

1.1 **Senator Wiklund from the Committee on Health and Human Services, to which**
1.2 **was referred**

1.3 **S.F. No. 1953:** A bill for an act relating to mental health; modifying the definition of
1.4 mental illness; making changes to medical assistance transportation reimbursement rates;
1.5 establishing a grant program for children at risk of bipolar disorder; requiring a report;
1.6 appropriating money for the children's first episode of psychosis program; amending
1.7 Minnesota Statutes 2024, sections 62A.673, subdivision 2; 245.462, subdivision 20;
1.8 256B.0625, subdivision 17.

1.9 Reports the same back with the recommendation that the bill be amended as follows:

1.10 Page 1, delete section 1

1.11 Page 3, after line 32, insert:

1.12 "(d) For purposes of enrolling in case management and community support services, a
1.13 "person with a complex post-traumatic stress disorder" or "C-PTSD" means an adult who
1.14 has a mental illness and meets the following criteria:

1.15 (1) the adult has post-traumatic stress disorder (PTSD) symptoms that significantly
1.16 interfere with daily functioning related to intergenerational trauma, racial trauma, or
1.17 unresolved historical grief; and

1.18 (2) the adult has a written opinion from a mental health professional that includes
1.19 documentation of:

1.20 (i) culturally sensitive assessments or screenings and identification of intergenerational
1.21 trauma, racial trauma, or unresolved historical grief;

1.22 (ii) significant impairment in functioning due to the PTSD symptoms that meet C-PTSD
1.23 condition eligibility; and

1.24 (iii) increasing concerns within the last three years that indicates the adult is at a
1.25 reasonable likelihood of experiencing significant episodes of PTSD with increased frequency,
1.26 impacting daily functioning unless mitigated by targeted case management or community
1.27 support services."

1.28 Page 4, line 1, delete "(d)" and insert "(e)"

1.29 Page 4, after line 3, insert:

1.30 "**EFFECTIVE DATE.** Paragraph (d) is effective upon federal approval. The
1.31 commissioner of human services shall notify the revisor of statutes when federal approval
1.32 is obtained."

1.33 Page 4, before line 4, insert:

2.1 "Sec. 2. Minnesota Statutes 2024, section 245.467, subdivision 4, is amended to read:

2.2 Subd. 4. **Referral for case management.** Each provider of emergency services, day
2.3 treatment services, outpatient treatment, community support services, residential treatment,
2.4 acute care hospital inpatient treatment, or regional treatment center inpatient treatment must
2.5 inform each of its clients with serious and persistent mental illness or a complex
2.6 post-traumatic stress disorder of the availability and potential benefits to the client of case
2.7 management. If the client consents, the provider must refer the client by notifying the county
2.8 employee designated by the county board to coordinate case management activities of the
2.9 client's name and address and by informing the client of whom to contact to request case
2.10 management. The provider must document compliance with this subdivision in the client's
2.11 record.

2.12 **EFFECTIVE DATE.** This section is effective upon federal approval. The commissioner
2.13 of human services shall notify the revisor of statutes when federal approval is obtained.

2.14 Sec. 3. Minnesota Statutes 2024, section 245.4711, subdivision 1, is amended to read:

2.15 Subdivision 1. **Availability of case management services.** (a) ~~By January 1, 1989,~~ The
2.16 county board shall provide case management services for all adults with serious and persistent
2.17 mental illness or a complex post-traumatic stress disorder who are residents of the county
2.18 and who request or consent to the services and to each adult for whom the court appoints a
2.19 case manager. Staffing ratios must be sufficient to serve the needs of the clients. The case
2.20 manager must meet the requirements in section 245.462, subdivision 4.

2.21 (b) Case management services provided to adults with serious and persistent mental
2.22 illness or a complex post-traumatic stress disorder eligible for medical assistance must be
2.23 billed to the medical assistance program under sections 256B.02, subdivision 8, and
2.24 256B.0625.

2.25 (c) Case management services are eligible for reimbursement under the medical assistance
2.26 program. Costs associated with mentoring, supervision, and continuing education may be
2.27 included in the reimbursement rate methodology used for case management services under
2.28 the medical assistance program.

2.29 **EFFECTIVE DATE.** This section is effective upon federal approval. The commissioner
2.30 of human services shall notify the revisor of statutes when federal approval is obtained.

3.1 Sec. 4. Minnesota Statutes 2024, section 245.4711, subdivision 4, is amended to read:

3.2 Subd. 4. **Individual community support plan.** (a) The case manager must develop an
3.3 individual community support plan for each adult that incorporates the client's individual
3.4 treatment plan. The individual treatment plan may not be a substitute for the development
3.5 of an individual community support plan. The individual community support plan must be
3.6 developed within 30 days of client intake and reviewed at least every 180 days after it is
3.7 developed, unless the case manager receives a written request from the client or the client's
3.8 family for a review of the plan every 90 days after it is developed. The case manager is
3.9 responsible for developing the individual community support plan based on a diagnostic
3.10 assessment and a functional assessment and for implementing and monitoring the delivery
3.11 of services according to the individual community support plan. To the extent possible, the
3.12 adult with serious and persistent mental illness or a complex post-traumatic stress disorder,
3.13 the person's family, advocates, service providers, and significant others must be involved
3.14 in all phases of development and implementation of the individual community support plan.

3.15 (b) The client's individual community support plan must state:

3.16 (1) the goals of each service;

3.17 (2) the activities for accomplishing each goal;

3.18 (3) a schedule for each activity; and

3.19 (4) the frequency of face-to-face contacts by the case manager, as appropriate to client
3.20 need and the implementation of the individual community support plan.

3.21 **EFFECTIVE DATE.** This section is effective upon federal approval. The commissioner
3.22 of human services shall notify the revisor of statutes when federal approval is obtained.

3.23 Sec. 5. Minnesota Statutes 2024, section 245.4712, subdivision 1, is amended to read:

3.24 Subdivision 1. **Availability of community support services.** (a) County boards must
3.25 provide or contract for sufficient community support services within the county to meet the
3.26 needs of adults with serious and persistent mental illness or a complex post-traumatic stress
3.27 disorder who are residents of the county. Adults may be required to pay a fee according to
3.28 section 245.481. The community support services program must be designed to improve
3.29 the ability of adults with serious and persistent mental illness or a complex post-traumatic
3.30 stress disorder to:

3.31 (1) find and maintain competitive employment;

3.32 (2) handle basic activities of daily living;

4.1 (3) participate in leisure time activities;

4.2 (4) set goals and plans; and

4.3 (5) obtain and maintain appropriate living arrangements.

4.4 The community support services program must also be designed to reduce the need for
4.5 and use of more intensive, costly, or restrictive placements both in number of admissions
4.6 and length of stay.

4.7 (b) Community support services are those services that are supportive in nature and not
4.8 necessarily treatment oriented, and include:

4.9 (1) conducting outreach activities such as home visits, health and wellness checks, and
4.10 problem solving;

4.11 (2) connecting people to resources to meet their basic needs;

4.12 (3) finding, securing, and supporting people in their housing;

4.13 (4) attaining and maintaining health insurance benefits;

4.14 (5) assisting with job applications, finding and maintaining employment, and securing
4.15 a stable financial situation;

4.16 (6) fostering social support, including support groups, mentoring, peer support, and other
4.17 efforts to prevent isolation and promote recovery; and

4.18 (7) educating about mental illness, treatment, and recovery.

4.19 (c) Community support services shall use all available funding streams. The county shall
4.20 maintain the level of expenditures for this program, as required under section 245.4835.

4.21 County boards must continue to provide funds for those services not covered by other
4.22 funding streams and to maintain an infrastructure to carry out these services. The county is
4.23 encouraged to fund evidence-based practices such as Individual Placement and Supported
4.24 Employment and Illness Management and Recovery.

4.25 (d) The commissioner shall collect data on community support services programs,
4.26 including, but not limited to, demographic information such as age, sex, race, the number
4.27 of people served, and information related to housing, employment, hospitalization, symptoms,
4.28 and satisfaction with services.

4.29 **EFFECTIVE DATE.** This section is effective upon federal approval. The commissioner
4.30 **of human services shall notify the revisor of statutes when federal approval is obtained.**

5.1 Sec. 6. Minnesota Statutes 2024, section 245.4712, subdivision 3, is amended to read:

5.2 Subd. 3. **Benefits assistance.** The county board must offer to help adults with serious
5.3 and persistent mental illness or a complex post-traumatic stress disorder in applying for
5.4 state and federal benefits, including Supplemental Security Income, medical assistance,
5.5 Medicare, general assistance, and Minnesota supplemental aid. The help must be offered
5.6 as part of the community support program available to adults with serious and persistent
5.7 mental illness or a complex post-traumatic stress disorder for whom the county is financially
5.8 responsible and who may qualify for these benefits.

5.9 Sec. 7. Minnesota Statutes 2024, section 245.4889, subdivision 1, is amended to read:

5.10 Subdivision 1. **Establishment and authority.** (a) The commissioner is authorized to
5.11 make grants from available appropriations to assist:

5.12 (1) counties;

5.13 (2) Indian tribes;

5.14 (3) children's collaboratives under section 142D.15 or 245.493; or

5.15 (4) mental health service providers.

5.16 (b) The following services are eligible for grants under this section:

5.17 (1) services to children with emotional disturbances as defined in section 245.4871,
5.18 subdivision 15, and their families;

5.19 (2) transition services under section 245.4875, subdivision 8, for young adults under
5.20 age 21 and their families;

5.21 (3) respite care services for children with emotional disturbances or severe emotional
5.22 disturbances who are at risk of residential treatment or hospitalization, who are already in
5.23 out-of-home placement in family foster settings as defined in chapter 142B and at risk of
5.24 change in out-of-home placement or placement in a residential facility or other higher level
5.25 of care, who have utilized crisis services or emergency room services, or who have
5.26 experienced a loss of in-home staffing support. Allowable activities and expenses for respite
5.27 care services are defined under subdivision 4. A child is not required to have case
5.28 management services to receive respite care services. Counties must work to provide access
5.29 to regularly scheduled respite care;

5.30 (4) children's mental health crisis services;

5.31 (5) child-, youth-, and family-specific mobile response and stabilization services models;

(6) mental health services for people from cultural and ethnic minorities, including supervision of clinical trainees who are Black, indigenous, or people of color;

(7) children's mental health screening and follow-up diagnostic assessment and treatment;

(8) services to promote and develop the capacity of providers to use evidence-based practices in providing children's mental health services;

(9) school-linked mental health services under section 245.4901;

(10) building evidence-based mental health intervention capacity for children birth to age five;

(11) suicide prevention and counseling services that use text messaging statewide;

(12) mental health first aid training;

(13) training for parents, collaborative partners, and mental health providers on the impact of adverse childhood experiences and trauma and development of an interactive website to share information and strategies to promote resilience and prevent trauma;

(14) transition age services to develop or expand mental health treatment and supports for adolescents and young adults 26 years of age or younger;

(15) early childhood mental health consultation;

(16) evidence-based interventions for youth at risk of developing or experiencing a first episode of psychosis, and a public awareness campaign on the signs and symptoms of psychosis;

(17) psychiatric consultation for primary care practitioners; ~~and~~

(18) providers to begin operations and meet program requirements when establishing a new children's mental health program. These may be start-up grants; and

(19) evidence-based interventions for youth and young adults at risk of developing or experiencing an early episode of bipolar disorder.

(c) Services under paragraph (b) must be designed to help each child to function and remain with the child's family in the community and delivered consistent with the child's treatment plan. Transition services to eligible young adults under this paragraph must be designed to foster independent living in the community.

(d) As a condition of receiving grant funds, a grantee shall obtain all available third-party reimbursement sources, if applicable.

(e) The commissioner may establish and design a pilot program to expand the mobile response and stabilization services model for children, youth, and families. The commissioner may use grant funding to consult with a qualified expert entity to assist in the formulation of measurable outcomes and explore and position the state to submit a Medicaid state plan amendment to scale the model statewide.

Sec. 8. **[245.4904] EARLY EPISODE OF BIPOLAR DISORDER GRANT PROGRAM.**

Subdivision 1. Establishment. The commissioner of human services must establish an early episode of bipolar disorder grant program within the department to fund evidence-based interventions for youth and young adults at risk of developing or experiencing an early episode of bipolar disorder.

Subd. 2. Definitions. For the purposes of this section, "youth and young adults" means individuals who are 15 years of age or older and under 41 years of age.

Subd. 3. Activities. (a) All grantees must:

(1) provide intensive treatment and support for youth and young adults experiencing or at risk of experiencing early episodes of bipolar disorder. Intensive treatment and support may include medication management, psychoeducation for an individual and the individual's family, case management, employment support, education support, cognitive behavioral approaches, social skills training, peer and 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 bipolar disorder symptoms, screening tools, the early episode of bipolar disorder grant program, and best practices; and

(3) use all available funding streams.

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

(c) Program activities must only be provided to youth and young adults experiencing bipolar disorder or early episodes of bipolar disorder.

Subd. 4. Outcomes and report. (a) The commissioner must annually evaluate the early episode of bipolar grant program.

8.1 (b) The evaluation must utilize evidence-based practices and must include the following
8.2 outcome evaluation criteria:

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

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

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

8.7 (c) By July 1, 2026, and every July 1 thereafter, the commissioner must provide a report
8.8 to the chairs and ranking minority members of the legislative committees with jurisdiction
8.9 over mental health, along with the chairs and ranking minority members of the senate finance
8.10 committee and house of representatives ways and means committee. The report must include
8.11 the number of grantees receiving funds under this section, the number of individuals served
8.12 under this section, data from the evaluation conducted under this subdivision, and information
8.13 on the use of state and federal funds for the services provided under this section.

8.14 Subd. 5. **Funding.** Early episode of bipolar disorder services are eligible for children's
8.15 mental health grants as specified in section 245.4889, subdivision 1, paragraph (b), clause
8.16 (19).

8.17 Subd. 6. **Federal aid or grants.** The commissioner of human services must comply with
8.18 all conditions and requirements necessary to receive federal aid or grants.

8.19 Sec. 9. Minnesota Statutes 2024, section 245I.05, subdivision 3, is amended to read:

8.20 Subd. 3. **Initial training.** (a) A staff person must receive training about:

8.21 (1) vulnerable adult maltreatment under section 245A.65, subdivision 3; and

8.22 (2) the maltreatment of minor reporting requirements and definitions in chapter 260E
8.23 within 72 hours of first providing direct contact services to a client.

8.24 (b) Before providing direct contact services to a client, a staff person must receive training
8.25 about:

8.26 (1) client rights and protections under section 245I.12;

8.27 (2) the Minnesota Health Records Act, including client confidentiality, family engagement
8.28 under section 144.294, and client privacy;

8.29 (3) emergency procedures that the staff person must follow when responding to a fire,
8.30 inclement weather, a report of a missing person, and a behavioral or medical emergency;

9.1 (4) specific activities and job functions for which the staff person is responsible, including
9.2 the license holder's program policies and procedures applicable to the staff person's position;

9.3 (5) professional boundaries that the staff person must maintain; and

9.4 (6) specific needs of each client to whom the staff person will be providing direct contact
9.5 services, including each client's developmental status, cognitive functioning, and physical
9.6 and mental abilities.

9.7 (c) Before providing direct contact services to a client, a mental health rehabilitation
9.8 worker, mental health behavioral aide, or mental health practitioner required to receive the
9.9 training according to section 245I.04, subdivision 4, must receive 30 hours of training about:

9.10 (1) mental illnesses;

9.11 (2) client recovery and resiliency;

9.12 (3) mental health de-escalation techniques;

9.13 (4) co-occurring mental illness and substance use disorders; and

9.14 (5) psychotropic medications and medication side effects, including tardive dyskinesia.

9.15 (d) Within 90 days of first providing direct contact services to an adult client, mental
9.16 health practitioner, mental health certified peer specialist, or mental health rehabilitation
9.17 worker must receive training about:

9.18 (1) trauma-informed care and secondary trauma;

9.19 (2) person-centered individual treatment plans, including seeking partnerships with
9.20 family and other natural supports;

9.21 (3) co-occurring substance use disorders; and

9.22 (4) culturally responsive treatment practices.

9.23 (e) Within 90 days of first providing direct contact services to a child client, mental
9.24 health practitioner, mental health certified family peer specialist, mental health certified
9.25 peer specialist, or mental health behavioral aide must receive training about the topics in
9.26 clauses (1) to (5). This training must address the developmental characteristics of each child
9.27 served by the license holder and address the needs of each child in the context of the child's
9.28 family, support system, and culture. Training topics must include:

9.29 (1) trauma-informed care and secondary trauma, including adverse childhood experiences
9.30 (ACEs);

(2) family-centered treatment plan development, including seeking partnership with a child client's family and other natural supports;

(3) mental illness and co-occurring substance use disorders in family systems;

(4) culturally responsive treatment practices; and

(5) child development, including cognitive functioning, and physical and mental abilities.

(f) For a mental health behavioral aide, the training under paragraph (e) must include parent team training using a curriculum approved by the commissioner.

Sec. 10. Minnesota Statutes 2024, section 245I.05, subdivision 5, is amended to read:

Subd. 5. Additional training for medication administration. (a) Prior to administering medications to a client under delegated authority or observing a client self-administer medications, a staff person who is not a licensed prescriber, registered nurse, or licensed practical nurse qualified under section 148.171, subdivision 8, must receive training about psychotropic medications, side effects including tardive dyskinesia, and medication management.

(b) Prior to administering medications to a client under delegated authority, a staff person must successfully complete a:

(1) medication administration training program for unlicensed personnel through an accredited Minnesota postsecondary educational institution with completion of the course documented in writing and placed in the staff person's personnel file; or

(2) formalized training program taught by a registered nurse or licensed prescriber that is offered by the license holder. A staff person's successful completion of the formalized training program must include direct observation of the staff person to determine the staff person's areas of competency.

Sec. 11. Minnesota Statutes 2024, section 245I.11, subdivision 5, is amended to read:

Subd. 5. Medication administration in residential programs. If a license holder is licensed as a residential program, the license holder must:

(1) assess and document each client's ability to self-administer medication. In the assessment, the license holder must evaluate the client's ability to: (i) comply with prescribed medication regimens; and (ii) store the client's medications safely and in a manner that protects other individuals in the facility. Through the assessment process, the license holder must assist the client in developing the skills necessary to safely self-administer medication;

11.1 (2) monitor the effectiveness of medications, side effects of medications, and adverse
11.2 reactions to medications, including symptoms and signs of tardive dyskinesia, for each
11.3 client. The license holder must address and document any concerns about a client's
11.4 medications;

11.5 (3) ensure that no staff person or client gives a legend drug supply for one client to
11.6 another client;

11.7 (4) have policies and procedures for: (i) keeping a record of each client's medication
11.8 orders; (ii) keeping a record of any incident of deferring a client's medications; (iii)
11.9 documenting any incident when a client's medication is omitted; and (iv) documenting when
11.10 a client refuses to take medications as prescribed; and

11.11 (5) document and track medication errors, document whether the license holder notified
11.12 anyone about the medication error, determine if the license holder must take any follow-up
11.13 actions, and identify the staff persons who are responsible for taking follow-up actions.

11.14 Sec. 12. Minnesota Statutes 2024, section 256B.0625, subdivision 3b, is amended to read:

11.15 Subd. 3b. **Telehealth services.** (a) Medical assistance covers medically necessary services
11.16 and consultations delivered by a health care provider through telehealth in the same manner
11.17 as if the service or consultation was delivered through in-person contact. Services or
11.18 consultations delivered through telehealth shall be paid at the full allowable rate.

11.19 (b) The commissioner may establish criteria that a health care provider must attest to in
11.20 order to demonstrate the safety or efficacy of delivering a particular service through
11.21 telehealth. The attestation may include that the health care provider:

11.22 (1) has identified the categories or types of services the health care provider will provide
11.23 through telehealth;

11.24 (2) has written policies and procedures specific to services delivered through telehealth
11.25 that are regularly reviewed and updated;

11.26 (3) has policies and procedures that adequately address patient safety before, during,
11.27 and after the service is delivered through telehealth;

11.28 (4) has established protocols addressing how and when to discontinue telehealth services;
11.29 and

11.30 (5) has an established quality assurance process related to delivering services through
11.31 telehealth.

12.1 (c) As a condition of payment, a licensed health care provider must document each
12.2 occurrence of a health service delivered through telehealth to a medical assistance enrollee.
12.3 Health care service records for services delivered through telehealth must meet the
12.4 requirements set forth in Minnesota Rules, part 9505.2175, subparts 1 and 2, and must
12.5 document:

12.6 (1) the type of service delivered through telehealth;

12.7 (2) the time the service began and the time the service ended, including an a.m. and p.m.
12.8 designation;

12.9 (3) the health care provider's basis for determining that telehealth is an appropriate and
12.10 effective means for delivering the service to the enrollee;

12.11 (4) the mode of transmission used to deliver the service through telehealth and records
12.12 evidencing that a particular mode of transmission was utilized;

12.13 (5) the location of the originating site and the distant site;

12.14 (6) if the claim for payment is based on a physician's consultation with another physician
12.15 through telehealth, the written opinion from the consulting physician providing the telehealth
12.16 consultation; and

12.17 (7) compliance with the criteria attested to by the health care provider in accordance
12.18 with paragraph (b).

12.19 (d) Telehealth visits provided through audio and visual communication or accessible
12.20 video-based platforms may be used to satisfy the face-to-face requirement for reimbursement
12.21 under the payment methods that apply to a federally qualified health center, rural health
12.22 clinic, Indian health service, 638 tribal clinic, and certified community behavioral health
12.23 clinic, if the service would have otherwise qualified for payment if performed in person.

12.24 (e) For purposes of this subdivision, unless otherwise covered under this chapter:

12.25 (1) "telehealth" means the delivery of health care services or consultations using real-time
12.26 two-way interactive audio and visual communication or accessible telehealth video-based
12.27 platforms to provide or support health care delivery and facilitate the assessment, diagnosis,
12.28 consultation, treatment, education, and care management of a patient's health care. Telehealth
12.29 includes: the application of secure video conferencing consisting of a real-time, full-motion
12.30 synchronized video; store-and-forward technology; and synchronous interactions, between
12.31 a patient located at an originating site and a health care provider located at a distant site.
12.32 Telehealth does not include communication between health care providers, or between a
12.33 health care provider and a patient that consists solely of an audio-only communication,

13.1 email, or facsimile transmission or as specified by law, except that between January 1, 2026,
13.2 and January 1, 2029, telehealth includes communication between a health care provider and
13.3 a patient that solely consists of audio-only communication;

13.4 (2) "health care provider" means a health care provider as defined under section 62A.673;
13.5 a community paramedic as defined under section 144E.001, subdivision 5f; a community
13.6 health worker who meets the criteria under subdivision 49, paragraph (a); a mental health
13.7 certified peer specialist under section 245I.04, subdivision 10; a mental health certified
13.8 family peer specialist under section 245I.04, subdivision 12; a mental health rehabilitation
13.9 worker under section 245I.04, subdivision 14; a mental health behavioral aide under section
13.10 245I.04, subdivision 16; a treatment coordinator under section 245G.11, subdivision 7; an
13.11 alcohol and drug counselor under section 245G.11, subdivision 5; or a recovery peer under
13.12 section 245G.11, subdivision 8; and

13.13 (3) "originating site," "distant site," and "store-and-forward technology" have the
13.14 meanings given in section 62A.673, subdivision 2.

13.15 **EFFECTIVE DATE.** This section is effective January 1, 2026, or upon federal approval,
13.16 whichever is later. The commissioner of human services shall notify the revisor of statutes
13.17 when federal approval is obtained."

13.18 Page 8, delete section 4 and insert:

13.19 "Sec. 14. Minnesota Statutes 2024, section 256B.0625, subdivision 20, is amended to
13.20 read:

13.21 Subd. 20. **Mental health case management.** (a) To the extent authorized by rule of the
13.22 state agency, medical assistance covers case management services to persons with serious
13.23 and persistent mental illness, persons with a complex post-traumatic stress disorder, and
13.24 children with severe emotional disturbance. Services provided under this section must meet
13.25 the relevant standards in sections 245.461 to 245.4887, the Comprehensive Adult and
13.26 Children's Mental Health Acts, Minnesota Rules, parts 9520.0900 to 9520.0926, and
13.27 9505.0322, excluding subpart 10.

13.28 (b) Entities meeting program standards set out in rules governing family community
13.29 support services as defined in section 245.4871, subdivision 17, are eligible for medical
13.30 assistance reimbursement for case management services for children with severe emotional
13.31 disturbance when these services meet the program standards in Minnesota Rules, parts
13.32 9520.0900 to 9520.0926 and 9505.0322, excluding subparts 6 and 10.

14.1 (c) Medical assistance and MinnesotaCare payment for mental health case management
14.2 shall be made on a monthly basis. In order to receive payment for an eligible child, the
14.3 provider must document at least a face-to-face contact either in person or by interactive
14.4 video that meets the requirements of subdivision 20b with the child, the child's parents, or
14.5 the child's legal representative. To receive payment for an eligible adult, the provider must
14.6 document:

14.7 (1) at least a face-to-face contact with the adult or the adult's legal representative either
14.8 in person or by interactive video that meets the requirements of subdivision 20b; or

14.9 (2) at least a telephone contact with the adult or the adult's legal representative and
14.10 document a face-to-face contact either in person or by interactive video that meets the
14.11 requirements of subdivision 20b with the adult or the adult's legal representative within the
14.12 preceding two months.

14.13 (d) Payment for mental health case management provided by county or state staff shall
14.14 be based on the monthly rate methodology under section 256B.094, subdivision 6, paragraph
14.15 (b), with separate rates calculated for child welfare and mental health, and within mental
14.16 health, separate rates for children and adults.

14.17 (e) Payment for mental health case management provided by Indian health services or
14.18 by agencies operated by Indian tribes may be made according to this section or other relevant
14.19 federally approved rate setting methodology.

14.20 (f) Payment for mental health case management provided by vendors who contract with
14.21 a county must be calculated in accordance with section 256B.076, subdivision 2. Payment
14.22 for mental health case management provided by vendors who contract with a Tribe must
14.23 be based on a monthly rate negotiated by the Tribe. The rate must not exceed the rate charged
14.24 by the vendor for the same service to other payers. If the service is provided by a team of
14.25 contracted vendors, the team shall determine how to distribute the rate among its members.
14.26 No reimbursement received by contracted vendors shall be returned to the county or tribe,
14.27 except to reimburse the county or tribe for advance funding provided by the county or tribe
14.28 to the vendor.

14.29 (g) If the service is provided by a team which includes contracted vendors, tribal staff,
14.30 and county or state staff, the costs for county or state staff participation in the team shall be
14.31 included in the rate for county-provided services. In this case, the contracted vendor, the
14.32 tribal agency, and the county may each receive separate payment for services provided by
14.33 each entity in the same month. In order to prevent duplication of services, each entity must

15.1 document, in the recipient's file, the need for team case management and a description of
15.2 the roles of the team members.

15.3 (h) Notwithstanding section 256B.19, subdivision 1, the nonfederal share of costs for
15.4 mental health case management shall be provided by the recipient's county of responsibility,
15.5 as defined in sections 256G.01 to 256G.12, from sources other than federal funds or funds
15.6 used to match other federal funds. If the service is provided by a tribal agency, the nonfederal
15.7 share, if any, shall be provided by the recipient's tribe. When this service is paid by the state
15.8 without a federal share through fee-for-service, 50 percent of the cost shall be provided by
15.9 the recipient's county of responsibility.

15.10 (i) Notwithstanding any administrative rule to the contrary, prepaid medical assistance
15.11 and MinnesotaCare include mental health case management. When the service is provided
15.12 through prepaid capitation, the nonfederal share is paid by the state and the county pays no
15.13 share.

15.14 (j) The commissioner may suspend, reduce, or terminate the reimbursement to a provider
15.15 that does not meet the reporting or other requirements of this section. The county of
15.16 responsibility, as defined in sections 256G.01 to 256G.12, or, if applicable, the tribal agency,
15.17 is responsible for any federal disallowances. The county or tribe may share this responsibility
15.18 with its contracted vendors.

15.19 (k) The commissioner shall set aside a portion of the federal funds earned for county
15.20 expenditures under this section to repay the special revenue maximization account under
15.21 section 256.01, subdivision 2, paragraph (n). The repayment is limited to:

15.22 (1) the costs of developing and implementing this section; and

15.23 (2) programming the information systems.

15.24 (l) Payments to counties and tribal agencies for case management expenditures under
15.25 this section shall only be made from federal earnings from services provided under this
15.26 section. When this service is paid by the state without a federal share through fee-for-service,
15.27 50 percent of the cost shall be provided by the state. Payments to county-contracted vendors
15.28 shall include the federal earnings, the state share, and the county share.

15.29 (m) Case management services under this subdivision do not include therapy, treatment,
15.30 legal, or outreach services.

15.31 (n) If the recipient is a resident of a nursing facility, intermediate care facility, or hospital,
15.32 and the recipient's institutional care is paid by medical assistance, payment for case
15.33 management services under this subdivision is limited to the lesser of:

16.1 (1) the last 180 days of the recipient's residency in that facility and may not exceed more
 16.2 than six months in a calendar year; or

16.3 (2) the limits and conditions which apply to federal Medicaid funding for this service.

16.4 (o) Payment for case management services under this subdivision shall not duplicate
 16.5 payments made under other program authorities for the same purpose.

16.6 (p) If the recipient is receiving care in a hospital, nursing facility, or residential setting
 16.7 licensed under chapter 245A or 245D that is staffed 24 hours a day, seven days a week,
 16.8 mental health targeted case management services must actively support identification of
 16.9 community alternatives for the recipient and discharge planning.

16.10 **EFFECTIVE DATE.** This section is effective upon federal approval. The commissioner
 16.11 of human services shall notify the revisor of statutes when federal approval is obtained.

16.12 Sec. 15. **APPROPRIATION; EARLY EPISODE OF BIPOLAR DISORDER GRANT**
 16.13 **PROGRAM.**

16.14 \$..... in fiscal year 2026 and \$..... in fiscal year 2027 are appropriated from the general
 16.15 fund to the commissioner of human services for the early episode of bipolar disorder grant
 16.16 program under Minnesota Statutes, section 245.4904."

16.17 Page 10, line 1, delete "CHILDREN'S" and insert "APPROPRIATION;" and after
 16.18 "PSYCHOSIS" insert "GRANT PROGRAM"

16.19 Page 10, line 2, before the first "\$....." insert "(a)"

16.20 Page 10, line 3, delete "to implement a" and insert "for the" and after "grant" insert
 16.21 "program"

16.22 Page 10, line 4, delete "New money"

16.23 Page 10, delete lines 5 to 8 and insert:

16.24 "(b) The commissioner of human services must fund current programs to ensure stability
 16.25 and continuity of care, as long as the program has met the requirements for past usage of
 16.26 funds. Funds may be used to fully fund current programs, increase a current program's
 16.27 capacity, and expand programs to outside the seven-county metropolitan area."

16.28 Renumber the sections in sequence

16.29 Amend the title accordingly

16.30 And when so amended the bill do pass and be re-referred to the Committee on Human
 16.31 Services. Amendments adopted. Report adopted.

SS1953R

(Committee Chair)

(Date of Committee recommendation)