peer services under subdivision 17; and
- (9) targeted case management under subdivision 18.

(b) A CCBHC may offer the services listed in paragraph (a) directly or through its designated collaborating organization. The CCBHC must deliver the services in a manner reflecting person- and family-centered care.

Subd. 5. Designated collaborating organization. (a) If a CCBHC is unable to provide mobile crisis services, the CCBHC may contract with another entity that is licensed to provide mobile crisis services under section 245I.24 and that meets the requirements of the federal CCBHC criteria as a designated collaborating organization.

(b) The CCBHC must submit a designated collaborating organization arrangement for approval to the commissioner as part of the licensing process.

(c) The commissioner must not approve a designated collaborating organization agreement under this section to provide services, other than mobile crisis services under section 245I.24, until the commissioner:

(1) implements a mechanism to administer payments for CCBHC services provided under a designated collaborating organization arrangement in a manner that ensures proper payment in compliance with state and federal law; or

(2) determines that the Medicaid Management Information System has the capability to pay for CCBHC services provided under a designated collaborating organization arrangement in compliance with state and federal law.

Subd. 6. Exemptions to host county approval. Notwithstanding any other law that requires a county contract or other form of county approval for a service listed in subdivision 4, a CCBHC that meets the requirements of this section may receive the prospective payment under section 256B.0625, subdivision 5m, for that service without a county contract or county approval.

Subd. 7. Variances. When the standards listed in this section or other applicable standards conflict or address similar issues in duplicative or incompatible ways, the commissioner may grant variances to state requirements if the variances do not conflict with federal requirements for services reimbursed under medical assistance. If standards overlap, the commissioner may substitute all or a part of a licensure or certification that is substantially the same as another licensure or certification. The commissioner must consult with stakeholders before granting variances under this provision. For a CCBHC that is licensed but not approved for prospective payment under section 256B.0625, subdivision 5m, the commissioner may grant a variance under this paragraph if the variance does not increase the state share of costs.

Subd. 8. Evidence-based practices. The commissioner must issue a list of required evidence-based practices to be delivered by CCBHCs and may also provide a list of recommended evidence-based practices. The commissioner may update the list to reflect advances in outcomes research and medical services for persons living with mental illnesses or substance use disorders. When developing the list, the commissioner must consider the adequacy of evidence to support the efficacy of the practice across cultures and ages, the workforce available, and the current availability of the practices in the state. At least 30 days before issuing the initial list or issuing any revisions, the commissioner must provide stakeholders with an opportunity to comment.

Subd. 9. **Outpatient mental health services.** (a) A license holder must provide outpatient mental health services that comply with the federal CCBHC criteria and applicable state standards in this chapter, except as provided in this subdivision.

(b) Completion of an initial or comprehensive evaluation fulfills the requirements to perform a diagnostic assessment in accordance with section 245I.10, subdivisions 2 and 6.

(c) An integrated treatment plan under this section fulfills the requirements to conduct treatment planning in accordance with section 245I.10, subdivisions 7 and 8.

(d) A license holder under this section is exempt from certification as a mental health clinic under section 245I.20.

Subd. 10. **Outpatient substance use disorder treatment.** (a) When a license holder provides substance use disorder treatment services to an individual with a substance use disorder diagnosis, the license holder must comply with the requirements for substance use disorder treatment services in chapter 245G, except as provided in this subdivision.

(b) Completion of a preliminary triage and risk assessment under this section fulfills the requirements to complete an initial services plan under section 245G.04, subdivision 1.

(c) Completion of a comprehensive evaluation under this section fulfills the requirements to administer a comprehensive assessment under section 245G.05.

(d) An integrated treatment plan under this section that contains a six-dimension analysis of the client's needs according to the most recently published edition of the American Society of Addiction Medicine criteria, as defined in section 254B.01, subdivision 2a, fulfills the requirements to provide an individual treatment plan under section 245G.06.

(e) A license holder under this section fulfills the requirement to document personnel files under section 245G.13, subdivision 3, by complying with the requirements of this chapter.

(f) A license holder under this section fulfills the requirement to protect client rights under section 245G.15 by complying with the requirements of section 245I.12.

(g) A license holder under this section fulfills the requirements to respond to behavioral emergencies under section 245G.16 by complying with the requirements of section 245I.03, subdivision 4.

(h) A license holder under this section is exempt from licensure under chapter 245G.

Subd. 11. **Preliminary triage and risk assessment.** (a) A license holder must have policies and procedures on:

- (1) how staff will implement the requirements of this subdivision;
- (2) staff positions authorized to complete triage and risk assessments;
- (3) documenting the results of the risk screenings; and
- (4) ensuring the client is offered timely services according to the federal CCBHC criteria.

(b) A license holder must conduct a preliminary triage and risk assessment when a new client requests services or is referred to services. A license holder may conduct a preliminary triage and risk assessment in person, by telephone, or through other remote communication. Based on the acuity of needs as assessed in

the preliminary triage and risk assessment, the client must be categorized as having emergency, urgent, or routine needs.

(c) Based on these categorizations, the license holder must offer services that meet the relevant timelines under the federal CCBHC criteria.

(d) The license holder must provide training that addresses:

- (1) when a prospective client requires intervention from qualified staff;
- (2) the use of standardized measures that screen for significant risks;
- (3) other factors that indicate a client has urgent needs besides the Columbia Suicide Severity Rating Scale or a self-harm screening; and
- (4) overdose and substance use disorder risks.

Subd. 12. Initial and comprehensive evaluation. (a) A license holder under this section must provide initial and comprehensive evaluations according to this section and federal CCBHC criteria.

(b) An initial evaluation is necessary to authorize the provision of all medically necessary CCBHC services until the completion of a comprehensive evaluation. A comprehensive evaluation is necessary to authorize the provision of all medically necessary CCBHC services on an ongoing basis. A license holder must ensure that each client's comprehensive evaluation reflects the needs and assessments for all services provided.

Subd. 13. Integrated treatment plan. (a) A license holder under this section must complete an integrated treatment plan for each client following the client's comprehensive evaluation no later than 60 calendar days after the date of the first request for services.

(b) A license holder must document all required services under subdivision 9 within the integrated treatment plan based on the client's needs.

(c) A license holder must review and update a client's integrated treatment plan as necessary to reflect the changing needs of the client and progress made in treatment. If the client has not made treatment progress, updates to the treatment plan must indicate changes in the license holder's approach to treatment to better meet the needs of the client. A license holder must review and update the integrated treatment plan at least every 180 days or as clinically indicated.

Subd. 14. Psychiatric rehabilitation services. (a) For children, a license holder under this section must provide children's therapeutic services and supports according to section 245I.30, except that an initial or comprehensive assessment under this section fulfills the requirement to perform a standard diagnostic assessment. A license holder under this section may elect to provide services according to section 245I.31 under their license.

(b) For adults, a license holder under this section must provide adult rehabilitative mental health services according to section 245I.22, except that:

- (1) the license holder is exempt from the requirement to perform a level of care assessment under section 245I.22, subdivision 6, paragraph (b); and
- (2) an initial or comprehensive assessment under this section fulfills the requirement to perform a standard diagnostic assessment.

(c) A license holder under this section is exempt from licensure under sections 245I.22, 245I.24, 245I.30, and 245I.31.

Subd. 15. **Community-based care for veterans.** (a) The license holder must provide services according to federal requirements for eligibility and coordination with TRICARE and the United States Department of Veterans Affairs.

(b) The license holder must assign and document a principal behavioral health provider for every veteran receiving services.

Subd. 16. **Primary care screening and monitoring.** To fulfill the requirements for primary care screening, a license holder under this section must have policies and procedures detailing the screenings to be performed with specific populations at the clinic. The policies and procedures must be approved by the medical director.

Subd. 17. **Peer services.** A license holder must be able to provide peer services as described by federal CCBHC criteria and sections 245G.07, subdivision 2, clause (8), 256B.0615, and 256B.0616.

Subd. 18. **Targeted case management.** (a) A license holder must provide mental health targeted case management as described by federal CCBHC criteria and section 256B.0625, subdivision 20.

(b) An initial or comprehensive evaluation under this section fulfills any requirement to perform a standard diagnostic assessment for targeted case management.

Subd. 19. **Community needs assessment.** (a) The applicant or licensed clinic shall conduct a community needs assessment every 36 months that meets all requirements outlined in the federal criteria.

(b) An existing license holder must include an analysis of which needs from prior needs assessments have been improved by the operation of the CCBHC.

Subd. 20. **Staffing plan.** (a) Based on an approved community needs assessment, the applicant or license holder must complete a staffing plan that is responsive to the community needs assessment and meets the federal criteria no less often than every 36 months.

(b) The commissioner must provide feedback and technical assistance if the commissioner determines the license holder must revise the staffing plan.

Subd. 21. **Data and evaluation.** A provider must submit documentation that establishes the ability of the clinic to complete the required data collection as a CCBHC, as determined by the commissioner. For an applicant that is an existing provider, the commissioner must review and evaluate data submitted related to federal and state CCBHC reporting standards to ensure the data meets reporting requirements.

Subd. 22. **Cost reporting.** A provider must submit a cost report on the forms and in the manner required in section 256B.0625, subdivision 5m.

Subd. 23. **Change of service area or population served.** (a) A CCBHC license holder may submit a request to the commissioner to modify the CCBHC's service area or population served by submitting updated documentation in a format approved by the commissioner.

(b) A CCBHC license holder may request a modification under this subdivision no more often than once every 12 months.

(c) The commissioner may deny a license holder's request to change its service area or populations under this subdivision if the license holder fails to demonstrate compliance with the federal criteria and scope of service requirements under section 223(a)(2)(D) of the federal Patient Access to Medicare Act of 2014.

History: *2026 c 121 art 7 s 31*

NOTE: This section, as added by Laws 2026, chapter 121, article 7, section 31, is effective January 1, 2028. Laws 2026, chapter 121, article 7, section 56.