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State of Minnesota
HOUSE OF REPRESENTATIVES

NINETY-THIRD SESSION

H. F. No. 4366

- 02/28/2024 Authored by Edelson, Noor, Fischer, Baker, Curran and others
The bill was read for the first time and referred to the Committee on Human Services Policy
- 03/07/2024 Adoption of Report: Amended and re-referred to the Committee on Public Safety Finance and Policy
- 03/13/2024 Adoption of Report: Re-referred to the Committee on Judiciary Finance and Civil Law
- 03/18/2024 Adoption of Report: Re-referred to the Committee on Health Finance and Policy
- 03/21/2024 Adoption of Report: Re-referred to the Committee on Human Services Finance

1.1 A bill for an act

1.2 relating to behavioral health; modifying civil commitment priority admission

1.3 requirements; specifying that a prisoner in a correctional facility is not responsible

1.4 for co-payments for mental health medications; allowing for reimbursement of

1.5 county co-payment expenses; appropriating money; amending Minnesota Statutes

1.6 2022, sections 245.4905; 246.18, subdivision 4a; 256B.0622, subdivisions 2a, 3a,

1.7 7a, 7d; 256B.0757, subdivision 5; 256B.76, subdivision 6; Minnesota Statutes

1.8 2023 Supplement, sections 246.54, subdivisions 1a, 1b; 253B.10, subdivision 1;

1.9 254B.04, subdivision 1a; 254B.05, subdivision 5; 256.969, subdivision 2b;

1.10 256B.0622, subdivision 7b; 256B.76, subdivision 1; 256B.761; 641.15, subdivision

1.11 2; proposing coding for new law in Minnesota Statutes, chapters 245; 253B;

1.12 repealing Minnesota Statutes 2022, section 256B.0625, subdivision 38.

1.13 BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MINNESOTA:

1.14 **ARTICLE 1**

1.15 **PRIORITY ADMISSIONS TO STATE-OPERATED TREATMENT PROGRAMS**

1.16 Section 1. Minnesota Statutes 2023 Supplement, section 253B.10, subdivision 1, is amended

1.17 to read:

1.18 Subdivision 1. **Administrative requirements.** (a) When a person is committed, the

1.19 court shall issue a warrant or an order committing the patient to the custody of the head of

1.20 the treatment facility, state-operated treatment program, or community-based treatment

1.21 program. The warrant or order shall state that the patient meets the statutory criteria for

1.22 civil commitment.

1.23 (b) ~~The commissioner shall prioritize patients being admitted from jail or a correctional~~

1.24 ~~institution who are~~ A person committed to the commissioner will be prioritized for admission

1.25 to a medically appropriate direct care and treatment program based on the decisions of

1.26 physicians in the executive medical director's office, using a priority admissions framework.

2.1 The framework must account for a range of factors for priority admission, including but
2.2 not limited to:

2.3 (1) ~~ordered confined in a state-operated treatment program for an examination under~~
2.4 ~~Minnesota Rules of Criminal Procedure, rules 20.01, subdivision 4, paragraph (a), and~~
2.5 ~~20.02, subdivision 2~~ the length of time the person has been on a waiting list for admission
2.6 to a direct care and treatment program;

2.7 (2) ~~under civil commitment for competency treatment and continuing supervision under~~
2.8 ~~Minnesota Rules of Criminal Procedure, rule 20.01, subdivision 7~~ the intensity of the
2.9 treatment the person needs, based on medical acuity;

2.10 (3) ~~found not guilty by reason of mental illness under Minnesota Rules of Criminal~~
2.11 ~~Procedure, rule 20.02, subdivision 8, and under civil commitment or are ordered to be~~
2.12 ~~detained in a state-operated treatment program pending completion of the civil commitment~~
2.13 ~~proceedings; or~~ the person's provisional discharge status;

2.14 (4) ~~committed under this chapter to the commissioner after dismissal of the patient's~~
2.15 ~~criminal charges.~~ the person's safety and safety of others in the person's current environment;

2.16 (5) whether the person has access to necessary treatment in a program that is not a direct
2.17 care and treatment program;

2.18 (6) negative impacts of an admission delay on the facility referring the individual for
2.19 treatment; and

2.20 (7) any relevant federal prioritization requirements.

2.21 ~~Patients described in this paragraph must be admitted to a state-operated treatment program~~
2.22 ~~within 48 hours. The commitment must be ordered by the court as provided in section~~
2.23 ~~253B.09, subdivision 1, paragraph (d).~~

2.24 (c) Upon the arrival of a patient at the designated treatment facility, state-operated
2.25 treatment program, or community-based treatment program, the head of the facility or
2.26 program shall retain the duplicate of the warrant and endorse receipt upon the original
2.27 warrant or acknowledge receipt of the order. The endorsed receipt or acknowledgment must
2.28 be filed in the court of commitment. After arrival, the patient shall be under the control and
2.29 custody of the head of the facility or program.

2.30 (d) Copies of the petition for commitment, the court's findings of fact and conclusions
2.31 of law, the court order committing the patient, the report of the court examiners, and the
2.32 prepetition report, and any medical and behavioral information available shall be provided
2.33 at the time of admission of a patient to the designated treatment facility or program to which

3.1 the patient is committed. Upon a patient's referral to the commissioner of human services
3.2 for admission pursuant to subdivision 1, paragraph (b), any inpatient hospital, treatment
3.3 facility, jail, or correctional facility that has provided care or supervision to the patient in
3.4 the previous two years shall, when requested by the treatment facility or commissioner,
3.5 provide copies of the patient's medical and behavioral records to the Department of Human
3.6 Services for purposes of preadmission planning. This information shall be provided by the
3.7 head of the treatment facility to treatment facility staff in a consistent and timely manner
3.8 and pursuant to all applicable laws.

3.9 (e) Patients described in paragraph (b) must be admitted to a state-operated treatment
3.10 program within 48 hours of the Office of Medical Director, under section 246.018, or a
3.11 designee determining that a medically appropriate bed is available. This paragraph expires
3.12 on June 30, 2025.

3.13 (f) A panel appointed by the commissioner, consisting of all members who served on
3.14 the Task Force on Priority Admissions to State-Operated Treatment Programs under Laws
3.15 2023, chapter 61, article 8, section 13, subdivision 2, must review deidentified data quarterly
3.16 for one year following the implementation of the priority admissions framework to ensure
3.17 that the framework is implemented and applied equitably. If the panel requests to review
3.18 data that is classified as private or confidential and the commissioner determines the data
3.19 requested is necessary for the scope of the panel's review, the commissioner is authorized
3.20 to disclose private or confidential data to the panel under this paragraph and pursuant to
3.21 section 13.05, subdivision 4, paragraph (b), for private or confidential data collected prior
3.22 to the effective date of this paragraph. The panel must also advise the commissioner on the
3.23 effectiveness of the framework and priority admissions generally. After the panel completes
3.24 its year of review, a quality committee established by the Department of Direct Care and
3.25 Treatment executive board will continue to review data and provide a routine report to the
3.26 executive board on the effectiveness of the framework and priority admissions.

3.27 (g) The commissioner may immediately approve an exception to add up to ten civilly
3.28 committed patients who are awaiting admission in hospital settings to the priority admissions
3.29 waiting list for admission to medically appropriate direct care and treatment programs.
3.30 Admissions of these patients must be managed according to the priority admissions
3.31 framework under paragraph (b). This paragraph expires upon the commissioner's approval
3.32 of the exception or on August 1, 2024, whichever is sooner.

ARTICLE 2

COMMUNITY BEHAVIORAL HEALTH SERVICES

Section 1. Minnesota Statutes 2022, section 245.4905, is amended to read:

245.4905 FIRST EPISODE OF PSYCHOSIS GRANT PROGRAM.

Subdivision 1. **Creation.** The first episode of psychosis grant program is established in the Department of Human Services to fund evidence-based interventions for youth and young adults at risk of developing or experiencing a an early or first episode of psychosis ~~and a public awareness campaign on the signs and symptoms of psychosis~~. First episode of psychosis services are eligible for children's mental health grants as specified in section 245.4889, subdivision 1, paragraph (b), clause (15). The Department of Human Services must seek to fund eligible providers of first episode of psychosis services and assist with program establishment throughout the state.

Subd. 2. **Activities.** (a) All first episode of psychosis grant programs must:

(1) provide intensive treatment and support for adolescents and young adults experiencing or at risk of experiencing a an early or first psychotic episode. Intensive treatment and support includes medication management, psychoeducation for an individual and an individual's family, case management, employment support, education support, cognitive behavioral approaches, social skills training, peer support, family peer support, crisis planning, and stress management;

(2) conduct outreach and provide training and guidance to mental health and health care professionals, including postsecondary health clinicians, on early psychosis symptoms, screening tools, the first episode of psychosis program, and best practices;

(3) ensure access for individuals to first psychotic episode services under this section; ~~including access for individuals who live in rural areas~~; and

(4) use all available funding streams.

(b) Grant money may also be used to pay for housing or travel expenses for individuals receiving services or to address other barriers preventing individuals and their families from participating in first psychotic episode services.

Subd. 3. **Eligibility.** Program activities must be provided to people 15 to 40 years old ~~with~~ who have early signs of psychosis or who have experienced an early or first episode of psychosis.

5.1 Subd. 4. **Outcomes.** Evaluation of program activities must utilize evidence-based
5.2 practices and must include the following outcome evaluation criteria:

5.3 (1) whether individuals experience a reduction in psychotic symptoms;

5.4 (2) whether individuals experience a decrease in inpatient mental health hospitalizations
5.5 or interactions with the criminal justice system; and

5.6 (3) whether individuals experience an increase in educational attainment or employment.

5.7 Subd. 5. **Federal aid or grants.** (a) The commissioner of human services must comply
5.8 with all conditions and requirements necessary to receive federal aid or grants.

5.9 (b) The commissioner must provide an annual report to the chairs and ranking minority
5.10 members of the legislative committees with jurisdiction over health and human services
5.11 policy and finance, the senate Finance Committee, and the house of representatives Ways
5.12 and Means Committee detailing the use of state and federal funds for the first episode of
5.13 psychosis grant program, the number of programs funded, the number of individuals served
5.14 across all grant-funded programs, and outcome and evaluation data.

5.15 Sec. 2. **[245.4908] EARLY EPISODE OF BIPOLAR DISORDER GRANT**
5.16 **PROGRAM.**

5.17 Subdivision 1. **Creation.** The early episode of bipolar disorder grant program is
5.18 established in the Department of Human Services, to fund evidence-based interventions for
5.19 youth and young adults at risk of developing or experiencing an early episode of bipolar
5.20 disorder. Early episode of bipolar disorder services are eligible for children's mental health
5.21 grants as specified in section 245.4889, subdivision 1, paragraph (b), clause (15). The
5.22 Department of Human Services must seek to fund eligible programs throughout the state.

5.23 Subd. 2. **Activities.** (a) All early episode of bipolar grant program recipients must:

5.24 (1) provide intensive treatment and support for adolescents and young adults experiencing
5.25 or at risk of experiencing early episode of bipolar disorder. Intensive treatment and support
5.26 includes medication management, psychoeducation for an individual and an individual's
5.27 family, case management, employment support, education support, cognitive behavioral
5.28 approaches, social skills training, peer and family peer support, crisis planning, and stress
5.29 management;

5.30 (2) conduct outreach and provide training and guidance to mental health and health care
5.31 professionals, including postsecondary health clinicians, on bipolar disorder symptoms,
5.32 screening tools, the recipient's program, and best practices; and

6.1 (3) use all available funding streams.

6.2 (b) Grant money may also be used to pay for housing or travel expenses for individuals
6.3 receiving services or to address other barriers preventing individuals and their families from
6.4 participating in early episode of bipolar disorder services.

6.5 Subd. 3. **Service eligibility.** A grant recipient's program activities must be provided to
6.6 individuals between 15 and 40 years of age who have early signs of or are experiencing
6.7 bipolar disorder.

6.8 Subd. 4. **Outcomes.** Evaluation of program activities must utilize evidence-based
6.9 practices and must include the following outcome evaluation criteria:

6.10 (1) whether individuals experience a reduction in symptoms;

6.11 (2) whether individuals experience a decrease in inpatient mental health hospitalizations
6.12 or interactions with the criminal justice system; and

6.13 (3) whether individuals experience an increase in educational attainment or employment.

6.14 Subd. 5. **Federal aid or grants.** (a) The commissioner of human services must comply
6.15 with all conditions and requirements necessary to receive federal aid or grants.

6.16 (b) The commissioner must provide an annual report to the chairs and ranking minority
6.17 members of the legislative committees with jurisdiction over health and human services
6.18 policy and finance, the senate Finance Committee, and the house of representatives Ways
6.19 and Means Committee detailing the use of state and federal funds for the early episode of
6.20 bipolar disorder grant program, the number of programs funded, the number of individuals
6.21 served across all grant-funded programs, and outcome and evaluation data.

6.22 **Sec. 3. [253B.042] ENGAGEMENT SERVICES PILOT GRANTS.**

6.23 Subdivision 1. **Creation.** The engagement services pilot grant program is established
6.24 in the Department of Human Services, to provide grants to counties or certified community
6.25 behavioral health centers to provide engagement services under section 253B.041.
6.26 Engagement services provide early interventions to prevent an individual from meeting the
6.27 criteria for civil commitment and promote positive outcomes.

6.28 Subd. 2. **Allowable grant activities.** (a) Grantees must use grant funding to:

6.29 (1) develop a system to respond to requests for engagement services;

6.30 (2) provide the following engagement services, taking into account an individual's
6.31 preferences for treatment services and supports:

7.1 (i) assertive attempts to engage an individual in voluntary treatment for mental illness
7.2 for at least 90 days;

7.3 (ii) efforts to engage an individual's existing support systems and interested persons,
7.4 including but not limited to providing education on restricting means of harm and suicide
7.5 prevention, when the provider determines that such engagement would be helpful; and

7.6 (iii) collaboration with the individual to meet the individual's immediate needs, including
7.7 but not limited to housing access, food and income assistance, disability verification,
7.8 medication management, and medical treatment;

7.9 (3) conduct outreach to families and providers; and

7.10 (4) evaluate the impact of engagement services on decreasing civil commitments,
7.11 increasing engagement in treatment, decreasing police involvement with individuals
7.12 exhibiting symptoms of serious mental illness, and other measures.

7.13 (b) Engagement services staff must have completed training on person-centered care.
7.14 Staff may include but are not limited to mobile crisis providers under section 256B.0624,
7.15 certified peer specialists under section 256B.0615, community-based treatment programs
7.16 staff, and homeless outreach workers.

7.17 Subd. 3. **Outcome evaluation.** The commissioner of management and budget must
7.18 formally evaluate outcomes of grants awarded under this section, using an experimental or
7.19 quasi-experimental design. The commissioner shall consult with the commissioner of
7.20 management and budget to ensure that grants are administered to facilitate this evaluation.
7.21 Grantees must collect and provide the information needed to the commissioner of human
7.22 services to complete the evaluation. The commissioner must provide the information collected
7.23 to the commissioner of management and budget to conduct the evaluation. The commissioner
7.24 of management and budget may obtain additional relevant data to support the evaluation
7.25 study pursuant to section 15.08.

7.26 Sec. 4. Minnesota Statutes 2023 Supplement, section 254B.04, subdivision 1a, is amended
7.27 to read:

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

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

8.9 (c) Notwithstanding paragraph (a), persons enrolled in medical assistance are eligible
8.10 for room and board services under section 254B.05, subdivision 5, paragraph (b), clause
8.11 (12).

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

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

8.15 (2) is eligible for medical assistance as determined under Minnesota Rules, parts
8.16 9505.0010 to 9505.0150;

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

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

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

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

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

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

8.31 (g) A client who is disenrolled from a state prepaid health plan during a treatment episode
8.32 is eligible for continued treatment service that is paid for by the behavioral health fund until

9.1 the treatment episode is completed or the client is re-enrolled in a state prepaid health plan
9.2 if the client:

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

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

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

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

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

9.16 Sec. 5. Minnesota Statutes 2023 Supplement, section 254B.05, subdivision 5, is amended
9.17 to read:

9.18 Subd. 5. **Rate requirements.** (a) The commissioner shall establish rates for substance
9.19 use disorder services and service enhancements funded under this chapter.

9.20 (b) Effective for services rendered on or after January 1, 2025, the commissioner shall
9.21 increase rates for residential services subject to this section by ... percent. The commissioner
9.22 shall adjust rates for such services annually according to the change from the midpoint of
9.23 the previous rate year to the midpoint of the rate year for which the rate is being determined
9.24 using the Centers for Medicare and Medicaid Services Medicare Economic Index as
9.25 forecasted in the fourth quarter of the calendar year before the rate year. This paragraph
9.26 does not apply to federally qualified health centers, rural health centers, Indian health
9.27 services, certified community behavioral health clinics, cost-based rates, and rates that are
9.28 negotiated with the county.

9.29 (c) For payments made under paragraph (b), if and to the extent that the commissioner
9.30 identifies that the state has received federal financial participation for behavioral health
9.31 services in excess of the amount allowed under Code of Federal Regulations, title 42, section
9.32 447.321, the state shall repay the excess amount to the Centers for Medicare and Medicaid
9.33 Services with state money and maintain the full payment rate under paragraph (b).

10.1 (d) Effective for services rendered on or after January 1, 2025, the commissioner shall
10.2 increase capitation payments made to managed care plans and county-based purchasing
10.3 plans to reflect the rate increase for residential services provided in paragraph (b). Managed
10.4 care and county-based purchasing plans must use the capitation rate increase provided under
10.5 this paragraph to increase payment rates to behavioral health services providers. The
10.6 commissioner must monitor the effect of this rate increase on enrollee access to services
10.7 provided under paragraph (b). If for any contract year federal approval is not received for
10.8 this paragraph, the commissioner must adjust the capitation rates paid to managed care plans
10.9 and county-based purchasing plans for that contract year to reflect the removal of this
10.10 provision. Contracts between managed care plans and county-based purchasing plans and
10.11 providers to whom this paragraph applies must allow recovery of payments from those
10.12 providers if capitation rates are adjusted in accordance with this paragraph. Payment
10.13 recoveries must not exceed the amount equal to any increase in rates that results from this
10.14 provision.

10.15 ~~(b)~~ (e) Eligible substance use disorder treatment services include:

10.16 (1) those licensed, as applicable, according to chapter 245G or applicable Tribal license
10.17 and provided according to the following ASAM levels of care:

10.18 (i) ASAM level 0.5 early intervention services provided according to section 254B.19,
10.19 subdivision 1, clause (1);

10.20 (ii) ASAM level 1.0 outpatient services provided according to section 254B.19,
10.21 subdivision 1, clause (2);

10.22 (iii) ASAM level 2.1 intensive outpatient services provided according to section 254B.19,
10.23 subdivision 1, clause (3);

10.24 (iv) ASAM level 2.5 partial hospitalization services provided according to section
10.25 254B.19, subdivision 1, clause (4);

10.26 (v) ASAM level 3.1 clinically managed low-intensity residential services provided
10.27 according to section 254B.19, subdivision 1, clause (5);

10.28 (vi) ASAM level 3.3 clinically managed population-specific high-intensity residential
10.29 services provided according to section 254B.19, subdivision 1, clause (6); and

10.30 (vii) ASAM level 3.5 clinically managed high-intensity residential services provided
10.31 according to section 254B.19, subdivision 1, clause (7);

10.32 (2) comprehensive assessments provided according to sections 245.4863, paragraph (a),
10.33 and 245G.05;

- 11.1 (3) treatment coordination services provided according to section 245G.07, subdivision
11.2 1, paragraph (a), clause (5);
- 11.3 (4) peer recovery support services provided according to section 245G.07, subdivision
11.4 2, clause (8);
- 11.5 (5) withdrawal management services provided according to chapter 245F;
- 11.6 (6) hospital-based treatment services that are licensed according to sections 245G.01 to
11.7 245G.17 or applicable tribal license and licensed as a hospital under sections 144.50 to
11.8 144.56;
- 11.9 (7) adolescent treatment programs that are licensed as outpatient treatment programs
11.10 according to sections 245G.01 to 245G.18 or as residential treatment programs according
11.11 to Minnesota Rules, parts 2960.0010 to 2960.0220, and 2960.0430 to 2960.0490, or
11.12 applicable tribal license;
- 11.13 (8) ASAM 3.5 clinically managed high-intensity residential services that are licensed
11.14 according to sections 245G.01 to 245G.17 and 245G.21 or applicable tribal license, which
11.15 provide ASAM level of care 3.5 according to section 254B.19, subdivision 1, clause (7),
11.16 and are provided by a state-operated vendor or to clients who have been civilly committed
11.17 to the commissioner, present the most complex and difficult care needs, and are a potential
11.18 threat to the community; and
- 11.19 (9) room and board facilities that meet the requirements of subdivision 1a.
- 11.20 ~~(e)~~ (f) The commissioner shall establish higher rates for programs that meet the
11.21 requirements of paragraph ~~(b)~~ (e) and one of the following additional requirements:
- 11.22 (1) programs that serve parents with their children if the program:
- 11.23 (i) provides on-site child care during the hours of treatment activity that:
- 11.24 (A) is licensed under chapter 245A as a child care center under Minnesota Rules, chapter
11.25 9503; or
- 11.26 (B) is licensed under chapter 245A and sections 245G.01 to 245G.19; or
- 11.27 (ii) arranges for off-site child care during hours of treatment activity at a facility that is
11.28 licensed under chapter 245A as:
- 11.29 (A) a child care center under Minnesota Rules, chapter 9503; or
- 11.30 (B) a family child care home under Minnesota Rules, chapter 9502;

12.1 (2) culturally specific or culturally responsive programs as defined in section 254B.01,
12.2 subdivision 4a;

12.3 (3) disability responsive programs as defined in section 254B.01, subdivision 4b;

12.4 (4) programs that offer medical services delivered by appropriately credentialed health
12.5 care staff in an amount equal to two hours per client per week if the medical needs of the
12.6 client and the nature and provision of any medical services provided are documented in the
12.7 client file; or

12.8 (5) programs that offer services to individuals with co-occurring mental health and
12.9 substance use disorder problems if:

12.10 (i) the program meets the co-occurring requirements in section 245G.20;

12.11 (ii) 25 percent of the counseling staff are licensed mental health professionals under
12.12 section 245I.04, subdivision 2, or are students or licensing candidates under the supervision
12.13 of a licensed alcohol and drug counselor supervisor and mental health professional under
12.14 section 245I.04, subdivision 2, except that no more than 50 percent of the mental health
12.15 staff may be students or licensing candidates with time documented to be directly related
12.16 to provisions of co-occurring services;

12.17 (iii) clients scoring positive on a standardized mental health screen receive a mental
12.18 health diagnostic assessment within ten days of admission;

12.19 (iv) the program has standards for multidisciplinary case review that include a monthly
12.20 review for each client that, at a minimum, includes a licensed mental health professional
12.21 and licensed alcohol and drug counselor, and their involvement in the review is documented;

12.22 (v) family education is offered that addresses mental health and substance use disorder
12.23 and the interaction between the two; and

12.24 (vi) co-occurring counseling staff shall receive eight hours of co-occurring disorder
12.25 training annually.

12.26 ~~(d)~~ (g) In order to be eligible for a higher rate under paragraph ~~(e)~~ (f), clause (1), a
12.27 program that provides arrangements for off-site child care must maintain current
12.28 documentation at the substance use disorder facility of the child care provider's current
12.29 licensure to provide child care services.

12.30 ~~(e)~~ (h) Adolescent residential programs that meet the requirements of Minnesota Rules,
12.31 parts 2960.0430 to 2960.0490 and 2960.0580 to 2960.0690, are exempt from the requirements
12.32 in paragraph ~~(e)~~ (f), clause (4), items (i) to (iv).

13.1 ~~(f)~~ (i) Subject to federal approval, substance use disorder services that are otherwise
13.2 covered as direct face-to-face services may be provided via telehealth as defined in section
13.3 256B.0625, subdivision 3b. The use of telehealth to deliver services must be medically
13.4 appropriate to the condition and needs of the person being served. Reimbursement shall be
13.5 at the same rates and under the same conditions that would otherwise apply to direct
13.6 face-to-face services.

13.7 ~~(g)~~ (j) For the purpose of reimbursement under this section, substance use disorder
13.8 treatment services provided in a group setting without a group participant maximum or
13.9 maximum client to staff ratio under chapter 245G shall not exceed a client to staff ratio of
13.10 48 to one. At least one of the attending staff must meet the qualifications as established
13.11 under this chapter for the type of treatment service provided. A recovery peer may not be
13.12 included as part of the staff ratio.

13.13 ~~(h)~~ (k) Payment for outpatient substance use disorder services that are licensed according
13.14 to sections 245G.01 to 245G.17 is limited to six hours per day or 30 hours per week unless
13.15 prior authorization of a greater number of hours is obtained from the commissioner.

13.16 ~~(i)~~ (l) Payment for substance use disorder services under this section must start from the
13.17 day of service initiation, when the comprehensive assessment is completed within the
13.18 required timelines.

13.19 Sec. 6. Minnesota Statutes 2023 Supplement, section 256.969, subdivision 2b, is amended
13.20 to read:

13.21 Subd. 2b. **Hospital payment rates.** (a) For discharges occurring on or after November
13.22 1, 2014, hospital inpatient services for hospitals located in Minnesota shall be paid according
13.23 to the following:

13.24 (1) critical access hospitals as defined by Medicare shall be paid using a cost-based
13.25 methodology;

13.26 (2) long-term hospitals as defined by Medicare shall be paid on a per diem methodology
13.27 under subdivision 25;

13.28 (3) rehabilitation hospitals or units of hospitals that are recognized as rehabilitation
13.29 distinct parts as defined by Medicare shall be paid according to the methodology under
13.30 subdivision 12; and

13.31 (4) all other hospitals shall be paid on a diagnosis-related group (DRG) methodology.

14.1 (b) For the period beginning January 1, 2011, through October 31, 2014, rates shall not
14.2 be rebased, except that a Minnesota long-term hospital shall be rebased effective January
14.3 1, 2011, based on its most recent Medicare cost report ending on or before September 1,
14.4 2008, with the provisions under subdivisions 9 and 23, based on the rates in effect on
14.5 December 31, 2010. For rate setting periods after November 1, 2014, in which the base
14.6 years are updated, a Minnesota long-term hospital's base year shall remain within the same
14.7 period as other hospitals.

14.8 (c) Effective for discharges occurring on and after November 1, 2014, payment rates
14.9 for hospital inpatient services provided by hospitals located in Minnesota or the local trade
14.10 area, except for the hospitals paid under the methodologies described in paragraph (a),
14.11 clauses (2) and (3), shall be rebased, incorporating cost and payment methodologies in a
14.12 manner similar to Medicare. The base year or years for the rates effective November 1,
14.13 2014, shall be calendar year 2012. The rebasing under this paragraph shall be budget neutral,
14.14 ensuring that the total aggregate payments under the rebased system are equal to the total
14.15 aggregate payments that were made for the same number and types of services in the base
14.16 year. Separate budget neutrality calculations shall be determined for payments made to
14.17 critical access hospitals and payments made to hospitals paid under the DRG system. Only
14.18 the rate increases or decreases under subdivision 3a or 3c that applied to the hospitals being
14.19 rebased during the entire base period shall be incorporated into the budget neutrality
14.20 calculation.

14.21 (d) For discharges occurring on or after November 1, 2014, through the next rebasing
14.22 that occurs, the rebased rates under paragraph (c) that apply to hospitals under paragraph
14.23 (a), clause (4), shall include adjustments to the projected rates that result in no greater than
14.24 a five percent increase or decrease from the base year payments for any hospital. Any
14.25 adjustments to the rates made by the commissioner under this paragraph and paragraph (e)
14.26 shall maintain budget neutrality as described in paragraph (c).

14.27 (e) For discharges occurring on or after November 1, 2014, the commissioner may make
14.28 additional adjustments to the rebased rates, and when evaluating whether additional
14.29 adjustments should be made, the commissioner shall consider the impact of the rates on the
14.30 following:

14.31 (1) pediatric services;

14.32 (2) behavioral health services;

14.33 (3) trauma services as defined by the National Uniform Billing Committee;

14.34 (4) transplant services;

- 15.1 (5) obstetric services, newborn services, and behavioral health services provided by
15.2 hospitals outside the seven-county metropolitan area;
- 15.3 (6) outlier admissions;
- 15.4 (7) low-volume providers; and
- 15.5 (8) services provided by small rural hospitals that are not critical access hospitals.
- 15.6 (f) Hospital payment rates established under paragraph (c) must incorporate the following:
- 15.7 (1) for hospitals paid under the DRG methodology, the base year payment rate per
15.8 admission is standardized by the applicable Medicare wage index and adjusted by the
15.9 hospital's disproportionate population adjustment;
- 15.10 (2) for critical access hospitals, payment rates for discharges between November 1, 2014,
15.11 and June 30, 2015, shall be set to the same rate of payment that applied for discharges on
15.12 October 31, 2014;
- 15.13 (3) the cost and charge data used to establish hospital payment rates must only reflect
15.14 inpatient services covered by medical assistance; and
- 15.15 (4) in determining hospital payment rates for discharges occurring on or after the rate
15.16 year beginning January 1, 2011, through December 31, 2012, the hospital payment rate per
15.17 discharge shall be based on the cost-finding methods and allowable costs of the Medicare
15.18 program in effect during the base year or years. In determining hospital payment rates for
15.19 discharges in subsequent base years, the per discharge rates shall be based on the cost-finding
15.20 methods and allowable costs of the Medicare program in effect during the base year or
15.21 years.
- 15.22 (g) The commissioner shall validate the rates effective November 1, 2014, by applying
15.23 the rates established under paragraph (c), and any adjustments made to the rates under
15.24 paragraph (d) or (e), to hospital claims paid in calendar year 2013 to determine whether the
15.25 total aggregate payments for the same number and types of services under the rebased rates
15.26 are equal to the total aggregate payments made during calendar year 2013.
- 15.27 (h) Effective for discharges occurring on or after July 1, 2017, and every two years
15.28 thereafter, payment rates under this section shall be rebased to reflect only those changes
15.29 in hospital costs between the existing base year or years and the next base year or years. In
15.30 any year that inpatient claims volume falls below the threshold required to ensure a
15.31 statistically valid sample of claims, the commissioner may combine claims data from two
15.32 consecutive years to serve as the base year. Years in which inpatient claims volume is
15.33 reduced or altered due to a pandemic or other public health emergency shall not be used as

16.1 a base year or part of a base year if the base year includes more than one year. Changes in
16.2 costs between base years shall be measured using the lower of the hospital cost index defined
16.3 in subdivision 1, paragraph (a), or the percentage change in the case mix adjusted cost per
16.4 claim. The commissioner shall establish the base year for each rebasing period considering
16.5 the most recent year or years for which filed Medicare cost reports are available, except
16.6 that the base years for the rebasing effective July 1, 2023, are calendar years 2018 and 2019.
16.7 The estimated change in the average payment per hospital discharge resulting from a
16.8 scheduled rebasing must be calculated and made available to the legislature by January 15
16.9 of each year in which rebasing is scheduled to occur, and must include by hospital the
16.10 differential in payment rates compared to the individual hospital's costs.

16.11 (i) Effective for discharges occurring on or after July 1, 2015, inpatient payment rates
16.12 for critical access hospitals located in Minnesota or the local trade area shall be determined
16.13 using a new cost-based methodology. The commissioner shall establish within the
16.14 methodology tiers of payment designed to promote efficiency and cost-effectiveness.
16.15 Payment rates for hospitals under this paragraph shall be set at a level that does not exceed
16.16 the total cost for critical access hospitals as reflected in base year cost reports. Until the
16.17 next rebasing that occurs, the new methodology shall result in no greater than a five percent
16.18 decrease from the base year payments for any hospital, except a hospital that had payments
16.19 that were greater than 100 percent of the hospital's costs in the base year shall have their
16.20 rate set equal to 100 percent of costs in the base year. The rates paid for discharges on and
16.21 after July 1, 2016, covered under this paragraph shall be increased by the inflation factor
16.22 in subdivision 1, paragraph (a). The new cost-based rate shall be the final rate and shall not
16.23 be settled to actual incurred costs. Hospitals shall be assigned a payment tier based on the
16.24 following criteria:

16.25 (1) hospitals that had payments at or below 80 percent of their costs in the base year
16.26 shall have a rate set that equals 85 percent of their base year costs;

16.27 (2) hospitals that had payments that were above 80 percent, up to and including 90
16.28 percent of their costs in the base year shall have a rate set that equals 95 percent of their
16.29 base year costs; and

16.30 (3) hospitals that had payments that were above 90 percent of their costs in the base year
16.31 shall have a rate set that equals 100 percent of their base year costs.

16.32 (j) The commissioner may refine the payment tiers and criteria for critical access hospitals
16.33 to coincide with the next rebasing under paragraph (h). The factors used to develop the new
16.34 methodology may include, but are not limited to:

17.1 (1) the ratio between the hospital's costs for treating medical assistance patients and the
17.2 hospital's charges to the medical assistance program;

17.3 (2) the ratio between the hospital's costs for treating medical assistance patients and the
17.4 hospital's payments received from the medical assistance program for the care of medical
17.5 assistance patients;

17.6 (3) the ratio between the hospital's charges to the medical assistance program and the
17.7 hospital's payments received from the medical assistance program for the care of medical
17.8 assistance patients;

17.9 (4) the statewide average increases in the ratios identified in clauses (1), (2), and (3);

17.10 (5) the proportion of that hospital's costs that are administrative and trends in
17.11 administrative costs; and

17.12 (6) geographic location.

17.13 (k) Effective for discharges occurring on or after January 1, 2024, the rates paid to
17.14 hospitals described in paragraph (a), clauses (2) to (4), must include a rate factor specific
17.15 to each hospital that qualifies for a medical education and research cost distribution under
17.16 section 62J.692, subdivision 4, paragraph (a).

17.17 (l) Effective for services rendered on or after January 1, 2025, the commissioner shall
17.18 increase payments for behavioral health services provided by hospitals paid on a
17.19 diagnosis-related group methodology for hospital inpatient services by increasing the
17.20 adjustment for behavioral health services under section 256.969, subdivision 2b, paragraph
17.21 (e).

17.22 (m) Effective for services rendered on or after January 1, 2025, the commissioner shall
17.23 increase capitation payments made to managed care plans and county-based purchasing
17.24 plans to reflect the rate increase provided under paragraph (l). Managed care and
17.25 county-based purchasing plans must use the capitation rate increase provided under this
17.26 paragraph to increase payment rates to behavioral health services providers. The
17.27 commissioner must monitor the effect of this rate increase on enrollee access to services
17.28 described in paragraph (l). If for any contract year federal approval is not received for this
17.29 paragraph, the commissioner must adjust the capitation rates paid to managed care plans
17.30 and county-based purchasing plans for that contract year to reflect the removal of this
17.31 provision. Contracts between managed care plans and county-based purchasing plans and
17.32 providers to whom this paragraph applies must allow recovery of payments from those
17.33 providers if capitation rates are adjusted in accordance with this paragraph. Payment

18.1 recoveries must not exceed the amount equal to any increase in rates that results from this
18.2 provision.

18.3 Sec. 7. Minnesota Statutes 2022, section 256B.0622, subdivision 2a, is amended to read:

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

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

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

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

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

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

18.24 (iii) significant difficulty maintaining a safe living situation;

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

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

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

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

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

- 19.1 (v) coexisting mental health and substance use disorders lasting at least six months;
- 19.2 (vi) recent history of involvement with the criminal justice system or demonstrated risk
19.3 of future involvement;
- 19.4 (vii) significant difficulty meeting basic survival needs;
- 19.5 (viii) residing in substandard housing, experiencing homelessness, or facing imminent
19.6 risk of homelessness;
- 19.7 (ix) significant impairment with social and interpersonal functioning such that basic
19.8 needs are in jeopardy;
- 19.9 (x) coexisting mental health and physical health disorders lasting at least six months;
- 19.10 (xi) residing in an inpatient or supervised community residence but clinically assessed
19.11 to be able to live in a more independent living situation if intensive services are provided;
- 19.12 (xii) requiring a residential placement if more intensive services are not available; ~~or~~
- 19.13 (xiii) difficulty effectively using traditional office-based outpatient services; or
- 19.14 (xiv) receiving services through a program that meets the requirements for the first
19.15 episode of psychosis grant program under section 245.4905 and having been determined to
19.16 need an ACT team;
- 19.17 (5) there are no indications that other available community-based services would be
19.18 equally or more effective as evidenced by consistent and extensive efforts to treat the
19.19 individual; and
- 19.20 (6) in the written opinion of a licensed mental health professional, has the need for mental
19.21 health services that cannot be met with other available community-based services, or is
19.22 likely to experience a mental health crisis or require a more restrictive setting if assertive
19.23 community treatment is not provided.

19.24 Sec. 8. Minnesota Statutes 2022, section 256B.0622, subdivision 3a, is amended to read:

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

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

19.29 ~~(2)~~ have each ACT team be certified by the state following the certification process and
19.30 procedures developed by the commissioner. The certification process determines whether
19.31 the ACT team meets the standards for assertive community treatment under this section,

20.1 the standards in chapter 245I as required in section 245I.011, subdivision 5, and minimum
20.2 program fidelity standards as measured by a nationally recognized fidelity tool approved
20.3 by the commissioner. Recertification must occur at least every three years.

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

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

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

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

20.9 (4) keep all necessary records required by law;

20.10 (5) be an enrolled Medicaid provider; and

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

20.13 (c) The commissioner may intervene at any time and decertify an ACT team with cause.

20.14 The commissioner shall establish a process for decertification of an ACT team and shall
20.15 require corrective action, medical assistance repayment, or decertification of an ACT team
20.16 that no longer meets the requirements in this section or that fails to meet the clinical quality
20.17 standards or administrative standards provided by the commissioner in the application and
20.18 certification process. The decertification is subject to appeal to the state.

20.19 Sec. 9. Minnesota Statutes 2022, section 256B.0622, subdivision 7a, is amended to read:

20.20 Subd. 7a. **Assertive community treatment team staff requirements and roles.** (a)

20.21 The required treatment staff qualifications and roles for an ACT team are:

20.22 (1) the team leader:

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

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

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

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

21.5 (2) the psychiatric care provider:

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

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

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

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

21.24 (v) shall have a minimum full-time equivalency that is prorated at a rate of 16 hours per
21.25 50 clients. Part-time psychiatric care providers shall have designated hours to work on the
21.26 team, with sufficient blocks of time on consistent days to carry out the provider's clinical,
21.27 supervisory, and administrative responsibilities. No more than two psychiatric care providers
21.28 may share this role; and

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

21.32 (3) the nursing staff:

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

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

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

22.13 (4) the co-occurring disorder specialist:

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

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

22.27 (5) the vocational specialist:

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

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

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

23.6 (6) the mental health certified peer specialist:

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

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

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

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

23.22 (8) additional staff:

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

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

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

23.30 (c) Each ACT team member must serve as a primary team member for clients assigned
23.31 by the team leader and are responsible for facilitating the individual treatment plan process
23.32 for those clients. The primary team member for a client is the responsible team member

24.1 knowledgeable about the client's life and circumstances and writes the individual treatment
24.2 plan. The primary team member provides individual supportive therapy or counseling, and
24.3 provides primary support and education to the client's family and support system.

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

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

24.12 Sec. 10. Minnesota Statutes 2023 Supplement, section 256B.0622, subdivision 7b, is
24.13 amended to read:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

27.4 Sec. 11. Minnesota Statutes 2022, section 256B.0622, subdivision 7d, is amended to read:

27.5 Subd. 7d. **Assertive community treatment assessment and individual treatment**
27.6 **plan.** (a) An initial assessment shall be completed the day of the client's admission to
27.7 assertive community treatment by the ACT team leader or the psychiatric care provider,
27.8 with participation by designated ACT team members and the client. The initial assessment
27.9 must include obtaining or completing a standard diagnostic assessment according to section
27.10 245I.10, subdivision 6, and completing a 30-day individual treatment plan. The team leader,
27.11 psychiatric care provider, or other mental health professional designated by the team leader
27.12 or psychiatric care provider, must update the client's diagnostic assessment ~~at least annually~~
27.13 as required under section 245I.10, subdivision 2, paragraphs (f) and (g).

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

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

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

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

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

27.32 (1) The individual treatment plan shall be developed in collaboration with the client and
27.33 the client's preferred natural supports, and guardian, if applicable and appropriate. The ACT

28.1 team shall evaluate, together with each client, the client's needs, strengths, and preferences
28.2 and develop the individual treatment plan collaboratively. The ACT team shall make every
28.3 effort to ensure that the client and the client's family and natural supports, with the client's
28.4 consent, are in attendance at the treatment planning meeting, are involved in ongoing
28.5 meetings related to treatment, and have the necessary supports to fully participate. The
28.6 client's participation in the development of the individual treatment plan shall be documented.

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

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

28.20 (4) The primary team member and the individual treatment team, together with the client
28.21 and the client's family and natural supports with the client's consent, are responsible for
28.22 reviewing and rewriting the treatment goals and individual treatment plan whenever there
28.23 is a major decision point in the client's course of treatment or at least every six months.

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

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

29.1 Sec. 12. Minnesota Statutes 2022, section 256B.0757, subdivision 5, is amended to read:

29.2 Subd. 5. **Payments.** (a) The commissioner shall make payments to each designated
 29.3 provider for the provision of health home services described in subdivision 3 to each eligible
 29.4 individual under subdivision 2 that selects the health home as a provider determine and
 29.5 implement a single statewide reimbursement rate for behavioral health home services under
 29.6 this section. The rate must be no less than \$408 per member, per month. The commissioner
 29.7 must adjust the statewide reimbursement rate annually according to the change from the
 29.8 midpoint of the previous rate year to the midpoint of the rate year for which the rate is being
 29.9 determined using the Centers for Medicare and Medicaid Services Medicare Economic
 29.10 Index as forecasted in the fourth quarter of the calendar year before the rate year.

29.11 (b) The commissioner must review and update the behavioral health home service rate
 29.12 under paragraph (a) at least every four years. The updated rate must account for the average
 29.13 hours required for behavioral health home team members spent providing services and the
 29.14 Department of Labor prevailing wage for required behavioral health home team members.
 29.15 The updated rate must ensure that behavioral health home services rates are sufficient to
 29.16 allow providers to meet required certifications, training, and practice transformation
 29.17 standards; staff qualification requirements; and service delivery standards.

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

29.21 Sec. 13. Minnesota Statutes 2023 Supplement, section 256B.76, subdivision 1, is amended
 29.22 to read:

29.23 Subdivision 1. **Physician and professional services reimbursement.** ~~(a) Effective for~~
 29.24 ~~services rendered on or after October 1, 1992, the commissioner shall make payments for~~
 29.25 ~~physician services as follows:~~

29.26 ~~(1) payment for level one Centers for Medicare and Medicaid Services' common~~
 29.27 ~~procedural coding system codes titled "office and other outpatient services," "preventive~~
 29.28 ~~medicine new and established patient," "delivery, antepartum, and postpartum care," "critical~~
 29.29 ~~care," cesarean delivery and pharmacologic management provided to psychiatric patients,~~
 29.30 ~~and level three codes for enhanced services for prenatal high risk, shall be paid at the lower~~
 29.31 ~~of (i) submitted charges, or (ii) 25 percent above the rate in effect on June 30, 1992;~~

29.32 ~~(2) payments for all other services shall be paid at the lower of (i) submitted charges,~~
 29.33 ~~or (ii) 15.4 percent above the rate in effect on June 30, 1992; and~~

30.1 ~~(3) all physician rates shall be converted from the 50th percentile of 1982 to the 50th~~
30.2 ~~percentile of 1989, less the percent in aggregate necessary to equal the above increases~~
30.3 ~~except that payment rates for home health agency services shall be the rates in effect on~~
30.4 ~~September 30, 1992.~~

30.5 ~~(b)~~ (a) Effective for services rendered on or after January 1, 2000, through December
30.6 31, 2024, payment rates for physician and professional services shall be increased by three
30.7 percent over the rates in effect on December 31, 1999, except for home health agency and
30.8 family planning agency services. The increases in this paragraph shall be implemented
30.9 January 1, 2000, for managed care.

30.10 ~~(e)~~ (b) Effective for services rendered on or after July 1, 2009, through December 31,
30.11 2024, payment rates for physician and professional services shall be reduced by five percent,
30.12 except that for the period July 1, 2009, through June 30, 2010, payment rates shall be reduced
30.13 by 6.5 percent for the medical assistance and general assistance medical care programs,
30.14 over the rates in effect on June 30, 2009. This reduction and the reductions in paragraph (d)
30.15 do not apply to office or other outpatient visits, preventive medicine visits and family
30.16 planning visits billed by physicians, advanced practice registered nurses, or physician
30.17 assistants in a family planning agency or in one of the following primary care practices:
30.18 general practice, general internal medicine, general pediatrics, general geriatrics, and family
30.19 medicine. This reduction and the reductions in paragraph (d) do not apply to federally
30.20 qualified health centers, rural health centers, and Indian health services. Effective October
30.21 1, 2009, payments made to managed care plans and county-based purchasing plans under
30.22 sections 256B.69, 256B.692, and 256L.12 shall reflect the payment reduction described in
30.23 this paragraph.

30.24 ~~(d)~~ (c) Effective for services rendered on or after July 1, 2010, through December 31,
30.25 2024, payment rates for physician and professional services shall be reduced an additional
30.26 seven percent over the five percent reduction in rates described in paragraph (c). This
30.27 additional reduction does not apply to physical therapy services, occupational therapy
30.28 services, and speech pathology and related services provided on or after July 1, 2010. This
30.29 additional reduction does not apply to physician services billed by a psychiatrist or an
30.30 advanced practice registered nurse with a specialty in mental health. Effective October 1,
30.31 2010, payments made to managed care plans and county-based purchasing plans under
30.32 sections 256B.69, 256B.692, and 256L.12 shall reflect the payment reduction described in
30.33 this paragraph.

30.34 ~~(e)~~ Effective for services rendered on or after September 1, 2011, through June 30, 2013,
30.35 ~~payment rates for physician and professional services shall be reduced three percent from~~

31.1 ~~the rates in effect on August 31, 2011. This reduction does not apply to physical therapy~~
31.2 ~~services, occupational therapy services, and speech pathology and related services.~~

31.3 ~~(f)~~ (d) Effective for services rendered on or after September 1, 2014, through December
31.4 31, 2024, payment rates for physician and professional services, including physical therapy,
31.5 occupational therapy, speech pathology, and mental health services shall be increased by
31.6 five percent from the rates in effect on August 31, 2014. In calculating this rate increase,
31.7 the commissioner shall not include in the base rate for August 31, 2014, the rate increase
31.8 provided under section 256B.76, subdivision 7. This increase does not apply to federally
31.9 qualified health centers, rural health centers, and Indian health services. Payments made to
31.10 managed care plans and county-based purchasing plans shall not be adjusted to reflect
31.11 payments under this paragraph.

31.12 ~~(g)~~ (e) Effective for services rendered on or after July 1, 2015, payment rates for physical
31.13 therapy, occupational therapy, and speech pathology and related services provided by a
31.14 hospital meeting the criteria specified in section 62Q.19, subdivision 1, paragraph (a), clause
31.15 (4), shall be increased by 90 percent from the rates in effect on June 30, 2015. Payments
31.16 made to managed care plans and county-based purchasing plans shall not be adjusted to
31.17 reflect payments under this paragraph.

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

31.20 ~~(i)~~ (g) The commissioner may reimburse physicians and other licensed professionals for
31.21 costs incurred to pay the fee for testing newborns who are medical assistance enrollees for
31.22 heritable and congenital disorders under section 144.125, subdivision 1, paragraph (c), when
31.23 the sample is collected outside of an inpatient hospital or freestanding birth center and the
31.24 cost is not recognized by another payment source.

31.25 Sec. 14. Minnesota Statutes 2022, section 256B.76, subdivision 6, is amended to read:

31.26 Subd. 6. **Medicare relative value units.** ~~Effective for services rendered on or after~~
31.27 ~~January 1, 2007, the commissioner shall make payments for physician and professional~~
31.28 ~~services based on the Medicare relative value units (RVU's). This change shall be budget~~
31.29 ~~neutral and the cost of implementing RVU's will be incorporated in the established conversion~~
31.30 ~~factor~~ (a) Effective for physician and professional services included in the Medicare Physician
31.31 Fee Schedule and rendered on or after January 1, 2025, the commissioner shall make
31.32 payments at rates at least equal to 100 percent of the corresponding rates in the Medicare
31.33 Physician Fee Schedule. Payment rates set under this paragraph must use Medicare relative

32.1 value units (RVUs) and conversion factors, at least equal to those in the Medicare Physician
32.2 Fee Schedule, to implement the resource-based relative value scale.

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

32.7 (c) The commissioner must revise and implement payment rates for mental health services
32.8 based on RVUs and rendered on or after January 1, 2025, such that the payment rates are
32.9 at least equal to 100 percent of the Medicare Physician Fee Schedule in accordance with
32.10 paragraph (a), before or at the same time as when the commissioner revises and implements
32.11 payment rates for other services under paragraph (a).

32.12 (d) All mental health services and substance use disorder services performed in a primary
32.13 care or mental health care health professional shortage area, medically underserved area,
32.14 or medically underserved population, as maintained and updated by the United States
32.15 Department of Health and Human Services, are eligible for a ten percent bonus payment.
32.16 The services are eligible for a bonus based upon the performance of the service in a health
32.17 professional shortage area if (1) the services were rendered in a health professional shortage
32.18 area, or (2) the provider maintains an office in a health professional shortage area.

32.19 (e) Effective for services rendered on or after January 1, 2025, the commissioner shall
32.20 increase capitation payments made to managed care plans and county-based purchasing
32.21 plans to reflect the rate increases provided under this subdivision. Managed care and
32.22 county-based purchasing plans must use the capitation rate increase provided under this
32.23 paragraph to increase payment rates to the providers corresponding to the rate increases.
32.24 The commissioner must monitor the effect of this rate increase on enrollee access to services
32.25 under this subdivision. If for any contract year federal approval is not received for this
32.26 paragraph, the commissioner must adjust the capitation rates paid to managed care plans
32.27 and county-based purchasing plans for that contract year to reflect the removal of this
32.28 provision. Contracts between managed care plans and county-based purchasing plans and
32.29 providers to whom this paragraph applies must allow recovery of payments from those
32.30 providers if capitation rates are adjusted in accordance with this paragraph. Payment
32.31 recoveries must not exceed the amount equal to any increase in rates that results from this
32.32 provision.

33.1 Sec. 15. Minnesota Statutes 2023 Supplement, section 256B.761, is amended to read:

33.2 **256B.761 REIMBURSEMENT FOR MENTAL HEALTH SERVICES.**

33.3 (a) Effective for services rendered on or after July 1, 2001, payment for medication
33.4 management provided to psychiatric patients, outpatient mental health services, day treatment
33.5 services, home-based mental health services, and family community support services shall
33.6 be paid at the lower of (1) submitted charges, or (2) 75.6 percent of the 50th percentile of
33.7 1999 charges.

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

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

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

33.26 (e) Effective for services rendered on or after January 1, 2024, payment rates for
33.27 behavioral health services included in the rate analysis required by Laws 2021, First Special
33.28 Session chapter 7, article 17, section 18, except for adult day treatment services under section
33.29 256B.0671, subdivision 3; early intensive developmental and behavioral intervention services
33.30 under section 256B.0949; and substance use disorder services under chapter 254B, must be
33.31 increased by three percent from the rates in effect on December 31, 2023. Effective for
33.32 services rendered on or after January 1, 2025, payment rates for behavioral health services
33.33 included in the rate analysis required by Laws 2021, First Special Session chapter 7, article
33.34 17, section 18, except for adult day treatment services under section 256B.0671, subdivision

34.1 3; early intensive developmental behavioral intervention services under section 256B.0949;
34.2 and substance use disorder services under chapter 254B, must be annually adjusted according
34.3 to the change from the midpoint of the previous rate year to the midpoint of the rate year
34.4 for which the rate is being determined using the Centers for Medicare and Medicaid Services
34.5 Medicare Economic Index as forecasted in the fourth quarter of the calendar year before
34.6 the rate year. For payments made in accordance with this paragraph, if and to the extent
34.7 that the commissioner identifies that the state has received federal financial participation
34.8 for behavioral health services in excess of the amount allowed under United States Code,
34.9 title 42, section 447.321, the state shall repay the excess amount to the Centers for Medicare
34.10 and Medicaid Services with state money and maintain the full payment rate under this
34.11 paragraph. This paragraph does not apply to federally qualified health centers, rural health
34.12 centers, Indian health services, certified community behavioral health clinics, cost-based
34.13 rates, and rates that are negotiated with the county. This paragraph expires upon legislative
34.14 implementation of the new rate methodology resulting from the rate analysis required by
34.15 Laws 2021, First Special Session chapter 7, article 17, section 18.

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

34.29 (g) Effective for services under this section billed and coded under HCPCS H, S, and T
34.30 codes and rendered on or after January 1, 2025, the payment rates shall be increased as
34.31 necessary to align with the Medicare Physician Fee Schedule.

34.32 (h) The commissioner shall revise fee-for-service payment methodologies under paragraph
34.33 (g), upon the issuance of a Medicare Physician Fee Schedule final rule by the Centers for
34.34 Medicare and Medicaid Services, as necessary to ensure the payments rates under paragraph
34.35 (g) align with the corresponding payment rates in the final rule.

35.1 Sec. 16. **DIRECTION TO COMMISSIONER OF HUMAN SERVICES; MEDICAID**
 35.2 **REENTRY SECTION 1115 DEMONSTRATION OPPORTUNITY WAIVER.**

35.3 (a) The commissioner of human services shall apply to the secretary of health and human
 35.4 services for a Medicaid Reentry Section 1115 Demonstration Opportunity waiver to provide
 35.5 short term medical assistance enrollment assistance and prerelease coverage for care transition
 35.6 services to incarcerated individuals who are soon to be released from incarceration, consistent
 35.7 with the statutory directive in section 5032 of the Substance Use-Disorder Prevention that
 35.8 Promotes Opioid Recovery and Treatment for Patients and Communities Act (Public Law
 35.9 115-271) and federal guidance. The commissioner's application must request coverage for
 35.10 at least the services under Minnesota Statutes, section 256B.0625, subdivision 72, for at
 35.11 least 30 days prior to an eligible incarcerated individual's expected release date.

35.12 (b) When preparing the application for the Section 1115 Demonstration Opportunity
 35.13 waiver, the commissioner of human services must consult with the commissioner of
 35.14 corrections, sheriffs, lead agencies, and individuals with lived experience of incarceration.

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

35.16 Sec. 17. **REVISOR INSTRUCTION.**

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

35.23 Sec. 18. **REPEALER.**

35.24 Minnesota Statutes 2022, section 256B.0625, subdivision 38, is repealed.

35.25 **ARTICLE 3**
 35.26 **MISCELLANEOUS**

35.27 Section 1. Minnesota Statutes 2022, section 246.18, subdivision 4a, is amended to read:

35.28 Subd. 4a. **Mental health innovation account.** The mental health innovation account is
 35.29 established in the special revenue fund. ~~Beginning in fiscal year 2018, \$1,000,000 of~~ The
 35.30 revenue generated by collection efforts from the Anoka-Metro Regional Treatment Center
 35.31 and community behavioral health hospitals under section 246.54 must annually be deposited

36.1 into the mental health innovation account. Money deposited in the mental health innovation
36.2 account is appropriated to the commissioner of human services for the mental health
36.3 innovation grant program under section 245.4662.

36.4 Sec. 2. Minnesota Statutes 2023 Supplement, section 246.54, subdivision 1a, is amended
36.5 to read:

36.6 Subd. 1a. **Anoka-Metro Regional Treatment Center.** (a) A county's payment of the
36.7 cost of care provided at Anoka-Metro Regional Treatment Center shall be according to the
36.8 following schedule:

36.9 (1) zero percent for the first 30 days;

36.10 (2) 20 percent for days 31 and over if the stay is determined to be clinically appropriate
36.11 for the client; and

36.12 (3) 100 percent for each day during the stay, including the day of admission, when the
36.13 facility determines that it is clinically appropriate for the client to be discharged.

36.14 (b) If payments received by the state under sections 246.50 to 246.53 exceed 80 percent
36.15 of the cost of care for days over 31 for clients who meet the criteria in paragraph (a), clause
36.16 (2), the county shall be responsible for paying the state only the remaining amount. The
36.17 county shall not be entitled to reimbursement from the client, the client's estate, or from the
36.18 client's relatives, except as provided in section 246.53.

36.19 ~~(e) Between July 1, 2023, and June 30, 2025, the county is not responsible for the cost~~
36.20 ~~of care under paragraph (a), clause (3), for a person who is committed as a person who has~~
36.21 ~~a mental illness and is dangerous to the public under section 253B.18 and who is awaiting~~
36.22 ~~transfer to another state-operated facility or program. This paragraph expires June 30, 2025.~~

36.23 ~~(d)~~ (c) Notwithstanding any law to the contrary, the client is not responsible for payment
36.24 of the cost of care under this subdivision.

36.25 (d) The county is not responsible for the cost of care under paragraph (a), clause (3), for
36.26 a client who is civilly committed, if the client:

36.27 (1) is awaiting transfer to a facility operated by the Department of Corrections; or

36.28 (2) is awaiting transfer to another state-operated facility or program, and the direct care
36.29 and treatment executive medical director's office has determined that:

36.30 (i) the client meets criteria for admission to that state-operated facility or program; and

37.1 (ii) the state-operated facility or program is the only facility or program that can
37.2 reasonably serve the client.

37.3 Sec. 3. Minnesota Statutes 2023 Supplement, section 246.54, subdivision 1b, is amended
37.4 to read:

37.5 Subd. 1b. **Community behavioral health hospitals.** (a) A county's payment of the cost
37.6 of care provided at state-operated community-based behavioral health hospitals for adults
37.7 and children shall be according to the following schedule:

37.8 (1) 100 percent for each day during the stay, including the day of admission, when the
37.9 facility determines that it is clinically appropriate for the client to be discharged; and

37.10 (2) the county shall not be entitled to reimbursement from the client, the client's estate,
37.11 or from the client's relatives, except as provided in section 246.53.

37.12 ~~(b) Between July 1, 2023, and June 30, 2025, the county is not responsible for the cost~~
37.13 ~~of care under paragraph (a), clause (1), for a person committed as a person who has a mental~~
37.14 ~~illness and is dangerous to the public under section 253B.18 and who is awaiting transfer~~
37.15 ~~to another state-operated facility or program. This paragraph expires June 30, 2025.~~

37.16 ~~(e)~~ (b) Notwithstanding any law to the contrary, the client is not responsible for payment
37.17 of the cost of care under this subdivision.

37.18 (c) The county is not responsible for the cost of care under paragraph (a), clause (1), for
37.19 a client who is civilly committed, if the client:

37.20 (1) is awaiting transfer to a facility operated by the Department of Corrections; or

37.21 (2) is awaiting transfer to another state-operated facility or program, and the direct care
37.22 and treatment executive medical director's office has determined that:

37.23 (i) the client meets criteria for admission to that state-operated facility or program; and

37.24 (ii) the state-operated facility or program is the only facility or program that can
37.25 reasonably serve the client.

37.26 Sec. 4. Minnesota Statutes 2023 Supplement, section 641.15, subdivision 2, is amended
37.27 to read:

37.28 Subd. 2. **Medical aid.** Except as provided in section 466.101, the county board shall
37.29 pay the costs of medical services provided to prisoners pursuant to this section. The amount
37.30 paid by the county board for a medical service shall not exceed the maximum allowed
37.31 medical assistance payment rate for the service, as determined by the commissioner of

38.1 human services. In the absence of a health or medical insurance or health plan that has a
38.2 contractual obligation with the provider or the prisoner, medical providers shall charge no
38.3 higher than the rate negotiated between the county and the provider. In the absence of an
38.4 agreement between the county and the provider, the provider may not charge an amount
38.5 that exceeds the maximum allowed medical assistance payment rate for the service, as
38.6 determined by the commissioner of human services. The county is entitled to reimbursement
38.7 from the prisoner for payment of medical bills to the extent that the prisoner to whom the
38.8 medical aid was provided has the ability to pay the bills. The prisoner shall, at a minimum,
38.9 incur co-payment obligations for health care services provided by a county correctional
38.10 facility. The county board shall determine the co-payment amount. A prisoner shall not
38.11 have a co-payment obligation for receiving a medication for mental health treatment in a
38.12 county correctional facility. The county board may seek reimbursement for mental health
38.13 medication co-payment costs from the commissioner of human services. Notwithstanding
38.14 any law to the contrary, the co-payment shall be deducted from any of the prisoner's funds
38.15 held by the county, to the extent possible. If there is a disagreement between the county and
38.16 a prisoner concerning the prisoner's ability to pay, the court with jurisdiction over the
38.17 defendant shall determine the extent, if any, of the prisoner's ability to pay for the medical
38.18 services. If a prisoner is covered by health or medical insurance or other health plan when
38.19 medical services are provided, the medical provider shall bill that health or medical insurance
38.20 or other plan. If the county providing the medical services for a prisoner that has coverage
38.21 under health or medical insurance or other plan, that county has a right of subrogation to
38.22 be reimbursed by the insurance carrier for all sums spent by it for medical services to the
38.23 prisoner that are covered by the policy of insurance or health plan, in accordance with the
38.24 benefits, limitations, exclusions, provider restrictions, and other provisions of the policy or
38.25 health plan. The county may maintain an action to enforce this subrogation right. The county
38.26 does not have a right of subrogation against the medical assistance program. The county
38.27 shall not charge prisoners for telephone calls to MNsure navigators, the Minnesota Warmline,
38.28 a mental health provider, or calls for the purpose of providing case management or mental
38.29 health services as defined in section 245.462 to prisoners.

38.30 **Sec. 5. JOINT INCIDENT COLLABORATION; DIRECTION TO COMMISSIONER**
38.31 **OF HUMAN SERVICES.**

38.32 The commissioner of human services and the Department of Direct Care and Treatment
38.33 executive board, once operational, shall coordinate to implement a joint incident collaboration
38.34 model with counties and community mental health treatment providers to actively arrange

39.1 discharges of direct care and treatment patients to appropriate community treatment settings
39.2 when the patients are medically stable for discharge.

39.3 **ARTICLE 4**

39.4 **APPROPRIATIONS**

39.5 Section 1. **CORRECTIONAL FACILITY MENTAL HEALTH COSTS AND**
39.6 **SERVICES.**

39.7 \$..... in fiscal year 2025 is appropriated from the general fund to the commissioner of
39.8 human services for services and costs for prisoners receiving mental health medications in
39.9 county correctional facilities. The commissioner must use these funds to:

39.10 (1) pay for injectable medications or neuroleptic medications used for mental health
39.11 treatment of prisoners in county correctional facilities and related billable provider costs;
39.12 and

39.13 (2) reimburse county boards for co-payment costs incurred for mental health medications
39.14 provided in county correctional facilities, pursuant to Minnesota Statutes, section 641.15,
39.15 subdivision 2.

39.16 Sec. 2. **DIRECT CARE AND TREATMENT; COUNTY CORRECTIONAL**
39.17 **FACILITY MENTAL HEALTH MEDICATIONS.**

39.18 \$..... in fiscal year 2025 is appropriated from the general fund to the commissioner of
39.19 human services to create a staff position within direct care and treatment to provide education,
39.20 support, and technical assistance to counties and county correctional facilities on the provision
39.21 of medications for mental health treatment and assist with finding providers to deliver the
39.22 medications.

39.23 Sec. 3. **FORENSIC EXAMINER SERVICES.**

39.24 \$9,230,000 in fiscal year 2025 is appropriated from the general fund to the supreme
39.25 court for the psychological and psychiatric forensic examiner services program to deliver
39.26 statutorily mandated psychological examinations for civil commitment, criminal competency,
39.27 and criminal responsibility evaluations. This appropriation must be used to increase forensic
39.28 examiner pay rates from \$125 to \$225 per hour.

40.1 Sec. 4. **DIRECT CARE AND TREATMENT CAPACITY AND UTILIZATION.**

40.2 \$..... in fiscal year 2025 is appropriated from the general fund to the commissioner of
40.3 human services to increase capacity and access to direct care and treatment services for all
40.4 levels of care. The commissioner must prioritize expanding capacity within the Forensic
40.5 Mental Health Program by ten to 20 percent, and Anoka Metro Regional Treatment Center
40.6 and community behavioral health hospitals by 20 percent, through renovation, construction,
40.7 reallocation of beds and staff, addition of beds and staff, or a combination of these activities.
40.8 The commissioner must also use money appropriated under this section to examine the
40.9 utilization of beds at the Forensic Mental Health Program to identify opportunities for the
40.10 most effective utilization of secured programming and to develop and fund direct care and
40.11 treatment transitional support resources.

40.12 Sec. 5. **HOSPITAL PAYMENT RATE INCREASES.**

40.13 \$8,785,000 in fiscal year 2025 is appropriated from the general fund to the commissioner
40.14 of human services for the hospital payment rate increases under Minnesota Statutes, section
40.15 256.969, subdivision 2b, paragraphs (l) and (m). The aggregate amount of the increased
40.16 payments under Minnesota Statutes, section 256.969, subdivision 2b, paragraphs (l) and
40.17 (m), must at least equal the amount of this appropriation.

40.18 Sec. 6. **ENGAGEMENT SERVICES PILOT GRANTS.**

40.19 \$2,000,000 in fiscal year 2025 is appropriated from the general fund to the commissioner
40.20 of human services for engagement services pilot grants under Minnesota Statutes, section
40.21 253B.042. This funding is added to the base.

40.22 Sec. 7. **EARLY EPISODE OF BIPOLAR GRANT PROGRAM.**

40.23 \$..... in fiscal year 2025 is appropriated from the general fund to the commissioner of
40.24 human services for the early episode of bipolar grant program under Minnesota Statutes,
40.25 section 245.4908. This funding is added to the base.

40.26 Sec. 8. **FIRST EPISODE OF PSYCHOSIS GRANT PROGRAM.**

40.27 \$2,000,000 in fiscal year 2025 is appropriated from the general fund to the commissioner
40.28 of human services for the first episode of psychosis grant program under Minnesota Statutes,
40.29 section 245.4905. This funding is added to the base. The commissioner may distribute this
40.30 funding to fully fund current grantee programs, increase a current grantee program's capacity,
40.31 and to expand grants for programs to outside the seven-county metropolitan area. The

- 41.1 commissioner must continue to fund current grantee programs to ensure stability and
- 41.2 continuity of care, if the current grantee programs have met requirements for usage of grant
- 41.3 funds previously received.

256B.0625 COVERED SERVICES.

Subd. 38. **Payments for mental health services.** Payments for mental health services covered under the medical assistance program that are provided by masters-prepared mental health professionals shall be 80 percent of the rate paid to doctoral-prepared professionals. Payments for mental health services covered under the medical assistance program that are provided by masters-prepared mental health professionals employed by community mental health centers shall be 100 percent of the rate paid to doctoral-prepared professionals. Payments for mental health services covered under the medical assistance program that are provided by physician assistants shall be 80.4 percent of the base rate paid to psychiatrists.