Senator ..... moves to amend S.F. No. 2449 as follows:

Page 1, after line 14, insert:

"ARTICLE 1

BEHAVIORAL HEALTH SERVICES MODIFICATIONS

Section 1. Minnesota Statutes 2022, section 245.4901, subdivision 4, is amended to read:

Subd. 4. **Data collection and outcome measurement.** Grantees shall provide data to the commissioner for the purpose of evaluating the effectiveness of the school-linked behavioral health grant program, no more frequently than twice per year. Data provided by grantees shall include the number of clients served, client demographics, payment information, duration and frequency of services and client-related clinic ancillary services including hours of direct client services, and hours of ancillary direct and indirect support services. Qualitative data may also be collected to demonstrate impact from client and school personnel perspectives."

Page 8, after line 24, insert:

"Sec. 8. Minnesota Statutes 2022, section 256B.0616, subdivision 3, is amended to read:

Subd. 3. **Eligibility.** Family peer support services ~~may~~ shall be provided to recipients ~~of inpatient hospitalization, partial hospitalization, residential treatment, children's intensive behavioral health services, day treatment, children's therapeutic services and supports, or crisis services~~ eligible under medical assistance, upon a determination of medical necessity by a licensed mental health professional."

Page 13, after line 14, insert:

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

Subd. 7b. **Assertive community treatment program size and opportunities.** (a) Each ACT team shall maintain an annual average caseload that does not exceed 100 clients. Staff-to-client ratios shall be based on team size as follows:

(1) a small ACT team must:

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

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

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

(iv) schedule ACT team staff ~~for at least eight-hour shift coverage~~ on weekdays and on-call duty to provide crisis services and deliver services after hours when staff are not working;

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

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

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

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

(2) a midsize ACT team shall:

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

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

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

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

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

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

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

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

(3) a large ACT team must:

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

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

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

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

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

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

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

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

Sec. 12. Minnesota Statutes 2022, section 256B.0622, subdivision 7c, is amended to read:

Subd. 7c. **Assertive community treatment program organization and communication requirements.** (a) An ACT team shall provide at least 75 percent of all services in the community in non-office-based or non-facility-based settings.

(b) ACT team members must know all clients receiving services, and interventions must be carried out with consistency and follow empirically supported practice.

(c) Each ACT team client shall be assigned an individual treatment team that is determined by a variety of factors, including team members' expertise and skills, rapport, and other factors specific to the individual's preferences. The majority of clients shall see at least three ACT team members in a given month.

(d) The ACT team shall have the capacity to rapidly increase service intensity to a client when the client's status requires it, regardless of geography, and provide flexible service in an individualized manner~~, and see clients on average three times per week for at least 120 minutes per week~~ at a frequency that meets the client's needs. Services must be available at times that meet client needs.

(e) ACT teams shall make deliberate efforts to assertively engage clients in services. Input of family members, natural supports, and previous and subsequent treatment providers is required in developing engagement strategies. ACT teams shall include the client, identified family, and other support persons in the admission, initial assessment, and planning process as primary stakeholders, meet with the client in the client's environment at times of the day

and week that honor the client's preferences, and meet clients at home and in jails or prisons, streets, homeless shelters, or hospitals.

(f) ACT teams shall ensure that a process is in place for identifying individuals in need of more or less assertive engagement. Interventions are monitored to determine the success of these techniques and the need to adapt the techniques or approach accordingly.

(g) ACT teams shall conduct daily team meetings to systematically update clinically relevant information, briefly discuss the status of assertive community treatment clients over the past 24 hours, problem solve emerging issues, plan approaches to address and prevent crises, and plan the service contacts for the following 24-hour period or weekend. All team members scheduled to work shall attend this meeting.

(h) ACT teams shall maintain a clinical log that succinctly documents important clinical information and develop a daily team schedule for the day's contacts based on a central file of the clients' weekly or monthly schedules, which are derived from interventions specified within the individual treatment plan. The team leader must have a record to ensure that all assigned contacts are completed."

Page 19, line 27, delete "and county-based purchasing"

Page 19, line 28, delete "twelve" and insert "no less than six" and after "months" insert ", provide an exemption to timely filing timelines for the resubmission of claims when there is a denial, a request for more information, or a systems issue,"

Page 20, after line 7, insert:

"ARTICLE 2

CERTIFIED COMMUNITY BEHAVIORAL HEALTH CLINICS

Section 1. Minnesota Statutes 2022, section 245.735, is amended by adding a subdivision to read:

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

(b) "Alcohol and drug counselor" has the meaning given in section 245G.11, subdivision 5.

(c) "Care coordination" means the activities required to coordinate care across settings and providers for a person served to ensure seamless transitions across the full spectrum of health services. Care coordination includes outreach and engagement; documenting a plan of care for medical, behavioral health, and social services and supports in the integrated

treatment plan; assisting with obtaining appointments; confirming appointments are kept; developing a crisis plan; tracking medication; and implementing care coordination agreements with external providers. Care coordination may include psychiatric consultation with primary care practitioners and with mental health clinical care practitioners.

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

(e) "Comprehensive evaluation" means a person-centered, family-centered, and trauma-informed evaluation meeting the requirements of subdivision 4b completed for the purposes of diagnosis and treatment planning.

(f) "Designated collaborating organization" means an entity meeting the requirements of subdivision 3c with a formal agreement with a CCBHC to furnish CCBHC services.

(g) "Functional assessment" means an assessment of a client's current level of functioning relative to functioning that is appropriate for someone the client's age and that meets the requirements of subdivision 4a.

(h) "Initial evaluation" means an evaluation completed by a mental health professional that gathers and documents information necessary to formulate a preliminary diagnosis and begin client services.

(i) "Integrated treatment plan" means a documented plan of care meeting the requirements of subdivision 4d that guides treatment and interventions addressing all services required, including but not limited to recovery supports, with provisions for monitoring progress toward the client's goals.

(j) "Medical director" means a physician who is responsible for overseeing the medical components of the CCBHC services.

(k) "Mental health professional" has the meaning given in section 245I.04, subdivision 2.

(l) "Mobile crisis services" has the meaning given in section 256B.0624, subdivision 2.

(m) "Preliminary screening and risk assessment" means a mandatory screening and risk assessment that is completed at the first contact with the prospective CCBHC service recipient and determines the acuity of client need.

Sec. 2. Minnesota Statutes 2022, section 245.735, subdivision 3, is amended to read:

Subd. 3. **Certified community behavioral health clinics.** (a) The commissioner shall establish a state certification and recertification process for certified community behavioral health clinics (CCBHCs) that satisfy all federal requirements necessary for CCBHCs certified under this section to be eligible for reimbursement under medical assistance, without service area limits based on geographic area or region. The commissioner shall consult with CCBHC stakeholders before establishing and implementing changes in the certification or recertification process and requirements. Any changes to the certification or recertification process or requirements must be consistent with the most recently issued Certified Community Behavioral Health Clinic Certification Criteria published by the Substance Abuse and Mental Health Services Administration.

(b) As part of the state CCBHC certification and recertification process, the commissioner shall provide to entities applying for certification or requesting recertification standard requirements of the community needs assessment and the staffing plan that are consistent with the most recently issued Certified Community Behavioral Health Clinic Certification Criteria published by the Substance Abuse and Mental Health Services Administration.

(c) The commissioner shall schedule a certification review that includes a site visit within 90 calendar days of receipt of an application for certification or recertification.

(d) Entities that choose to be CCBHCs must:

(1) complete a community needs assessment and complete a staffing plan that is responsive to the needs identified in the community needs assessment and update both the community needs assessment and the staffing plan no less frequently than every 36 months;

(2) comply with state licensing requirements and other requirements issued by the commissioner;

~~(2)~~ (3) employ or contract with a medical director. A medical director must be a physician licensed under chapter 147 and either certified by the American Board of Psychiatry and Neurology, certified by the American Osteopathic Board of Neurology and Psychiatry, or eligible for board certification in psychiatry. A registered nurse who is licensed under sections 148.171 to 148.285 and is certified as a nurse practitioner in adult or family psychiatric and mental health nursing by a national nurse certification organization may serve as the medical director when a CCBHC is unable to employ or contract a qualified physician;

(4) employ or contract for clinic staff who have backgrounds in diverse disciplines, including licensed mental health professionals and licensed alcohol and drug counselors, and staff who are culturally and linguistically trained to meet the needs of the population the clinic serves;

~~(3)~~ (5) ensure that clinic services are available and accessible to individuals and families of all ages and genders with access on evenings and weekends and that crisis management services are available 24 hours per day;

~~(4)~~ (6) establish fees for clinic services for individuals who are not enrolled in medical assistance using a sliding fee scale that ensures that services to patients are not denied or limited due to an individual's inability to pay for services;

~~(5)~~ (7) comply with quality assurance reporting requirements and other reporting requirements~~, including any required reporting of encounter data, clinical outcomes data, and quality data~~ included in the most recently issued Certified Community Behavioral Health Clinic Certification Criteria published by the Substance Abuse and Mental Health Services Administration;

~~(6)~~ (8) provide crisis mental health and substance use services, withdrawal management services, emergency crisis intervention services, and stabilization services through existing mobile crisis services; screening, assessment, and diagnosis services, including risk assessments and level of care determinations; person- and family-centered treatment planning; outpatient mental health and substance use services; targeted case management; psychiatric rehabilitation services; peer support and counselor services and family support services; and intensive community-based mental health services, including mental health services for members of the armed forces and veterans. CCBHCs must directly provide the majority of these services to enrollees, but may coordinate some services with another entity through a collaboration or agreement, pursuant to ~~paragraph (b)~~ subdivision 3c;

~~(7)~~ (9) provide coordination of care across settings and providers to ensure seamless transitions for individuals being served across the full spectrum of health services, including acute, chronic, and behavioral needs~~. Care coordination may be accomplished through partnerships or formal contracts with:~~

~~(i) counties, health plans, pharmacists, pharmacies, rural health clinics, federally qualified health centers, inpatient psychiatric facilities, substance use and detoxification facilities, or community-based mental health providers; and~~

~~(ii) other community services, supports, and providers, including schools, child welfare agencies, juvenile and criminal justice agencies, Indian health services clinics, tribally~~

~~licensed health care and mental health facilities, urban Indian health clinics, Department of Veterans Affairs medical centers, outpatient clinics, drop-in centers, acute care hospitals, and hospital outpatient clinics~~;

~~(8)~~ (10) be certified as a mental health clinic under section 245I.20;

~~(9)~~ (11) comply with standards established by the commissioner relating to CCBHC screenings, assessments, and evaluations that are consistent with this section;

~~(10)~~ (12) be licensed to provide substance use disorder treatment under chapter 245G;

~~(11)~~ (13) be certified to provide children's therapeutic services and supports under section 256B.0943;

~~(12)~~ (14) be certified to provide adult rehabilitative mental health services under section 256B.0623;

~~(13)~~ (15) be enrolled to provide mental health crisis response services under section 256B.0624;

~~(14)~~ (16) be enrolled to provide mental health targeted case management under section 256B.0625, subdivision 20;

~~(15) comply with standards relating to mental health case management in Minnesota Rules, parts 9520.0900 to 9520.0926;~~

~~(16)~~ (17) provide services that comply with the evidence-based practices described in ~~paragraph (c)~~ subdivision 3f; ~~and~~

~~(17) comply with standards relating to~~ (18) provide peer services ~~under~~ as defined in sections 256B.0615, 256B.0616, and 245G.07, subdivision 2, clause (8), as applicable when peer services are provided; and

(19) inform all clients upon initiation of care of the full array of services available under the CCBHC model.

~~(b) If a certified CCBHC is unable to provide one or more of the services listed in paragraph (a), clauses (6) to (17), the CCBHC may contract with another entity that has the required authority to provide that service and that meets the following criteria as a designated collaborating organization:~~

~~(1) the entity has a formal agreement with the CCBHC to furnish one or more of the services under paragraph (a), clause (6);~~

~~(2) the entity provides assurances that it will provide services according to CCBHC service standards and provider requirements;~~

~~(3) the entity agrees that the CCBHC is responsible for coordinating care and has clinical and financial responsibility for the services that the entity provides under the agreement; and~~

~~(4) the entity meets any additional requirements issued by the commissioner.~~

~~(c) Notwithstanding any other law that requires a county contract or other form of county approval for certain services listed in paragraph (a), clause (6), a clinic that otherwise meets CCBHC requirements may receive the prospective payment under section 256B.0625, subdivision 5m, for those services without a county contract or county approval. As part of the certification process in paragraph (a), the commissioner shall require a letter of support from the CCBHC's host county confirming that the CCBHC and the county or counties it serves have an ongoing relationship to facilitate access and continuity of care, especially for individuals who are uninsured or who may go on and off medical assistance.~~

~~(d) When the standards listed in paragraph (a) or other applicable standards conflict or address similar issues in duplicative or incompatible ways, the commissioner may grant variances to state requirements if the variances do not conflict with federal requirements for services reimbursed under medical assistance. If standards overlap, the commissioner may substitute all or a part of a licensure or certification that is substantially the same as another licensure or certification. The commissioner shall consult with stakeholders, as described in subdivision 4, before granting variances under this provision. For the CCBHC that is certified but not approved for prospective payment under section 256B.0625, subdivision 5m, the commissioner may grant a variance under this paragraph if the variance does not increase the state share of costs.~~

~~(e) The commissioner shall issue a list of required evidence-based practices to be delivered by CCBHCs, and may also provide a list of recommended evidence-based practices. The commissioner may update the list to reflect advances in outcomes research and medical services for persons living with mental illnesses or substance use disorders. The commissioner shall take into consideration the adequacy of evidence to support the efficacy of the practice, the quality of workforce available, and the current availability of the practice in the state. At least 30 days before issuing the initial list and any revisions, the commissioner shall provide stakeholders with an opportunity to comment.~~

~~(f) The commissioner shall recertify CCBHCs at least every three years. The commissioner shall establish a process for decertification and shall require corrective action,~~

~~medical assistance repayment, or decertification of a CCBHC that no longer meets the requirements in this section or that fails to meet the standards provided by the commissioner in the application and certification process.~~

Sec. 3. Minnesota Statutes 2022, section 245.735, is amended by adding a subdivision to read:

Subd. 3c. **Designated collaborating organizations.** If a certified CCBHC is unable to provide one or more of the services listed in subdivision 3, paragraph (d), clauses (8) to (19), the CCBHC may contract with another entity that has the required authority to provide that service and that meets the following criteria as a designated collaborating organization:

(1) the entity has a formal agreement with the CCBHC to furnish one or more of the services under subdivision 3, paragraph (d), clause (8);

(2) the entity provides assurances that it will provide services according to CCBHC service standards and provider requirements;

(3) the entity agrees that the CCBHC is responsible for coordinating care and has clinical and financial responsibility for the services that the entity provides under the agreement; and

(4) the entity meets any additional requirements issued by the commissioner.

Sec. 4. Minnesota Statutes 2022, section 245.735, is amended by adding a subdivision to read:

Subd. 3d. **Exemptions to host county approval.** Notwithstanding any other law that requires a county contract or other form of county approval for a service listed in subdivision 3, paragraph (d), clause (8), a CCBHC that meets the requirements of this section may receive the prospective payment under section 256B.0625, subdivision 5m, for that service without a county contract or county approval.

Sec. 5. Minnesota Statutes 2022, section 245.735, is amended by adding a subdivision to read:

Subd. 3e. **Variances.** When the standards listed in this section or other applicable standards conflict or address similar issues in duplicative or incompatible ways, the commissioner may grant variances to state requirements if the variances do not conflict with federal requirements for services reimbursed under medical assistance. If standards overlap, the commissioner may substitute all or a part of a licensure or certification that is

substantially the same as another licensure or certification. The commissioner shall consult with stakeholders before granting variances under this provision. For a CCBHC that is certified but not approved for prospective payment under section 256B.0625, subdivision 5m, the commissioner may grant a variance under this paragraph if the variance does not increase the state share of costs.

Sec. 6. Minnesota Statutes 2022, section 245.735, is amended by adding a subdivision to read:

Subd. 3f. **Evidence-based practices.** The commissioner shall issue a list of required evidence-based practices to be delivered by CCBHCs, and may also provide a list of recommended evidence-based practices. The commissioner may update the list to reflect advances in outcomes research and medical services for persons living with mental illnesses or substance use disorders. The commissioner shall take into consideration the adequacy of evidence to support the efficacy of the practice across cultures and ages, the workforce available, and the current availability of the practice in the state. At least 30 days before issuing the initial list or issuing any revisions, the commissioner shall provide stakeholders with an opportunity to comment.

Sec. 7. Minnesota Statutes 2022, section 245.735, is amended by adding a subdivision to read:

Subd. 3g. **Recertification.** A CCBHC must apply for recertification every 36 months.

Sec. 8. Minnesota Statutes 2022, section 245.735, is amended by adding a subdivision to read:

Subd. 3h. **Opportunity to cure.** (a) The commissioner shall provide a formal written notice outlining the determination of the application and process for applicable and necessary corrective action required of the applicant signed by the commissioner or appropriate division director to applicant entities within 30 calendar days of the site visit.

(b) The commissioner may reject an application if the applicant entity does not take all corrective actions specified in the notice and notify the commissioner that the applicant entity has done so within 60 calendar days.

(c) The commissioner must send the applicant entity a final decision on the corrected application within 30 calendar days of the applicant entity's notice to the commissioner that the applicant has taken the required corrective actions.

Sec. 9. Minnesota Statutes 2022, section 245.735, is amended by adding a subdivision to read:

Subd. 3i. **Decertification process.** The commissioner must establish a process for decertification. The commissioner must require corrective action, medical assistance repayment, or decertification of a CCBHC that no longer meets the requirements in this section or that fails to meet the standards provided by the commissioner in the application, certification, or recertification process.

Sec. 10. Minnesota Statutes 2022, section 245.735, is amended by adding a subdivision to read:

Subd. 4a. **Functional assessment requirements.** (a) For adults, a functional assessment may be complete via a Daily Living Activities-20 (DLA-20) tool.

(b) Notwithstanding any law to the contrary, a functional assessment performed by a CCBHC that meets the requirements of this subdivision satisfies the requirements in:

(1) section 256B.0623, subdivision 9;

(2) section 245.4711, subdivision 3; and

(3) Minnesota Rules, part 9520.0914, subpart 2.

Sec. 11. Minnesota Statutes 2022, section 245.735, is amended by adding a subdivision to read:

Subd. 4b. **Requirements for comprehensive evaluations.** (a) A comprehensive evaluation must be completed for all new clients within 60 calendar days following the preliminary screening and risk assessment.

(b) Only a mental health professional may complete a comprehensive evaluation. The mental health professional must consult with an alcohol and drug counselor when substance use disorder services are deemed clinically appropriate.

(c) The comprehensive evaluation must consist of the synthesis of existing information including but not limited to an external diagnostic assessment, crisis assessment, preliminary screening and risk assessment, initial evaluation, and primary care screenings.

(d) A comprehensive evaluation must be completed in the cultural context of the client and updated to reflect changes in the client's conditions, and at the client's request or when the client's condition no longer meets the existing diagnosis.

(e) The psychiatric evaluation and management service fulfills requirements for the comprehensive evaluation when a client of a CCBHC is receiving exclusively psychiatric evaluation and management services. The CCBHC shall complete the comprehensive evaluation within 60 calendar days of a client's referral for additional CCBHC services.

(f) For clients engaging exclusively in substance use disorder services at the CCBHC, a substance use disorder comprehensive assessment as defined in section 245G.05, subdivision 2, that is completed within 60 calendar days of service initiation shall fulfill requirements of the comprehensive evaluation.

(g) Notwithstanding any law to the contrary, a comprehensive evaluation performed by a CCBHC that meets the requirements of this subdivision satisfies the requirements in:

(1) section 245I.10, subdivisions 4 to 6;

(2) section 245G.04, subdivision 1;

(3) section 256B.0943, subdivision 3, and subdivision 6, paragraph (b), clause (1);

(4) section 256B.0623, subdivision 3, clause (4), and subdivisions 8 and 10;

(5) section 245.462, subdivision 20, paragraph (c);

(6) section 245.4871, subdivision 6;

(7) section 245.4711, subdivision 2, paragraph (b);

(8) section 245.4881, subdivision 2, paragraph (c);

(9) section 245G.05, subdivision 1;

(10) Minnesota Rules, part 9520.0910, subparts 1 and 2;

(11) Minnesota Rules, part 9520.0909, subpart 1; and

(12) Minnesota Rules, part 9520.0914, subpart 2.

Sec. 12. Minnesota Statutes 2022, section 245.735, is amended by adding a subdivision to read:

Subd. 4c. **Requirements for initial evaluations.** (a) A CCBHC must complete either an initial evaluation or a comprehensive evaluation within ten business days of the preliminary screening and risk assessment.

(b) Notwithstanding any law to the contrary, an initial evaluation performed by a CCBHC that meets the requirements of this subdivision satisfies the requirements in:

(1) section 245I.10, subdivision 5;

(2) section 256B.0943, subdivision 3, and subdivision 6, paragraph (b), clauses (1) and (2);

(3) section 256B.0623, subdivision 3, clause (4), and subdivisions 8 and 10;

(4) section 245.4881, subdivisions 3 and 4;

(5) section 245.4711, subdivision 4;

(6) Minnesota Rules, part 9520.0909, subpart 1;

(7) Minnesota Rules, part 9520.0910, subpart 1;

(8) Minnesota Rules, part 9520.0914, subpart 2;

(9) Minnesota Rules, part 9520.0918, subparts 1 and 2; and

(10) Minnesota Rules, part 9520.0919, subpart 2.

Sec. 13. Minnesota Statutes 2022, section 245.735, is amended by adding a subdivision to read:

Subd. 4d. **Requirements for integrated treatment plans.** (a) An integrated treatment plan must be completed within 60 calendar days following the preliminary screening and risk assessment and updated no less frequently than every six months or when the client's circumstances change.

(b) Only a mental health professional may complete an integrated treatment plan. The mental health professional must consult with an alcohol and drug counselor when substance use disorder services are deemed clinically appropriate. An alcohol and drug counselor may approve the integrated treatment plan. The integrated treatment plan must be developed through a shared decision making process with the client, the client's support system if the client chooses, or for children, with the family or caregivers.

(c) The integrated treatment plan must:

(1) use the ASAM 6 dimensional framework; and

(2) incorporate prevention, medical and behavioral health needs, and service delivery.

(d) The psychiatric evaluation and management service fulfills requirements for the integrated treatment plan when a client of a CCBHC is receiving exclusively psychiatric evaluation and management services. The CCBHC must complete an integrated treatment plan within 60 calendar days of a client's referral for additional CCBHC services.

(e) Notwithstanding any law to the contrary, an integrated treatment plan developed by a CCBHC that meets the requirements of this subdivision satisfies the requirements in:

(1) section 256B.0943, subdivision 6, paragraph (b), clause (2);

(2) section 256B.0623, subdivision 10;

(3) section 245I.10, subdivisions 7 and 8;

(4) section 245G.06, subdivision 1; and

(5) section 245G.09, subdivision 3, clause (6).

Sec. 14. Minnesota Statutes 2022, section 245.735, subdivision 5, is amended to read:

Subd. 5. **Information systems support.** The commissioner and the state chief information officer shall provide information systems support to the projects as necessary to comply with state and federal requirements, including data reporting requirements.

Sec. 15. Minnesota Statutes 2022, section 245.735, subdivision 6, is amended to read:

Subd. 6. ~~**Demonstration**~~ **Section 223 Protecting Access to Medicare Act entities.** The commissioner ~~may operate~~ must request federal approval to reenter the demonstration program established by section 223 of the Protecting Access to Medicare Act and if approved continue to operate the demonstration program as long as federal funding for the demonstration program remains available from the United States Department of Health and Human Services. ~~To the extent practicable, the commissioner shall align the requirements of the demonstration program with the requirements under this section for CCBHCs receiving medical assistance reimbursement.~~ A CCBHC may not apply to participate as a billing provider in both the CCBHC federal demonstration and the benefit for CCBHCs under the medical assistance program.

Sec. 16. Minnesota Statutes 2022, section 245.735, is amended by adding a subdivision to read:

Subd. 7. **Addition of CCBHCs to section 223 state demonstration programs.** (a) If the commissioner's request under subdivision 6 to reenter the demonstration program established by section 223 of the Protecting Access to Medicare Act is approved, upon reentry the commissioner must provide all CCBHCs the option to be added to the demonstration. At the time a clinic joins the demonstration, the clinic must meet the demonstration certification criteria and prospective payment system guidance in effect at that time and be certified as a CCBHC by the state. The SAMHSA attestation process for

the CCBHC expansion grants is not sufficient to constitute state certification. CCBHCs newly added to the demonstration must participate in all aspects of the state demonstration program, including but not limited to quality measurement and reporting, evaluation activities, and state CCBHC demonstration program requirements such as use of state-specified evidence-based practices. A newly added CCBHC must report on quality measures before its first full demonstration year if it joined the demonstration program in calendar year 2023 out of alignment with the state's demonstration year cycle. A CCBHC may provide services in multiple locations and in community-based settings. If a facility meets the definition of a satellite facility as defined by the Substance Abuse and Mental Health Services Administration and was established after April 1, 2014, the facility cannot receive payment as a part of the demonstration program.

(b) The commissioner must submit the following materials for approval to the Substance Abuse and Mental Health Services Administration and Centers for Medicare and Medicaid Services within 60 days following receipt of a complete application from a CCBHC:

(1) a list of new CCBHCs to be added, including the date when the state intends to add the clinics to the CCBHC demonstration;

(2) a timeline for conducting a needs assessment for each newly added CCBHC, as required in the CCBHC certification criteria;

(3) a timeline for certifying as CCBHCs the clinics that the state is planning to add to the demonstration;

(4) a description of the certification process for new CCBHCs participating in the state demonstration program that includes:

(i) the CCBHC criteria checklist;

(ii) a description of the selection processes and review procedures that the state is using to certify clinics including attention to quality of care, access, and availability of services;

(iii) a description of how the state facilitated cultural, procedural, and organizational changes to CCBHCs that will result in the delivery of high-quality, comprehensive, person-centered, and evidence-based services that are accessible to the target population;

(iv) a description of how the CCBHC needs assessment process addresses the following:

(A) input from individuals with lived experience of mental health and substance use challenges, and other stakeholders;

(B) behavioral health needs and resources in the service area; and

(C) transportation, income, culture, and other barriers; and

(v) a description of the guidance to CCBHCs regarding the CCBHC's organization governance that ensures meaningful input by clients, people with lived experience of mental health and substance use conditions, and family members;

(5) a description of how the state is preparing new CCBHCs to use data to inform and support continuous quality improvement processes, including fidelity to evidence-based practices; delivery of person-centered, recovery-oriented care; and tracking and addressing health disparities during the demonstration;

(6) a description of how the state is assisting new CCBHCs with collection and reporting of the CCBHC Behavioral Health Clinic Quality Measures to comply with the existing state reporting schedules for these measures;

(7) a description of how the state is assisting new CCBHCs to ensure they are using either CCBHC- or state-specific billing codes to identify CCBHC service level details on claims;

(8) a description of how the state is assisting new CCBHCs with the cost reporting process and how the rates will be set; and

(9) estimates of the clinic-specific rates for each new CCBHC to be added under the state's existing demonstration program and the timeframe in which these new CCBHC's initial prospective payment system rates will be in effect.

(c) The state must use the existing approved state demonstration prospective payment system methodology for any added CCBHCs. Reimbursement under the CCBHC demonstration for new CCBHCs must not be retroactive and must start on the approved effective date for new clinics being added to the CCBHC demonstration. The commissioner must use the Centers for Medicare & Medicaid Services CCBHC cost report to set initial rates for new CCBHCs, unless the commissioner has a state-specific CCBHC cost report that has been previously approved by Centers for Medicare & Medicaid Services for use in the demonstration. The commissioner must submit final rates for the newly added clinics at most 30 days prior to the date on which the state intends to add them. The commissioner must follow the Centers for Medicare & Medicaid Services Prospective Payment System guidance related to updating and rebasing Prospective Payment System rates. The commissioner must update the Prospective Payment System rates for CCBHCs after their first full demonstration year using actual costs. Updated rates must be effective for the following demonstration year. Payments must be made in alignment with demonstration Prospective Payment System guidance.

Sec. 17. Minnesota Statutes 2022, section 245.735, is amended by adding a subdivision to read:

Subd. 8. **Grievance procedures required.** CCBHCs and designated collaborating organizations must allow all service recipients access to grievance procedures, which must satisfy the minimum requirements of medical assistance and other grievance requirements such as those that may be mandated by relevant accrediting entities.

Sec. 18. Minnesota Statutes 2022, section 256B.0625, subdivision 5m, is amended to read:

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

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

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

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

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

(3) initial CCBHC daily bundled rates for newly certified CCBHCs under section 245.735, subdivision 3, shall be established by the commissioner using a provider-specific rate based

on the newly certified CCBHC's audited historical cost report data adjusted for the expected cost of delivering CCBHC services. Estimates are subject to review by the commissioner and must include the expected cost of providing the full scope of CCBHC services and the expected number of visits for the rate period;

(4) the commissioner shall rebase CCBHC rates once every ~~three~~ two years following the last rebasing and no less than 12 months following an initial rate or a rate change due to a change in the scope of services;

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

(6) ~~the CCBHC daily bundled rate under this section does not apply to services rendered by CCBHCs to individuals who are dually eligible for Medicare and medical assistance when Medicare is the primary payer for the service. An entity that receives a CCBHC daily bundled rate system that overlaps with the CCBHC rate is not eligible for the CCBHC rate~~ if the commissioner has not reentered the CCBHC demonstration program by July 1, 2023, CCBHCs shall be paid the daily bundled rate under this section for services rendered to individuals who are duly eligible for Medicare and medical assistance;

(7) payments for CCBHC services to individuals enrolled in managed care shall be coordinated with the state's phase-out of CCBHC wrap payments. The commissioner shall complete the phase-out of CCBHC wrap payments within 60 days of the implementation of the CCBHC daily bundled rate system in the Medicaid Management Information System (MMIS), for CCBHCs reimbursed under this chapter, with a final settlement of payments due made payable to CCBHCs no later than 18 months thereafter;

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

(9) a CCBHC may request a rate adjustment for changes in the CCBHC's scope of services when such changes are expected to result in an adjustment to the CCBHC payment rate by 2.5 percent or more. The CCBHC must provide the commissioner with information regarding the changes in the scope of services, including the estimated cost of providing the new or modified services and any projected increase or decrease in the number of visits resulting from the change. Estimated costs are subject to review by the commissioner. Rate

adjustments for changes in scope shall occur no more than once per year in between rebasing periods per CCBHC and are effective on the date of the annual CCBHC rate update.

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

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

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

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

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

(4) a CCBHC must provide the commissioner with data needed to determine incentive payment eligibility within six months following the measurement year. The commissioner shall notify CCBHC providers of their performance on the required measures and the incentive payment amount within 12 months following the measurement year.

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

(1) one or more managed care plans does not comply with the federal requirement for payment of clean claims to CCBHCs, as defined in Code of Federal Regulations, title 42,

section 447.45(b), and the managed care plan does not resolve the payment issue within 30 days of noncompliance; and

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

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

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

EFFECTIVE DATE. This section is effective July 1, 2023, or upon federal approval, whichever is later. The commissioner of human services shall inform the revisor of statutes when federal approval is obtained.

Sec. 19. **DIRECTION TO COMMISSIONER; CERTIFIED COMMUNITY BEHAVIORAL HEALTH CLINICS AND MENTAL HEALTH SERVICE CERTIFICATIONS TRANSITION TO LICENSURE.**

(a) The commissioner of human services must transition all of the following mental health services from certification under Minnesota Statutes, chapters 245 and 256B, to licensure under Minnesota Statutes, chapter 245A, according to the Mental Health Uniform Service Standards in Minnesota Statutes, chapter 245I, to be effective on or before January 1, 2026:

(1) certified community behavioral health clinics;

(2) adult rehabilitative mental health services;

(3) mobile mental health crisis response services;

(4) children's therapeutic services and supports; and

(5) community mental health centers.

(b) No later than January 1, 2025, the commissioner must submit the proposed legislation necessary to implement the transition in paragraph (a) to the chairs and ranking minority members of the legislative committees with jurisdiction over behavioral health services.

(c) The commissioner must consult with stakeholders to develop the proposed legislation described in paragraph (b)."

Renumber the sections in sequence

Amend the title accordingly