256B.0632 INTENSIVE RESIDENTIAL TREATMENT SERVICES.

Subdivision 1. **Scope.** (a) Subject to federal approval, medical assistance covers medically necessary, intensive residential treatment services when the services are provided by an entity licensed under and meeting the standards in section 245I.23.

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

Subd. 2. **Provider entity licensure and contract requirements for intensive residential treatment services.** (a) The commissioner shall develop procedures for counties and providers to submit other documentation as needed to allow the commissioner to determine whether the standards in this section are met.

(b) A provider entity must specify in the provider entity's application what geographic area and populations will be served by the proposed program. A provider entity must document that the capacity or program specialties of existing programs are not sufficient to meet the service needs of the target population. A provider entity must submit evidence of ongoing relationships with other providers and levels of care to facilitate referrals to and from the proposed program.

(c) A provider entity must submit documentation that the provider entity requested a statement of need from each county board and Tribal authority that serves as a local mental health authority in the proposed service area. The statement of need must specify if the local mental health authority supports or does not support the need for the proposed program and the basis for this determination. If a local mental health authority does not respond within 60 days of the receipt of the request, the commissioner shall determine the need for the program based on the documentation submitted by the provider entity.

Subd. 3. **Medical assistance payment for intensive residential treatment services.** (a) Payment for intensive residential treatment services in this section shall be based on one daily rate per provider inclusive of the following services received by an eligible client in a given calendar day: all rehabilitative services under this section, staff travel time to provide rehabilitative services under this section, and nonresidential crisis stabilization services under section 256B.0624.

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

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

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

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

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

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

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

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

(2) actual costs are defined as costs which are allowable, allocable, and reasonable, and consistent with federal reimbursement requirements under Code of Federal Regulations, title 48, chapter 1, part 31, relating to for-profit entities, and Office of Management and Budget Uniform Guidance under Code of Federal Regulations, title 2, section 200, relating to nonprofit entities;

(3) the number of services units;

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

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

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

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

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

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

(i) Effective upon the expiration of section 256B.0622, subdivision 8, paragraph (i), and effective for rate years beginning on and after January 1, 2024, rates for intensive residential treatment services and adult residential crisis stabilization services must be annually adjusted for inflation using the Centers for Medicare and Medicaid Services Medicare Economic Index, as forecasted in the third quarter of the calendar year

before the rate year. The inflation adjustment must be based on the 12-month period from the midpoint of the previous rate year to the midpoint of the rate year for which the rate is being determined.

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

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

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

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

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

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

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

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

History: *2025 c 38 art 6 s 5*