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ARTICLE 2
CHEMICAL AND MENTAL HEALTH SERVICES

Section 1. Minnesota Statutes 2014, section 13.46, subdivision 2, is amended to read:

Subd. 2. **General.** (a) Data on individuals collected, maintained, used, or disseminated by the welfare system are private data on individuals, and shall not be disclosed except:

(1) according to section 13.05;

(2) according to court order;

(3) according to a statute specifically authorizing access to the private data;

(4) to an agent of the welfare system and an investigator acting on behalf of a county, the state, or the federal government, including a law enforcement person or attorney in the investigation or prosecution of a criminal, civil, or administrative proceeding relating to the administration of a program;

(5) to personnel of the welfare system who require the data to verify an individual's identity; determine eligibility, amount of assistance, and the need to provide services to an individual or family across programs; coordinate services for an individual or family; evaluate the effectiveness of programs; assess parental contribution amounts; and investigate suspected fraud;

(6) to administer federal funds or programs;

(7) between personnel of the welfare system working in the same program;

(8) to the Department of Revenue to assess parental contribution amounts for purposes of section 252.27, subdivision 2a, administer and evaluate tax refund or tax credit programs and to identify individuals who may benefit from these programs. The following information may be disclosed under this paragraph: an individual's and their dependent's names, dates of birth, Social Security numbers, income, addresses, and other data as required, upon request by the Department of Revenue. Disclosures by the commissioner of revenue to the commissioner of human services for the purposes described in this clause are governed by section 270B.14, subdivision 1. Tax refund or tax credit programs include, but are not limited to, the dependent care credit under section 290.067, the Minnesota working family credit under section 290.0671, the property tax refund and rental credit under section 290A.04, and the Minnesota education credit under section 290.0674;

(9) between the Department of Human Services, the Department of Employment and Economic Development, and when applicable, the Department of Education, for the following purposes:

(i) to monitor the eligibility of the data subject for unemployment benefits, for any employment or training program administered, supervised, or certified by that agency;

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ARTICLE 8
CHEMICAL AND MENTAL HEALTH

Section 1. Minnesota Statutes 2014, section 13.46, subdivision 2, is amended to read:

Subd. 2. **General.** (a) Data on individuals collected, maintained, used, or disseminated by the welfare system are private data on individuals, and shall not be disclosed except:

(1) according to section 13.05;

(2) according to court order;

(3) according to a statute specifically authorizing access to the private data;

(4) to an agent of the welfare system and an investigator acting on behalf of a county, the state, or the federal government, including a law enforcement person or attorney in the investigation or prosecution of a criminal, civil, or administrative proceeding relating to the administration of a program;

(5) to personnel of the welfare system who require the data to verify an individual's identity; determine eligibility, amount of assistance, and the need to provide services to an individual or family across programs; coordinate services for an individual or family; evaluate the effectiveness of programs; assess parental contribution amounts; and investigate suspected fraud;

(6) to administer federal funds or programs;

(7) between personnel of the welfare system working in the same program;

(8) to the Department of Revenue to assess parental contribution amounts for purposes of section 252.27, subdivision 2a, administer and evaluate tax refund or tax credit programs and to identify individuals who may benefit from these programs. The following information may be disclosed under this paragraph: an individual's and their dependent's names, dates of birth, Social Security numbers, income, addresses, and other data as required, upon request by the Department of Revenue. Disclosures by the commissioner of revenue to the commissioner of human services for the purposes described in this clause are governed by section 270B.14, subdivision 1. Tax refund or tax credit programs include, but are not limited to, the dependent care credit under section 290.067, the Minnesota working family credit under section 290.0671, the property tax refund and rental credit under section 290A.04, and the Minnesota education credit under section 290.0674;

(9) between the Department of Human Services, the Department of Employment and Economic Development, and when applicable, the Department of Education, for the following purposes:

(i) to monitor the eligibility of the data subject for unemployment benefits, for any employment or training program administered, supervised, or certified by that agency;

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(ii) to administer any rehabilitation program or child care assistance program, whether alone or in conjunction with the welfare system;

(iii) to monitor and evaluate the Minnesota family investment program or the child care assistance program by exchanging data on recipients and former recipients of food support, cash assistance under chapter 256, 256D, 256J, or 256K, child care assistance under chapter 119B, or medical programs under chapter 256B, 256D, or 256L; and

(iv) to analyze public assistance employment services and program utilization, cost, effectiveness, and outcomes as implemented under the authority established in Title II, Sections 201-204 of the Ticket to Work and Work Incentives Improvement Act of 1999. Health records governed by sections 144.291 to 144.298 and "protected health information" as defined in Code of Federal Regulations, title 45, section 160.103, and governed by Code of Federal Regulations, title 45, parts 160-164, including health care claims utilization information, must not be exchanged under this clause;

(10) to appropriate parties in connection with an emergency if knowledge of the information is necessary to protect the health or safety of the individual or other individuals or persons;

(11) data maintained by residential programs as defined in section 245A.02 may be disclosed to the protection and advocacy system established in this state according to Part C of Public Law 98-527 to protect the legal and human rights of persons with developmental disabilities or other related conditions who live in residential facilities for these persons if the protection and advocacy system receives a complaint by or on behalf of that person and the person does not have a legal guardian or the state or a designee of the state is the legal guardian of the person;

(12) to the county medical examiner or the county coroner for identifying or locating relatives or friends of a deceased person;

(13) data on a child support obligor who makes payments to the public agency may be disclosed to the Minnesota Office of Higher Education to the extent necessary to determine eligibility under section 136A.121, subdivision 2, clause (5);

(14) participant Social Security numbers and names collected by the telephone assistance program may be disclosed to the Department of Revenue to conduct an electronic data match with the property tax refund database to determine eligibility under section 237.70, subdivision 4a;

(15) the current address of a Minnesota family investment program participant may be disclosed to law enforcement officers who provide the name of the participant and notify the agency that:

(i) the participant:

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(ii) to administer any rehabilitation program or child care assistance program, whether alone or in conjunction with the welfare system;

(iii) to monitor and evaluate the Minnesota family investment program or the child care assistance program by exchanging data on recipients and former recipients of food support, cash assistance under chapter 256, 256D, 256J, or 256K, child care assistance under chapter 119B, or medical programs under chapter 256B, 256D, or 256L; and

(iv) to analyze public assistance employment services and program utilization, cost, effectiveness, and outcomes as implemented under the authority established in Title II, Sections 201-204 of the Ticket to Work and Work Incentives Improvement Act of 1999. Health records governed by sections 144.291 to 144.298 and "protected health information" as defined in Code of Federal Regulations, title 45, section 160.103, and governed by Code of Federal Regulations, title 45, parts 160-164, including health care claims utilization information, must not be exchanged under this clause;

(10) to appropriate parties in connection with an emergency if knowledge of the information is necessary to protect the health or safety of the individual or other individuals or persons;

(11) data maintained by residential programs as defined in section 245A.02 may be disclosed to the protection and advocacy system established in this state according to Part C of Public Law 98-527 to protect the legal and human rights of persons with developmental disabilities or other related conditions who live in residential facilities for these persons if the protection and advocacy system receives a complaint by or on behalf of that person and the person does not have a legal guardian or the state or a designee of the state is the legal guardian of the person;

(12) to the county medical examiner or the county coroner for identifying or locating relatives or friends of a deceased person;

(13) data on a child support obligor who makes payments to the public agency may be disclosed to the Minnesota Office of Higher Education to the extent necessary to determine eligibility under section 136A.121, subdivision 2, clause (5);

(14) participant Social Security numbers and names collected by the telephone assistance program may be disclosed to the Department of Revenue to conduct an electronic data match with the property tax refund database to determine eligibility under section 237.70, subdivision 4a;

(15) the current address of a Minnesota family investment program participant may be disclosed to law enforcement officers who provide the name of the participant and notify the agency that:

(i) the participant:

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(A) is a fugitive felon fleeing to avoid prosecution, or custody or confinement after conviction, for a crime or attempt to commit a crime that is a felony under the laws of the jurisdiction from which the individual is fleeing; or

(B) is violating a condition of probation or parole imposed under state or federal law;

(ii) the location or apprehension of the felon is within the law enforcement officer's official duties; and

(iii) the request is made in writing and in the proper exercise of those duties;

(16) the current address of a recipient of general assistance or general assistance medical care may be disclosed to probation officers and corrections agents who are supervising the recipient and to law enforcement officers who are investigating the recipient in connection with a felony level offense;

(17) information obtained from food support applicant or recipient households may be disclosed to local, state, or federal law enforcement officials, upon their written request, for the purpose of investigating an alleged violation of the Food Stamp Act, according to Code of Federal Regulations, title 7, section 272.1(c);

(18) the address, Social Security number, and, if available, photograph of any member of a household receiving food support shall be made available, on request, to a local, state, or federal law enforcement officer if the officer furnishes the agency with the name of the member and notifies the agency that:

(i) the member:

(A) is fleeing to avoid prosecution, or custody or confinement after conviction, for a crime or attempt to commit a crime that is a felony in the jurisdiction the member is fleeing;

(B) is violating a condition of probation or parole imposed under state or federal law; or

(C) has information that is necessary for the officer to conduct an official duty related to conduct described in subitem (A) or (B);

(ii) locating or apprehending the member is within the officer's official duties; and

(iii) the request is made in writing and in the proper exercise of the officer's official duty;

(19) the current address of a recipient of Minnesota family investment program, general assistance, general assistance medical care, or food support may be disclosed to law enforcement officers who, in writing, provide the name of the recipient and notify the agency that the recipient is a person required to register under section 243.166, but is not residing at the address at which the recipient is registered under section 243.166;

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(A) is a fugitive felon fleeing to avoid prosecution, or custody or confinement after conviction, for a crime or attempt to commit a crime that is a felony under the laws of the jurisdiction from which the individual is fleeing; or

(B) is violating a condition of probation or parole imposed under state or federal law;

(ii) the location or apprehension of the felon is within the law enforcement officer's official duties; and

(iii) the request is made in writing and in the proper exercise of those duties;

(16) the current address of a recipient of general assistance or general assistance medical care may be disclosed to probation officers and corrections agents who are supervising the recipient and to law enforcement officers who are investigating the recipient in connection with a felony level offense;

(17) information obtained from food support applicant or recipient households may be disclosed to local, state, or federal law enforcement officials, upon their written request, for the purpose of investigating an alleged violation of the Food Stamp Act, according to Code of Federal Regulations, title 7, section 272.1(c);

(18) the address, Social Security number, and, if available, photograph of any member of a household receiving food support shall be made available, on request, to a local, state, or federal law enforcement officer if the officer furnishes the agency with the name of the member and notifies the agency that:

(i) the member:

(A) is fleeing to avoid prosecution, or custody or confinement after conviction, for a crime or attempt to commit a crime that is a felony in the jurisdiction the member is fleeing;

(B) is violating a condition of probation or parole imposed under state or federal law; or

(C) has information that is necessary for the officer to conduct an official duty related to conduct described in subitem (A) or (B);

(ii) locating or apprehending the member is within the officer's official duties; and

(iii) the request is made in writing and in the proper exercise of the officer's official duty;

(19) the current address of a recipient of Minnesota family investment program, general assistance, general assistance medical care, or food support may be disclosed to law enforcement officers who, in writing, provide the name of the recipient and notify the agency that the recipient is a person required to register under section 243.166, but is not residing at the address at which the recipient is registered under section 243.166;

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(20) certain information regarding child support obligors who are in arrears may be made public according to section 518A.74;

(21) data on child support payments made by a child support obligor and data on the distribution of those payments excluding identifying information on obligees may be disclosed to all obligees to whom the obligor owes support, and data on the enforcement actions undertaken by the public authority, the status of those actions, and data on the income of the obligor or obligee may be disclosed to the other party;

(22) data in the work reporting system may be disclosed under section 256.998, subdivision 7;

(23) to the Department of Education for the purpose of matching Department of Education student data with public assistance data to determine students eligible for free and reduced-price meals, meal supplements, and free milk according to United States Code, title 42, sections 1758, 1761, 1766, 1766a, 1772, and 1773; to allocate federal and state funds that are distributed based on income of the student's family; and to verify receipt of energy assistance for the telephone assistance plan;

(24) the current address and telephone number of program recipients and emergency contacts may be released to the commissioner of health or a community health board as defined in section 145A.02, subdivision 5, when the commissioner or community health board has reason to believe that a program recipient is a disease case, carrier, suspect case, or at risk of illness, and the data are necessary to locate the person;

(25) to other state agencies, statewide systems, and political subdivisions of this state, including the attorney general, and agencies of other states, interstate information networks, federal agencies, and other entities as required by federal regulation or law for the administration of the child support enforcement program;

(26) to personnel of public assistance programs as defined in section 256.741, for access to the child support system database for the purpose of administration, including monitoring and evaluation of those public assistance programs;

(27) to monitor and evaluate the Minnesota family investment program by exchanging data between the Departments of Human Services and Education, on recipients and former recipients of food support, cash assistance under chapter 256, 256D, 256J, or 256K, child care assistance under chapter 119B, or medical programs under chapter 256B, 256D, or 256L;

(28) to evaluate child support program performance and to identify and prevent fraud in the child support program by exchanging data between the Department of Human Services, Department of Revenue under section 270B.14, subdivision 1, paragraphs (a) and (b), without regard to the limitation of use in paragraph (c), Department of Health, Department of Employment and Economic Development, and other state agencies as is reasonably necessary to perform these functions;

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(20) certain information regarding child support obligors who are in arrears may be made public according to section 518A.74;

(21) data on child support payments made by a child support obligor and data on the distribution of those payments excluding identifying information on obligees may be disclosed to all obligees to whom the obligor owes support, and data on the enforcement actions undertaken by the public authority, the status of those actions, and data on the income of the obligor or obligee may be disclosed to the other party;

(22) data in the work reporting system may be disclosed under section 256.998, subdivision 7;

(23) to the Department of Education for the purpose of matching Department of Education student data with public assistance data to determine students eligible for free and reduced-price meals, meal supplements, and free milk according to United States Code, title 42, sections 1758, 1761, 1766, 1766a, 1772, and 1773; to allocate federal and state funds that are distributed based on income of the student's family; and to verify receipt of energy assistance for the telephone assistance plan;

(24) the current address and telephone number of program recipients and emergency contacts may be released to the commissioner of health or a community health board as defined in section 145A.02, subdivision 5, when the commissioner or community health board has reason to believe that a program recipient is a disease case, carrier, suspect case, or at risk of illness, and the data are necessary to locate the person;

(25) to other state agencies, statewide systems, and political subdivisions of this state, including the attorney general, and agencies of other states, interstate information networks, federal agencies, and other entities as required by federal regulation or law for the administration of the child support enforcement program;

(26) to personnel of public assistance programs as defined in section 256.741, for access to the child support system database for the purpose of administration, including monitoring and evaluation of those public assistance programs;

(27) to monitor and evaluate the Minnesota family investment program by exchanging data between the Departments of Human Services and Education, on recipients and former recipients of food support, cash assistance under chapter 256, 256D, 256J, or 256K, child care assistance under chapter 119B, or medical programs under chapter 256B, 256D, or 256L;

(28) to evaluate child support program performance and to identify and prevent fraud in the child support program by exchanging data between the Department of Human Services, Department of Revenue under section 270B.14, subdivision 1, paragraphs (a) and (b), without regard to the limitation of use in paragraph (c), Department of Health, Department of Employment and Economic Development, and other state agencies as is reasonably necessary to perform these functions;

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(29) counties operating child care assistance programs under chapter 119B may disseminate data on program participants, applicants, and providers to the commissioner of education; ~~or~~

(30) child support data on the child, the parents, and relatives of the child may be disclosed to agencies administering programs under titles IV-B and IV-E of the Social Security Act, as authorized by federal law~~.~~; or

(31) to a health care provider governed by sections 144.291 to 144.298, to the extent necessary to coordinate services, provided that a health record may be disclosed only as provided under section 144.293.

(b) Information on persons who have been treated for drug or alcohol abuse may only be disclosed according to the requirements of Code of Federal Regulations, title 42, sections 2.1 to 2.67.

(c) Data provided to law enforcement agencies under paragraph (a), clause (15), (16), (17), or (18), or paragraph (b), are investigative data and are confidential or protected nonpublic while the investigation is active. The data are private after the investigation becomes inactive under section 13.82, subdivision 5, paragraph (a) or (b).

(d) Mental health data shall be treated as provided in subdivisions 7, 8, and 9, but are not subject to the access provisions of subdivision 10, paragraph (b).

For the purposes of this subdivision, a request will be deemed to be made in writing if made through a computer interface system.

Sec. 2. Minnesota Statutes 2014, section 13.46, subdivision 7, is amended to read:

Subd. 7. **Mental health data.** (a) Mental health data are private data on individuals and shall not be disclosed, except:

(1) pursuant to section 13.05, as determined by the responsible authority for the community mental health center, mental health division, or provider;

(2) pursuant to court order;

(3) pursuant to a statute specifically authorizing access to or disclosure of mental health data or as otherwise provided by this subdivision; ~~or~~

(4) to personnel of the welfare system working in the same program or providing services to the same individual or family to the extent necessary to coordinate services, provided that a health record may be disclosed only as provided under section 144.293;

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(29) counties operating child care assistance programs under chapter 119B may disseminate data on program participants, applicants, and providers to the commissioner of education; ~~or~~

(30) child support data on the child, the parents, and relatives of the child may be disclosed to agencies administering programs under titles IV-B and IV-E of the Social Security Act, as authorized by federal law~~.~~; or

(31) to a health care provider governed by sections 144.291 to 144.298, to the extent necessary to coordinate services, provided that a health record may be disclosed only as provided under section 144.293, if the patient has provided annual consent, consistent with section 144.293, subdivisions 2 and 4.

(b) Information on persons who have been treated for drug or alcohol abuse may only be disclosed according to the requirements of Code of Federal Regulations, title 42, sections 2.1 to 2.67.

(c) Data provided to law enforcement agencies under paragraph (a), clause (15), (16), (17), or (18), or paragraph (b), are investigative data and are confidential or protected nonpublic while the investigation is active. The data are private after the investigation becomes inactive under section 13.82, subdivision 5, paragraph (a) or (b).

(d) Mental health data shall be treated as provided in subdivisions 7, 8, and 9, but are not subject to the access provisions of subdivision 10, paragraph (b).

For the purposes of this subdivision, a request will be deemed to be made in writing if made through a computer interface system.

Sec. 2. Minnesota Statutes 2014, section 13.46, subdivision 7, is amended to read:

Subd. 7. **Mental health data.** (a) Mental health data are private data on individuals and shall not be disclosed, except:

(1) pursuant to section 13.05, as determined by the responsible authority for the community mental health center, mental health division, or provider;

(2) pursuant to court order;

(3) pursuant to a statute specifically authorizing access to or disclosure of mental health data or as otherwise provided by this subdivision; ~~or~~

(4) to personnel of the welfare system working in the same program or providing services to the same individual or family to the extent necessary to coordinate services, provided that a health record may be disclosed only as provided under section 144.293, if the patient has provided annual consent, consistent with section 144.293, subdivisions 2 and 4;

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(5) to a health care provider governed by sections 144.291 to 144.298, to the extent necessary to coordinate services, provided that a health record may be disclosed only as provided under section 144.293; or

(6) with the consent of the client or patient.

(b) An agency of the welfare system may not require an individual to consent to the release of mental health data as a condition for receiving services or for reimbursing a community mental health center, mental health division of a county, or provider under contract to deliver mental health services.

(c) Notwithstanding section 245.69, subdivision 2, paragraph (f), or any other law to the contrary, the responsible authority for a community mental health center, mental health division of a county, or a mental health provider must disclose mental health data to a law enforcement agency if the law enforcement agency provides the name of a client or patient and communicates that the:

(1) client or patient is currently involved in an emergency interaction with the law enforcement agency; and

(2) data is necessary to protect the health or safety of the client or patient or of another person.

The scope of disclosure under this paragraph is limited to the minimum necessary for law enforcement to respond to the emergency. Disclosure under this paragraph may include, but is not limited to, the name and telephone number of the psychiatrist, psychologist, therapist, mental health professional, practitioner, or case manager of the client or patient. A law enforcement agency that obtains mental health data under this paragraph shall maintain a record of the requestor, the provider of the information, and the client or patient name. Mental health data obtained by a law enforcement agency under this paragraph are private data on individuals and must not be used by the law enforcement agency for any other purpose. A law enforcement agency that obtains mental health data under this paragraph shall inform the subject of the data that mental health data was obtained.

(d) In the event of a request under paragraph (a), clause (4), a community mental health center, county mental health division, or provider must release mental health data to Criminal Mental Health Court personnel in advance of receiving a copy of a consent if the Criminal Mental Health Court personnel communicate that the:

(1) client or patient is a defendant in a criminal case pending in the district court;

(2) data being requested is limited to information that is necessary to assess whether the defendant is eligible for participation in the Criminal Mental Health Court; and

(3) client or patient has consented to the release of the mental health data and a copy of the consent will be provided to the community mental health center, county mental health division, or provider within 72 hours of the release of the data.

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(5) to a health care provider governed by sections 144.291 to 144.298, to the extent necessary to coordinate services, provided that a health record may be disclosed only as provided under section 144.293, if the patient has provided annual consent, consistent with section 144.293, subdivisions 2 and 4; or

(6) with the consent of the client or patient.

(b) An agency of the welfare system may not require an individual to consent to the release of mental health data as a condition for receiving services or for reimbursing a community mental health center, mental health division of a county, or provider under contract to deliver mental health services.

(c) Notwithstanding section 245.69, subdivision 2, paragraph (f), or any other law to the contrary, the responsible authority for a community mental health center, mental health division of a county, or a mental health provider must disclose mental health data to a law enforcement agency if the law enforcement agency provides the name of a client or patient and communicates that the:

(1) client or patient is currently involved in an emergency interaction with the law enforcement agency; and

(2) data is necessary to protect the health or safety of the client or patient or of another person.

The scope of disclosure under this paragraph is limited to the minimum necessary for law enforcement to respond to the emergency. Disclosure under this paragraph may include, but is not limited to, the name and telephone number of the psychiatrist, psychologist, therapist, mental health professional, practitioner, or case manager of the client or patient. A law enforcement agency that obtains mental health data under this paragraph shall maintain a record of the requestor, the provider of the information, and the client or patient name. Mental health data obtained by a law enforcement agency under this paragraph are private data on individuals and must not be used by the law enforcement agency for any other purpose. A law enforcement agency that obtains mental health data under this paragraph shall inform the subject of the data that mental health data was obtained.

(d) In the event of a request under paragraph (a), clause (4), a community mental health center, county mental health division, or provider must release mental health data to Criminal Mental Health Court personnel in advance of receiving a copy of a consent if the Criminal Mental Health Court personnel communicate that the:

(1) client or patient is a defendant in a criminal case pending in the district court;

(2) data being requested is limited to information that is necessary to assess whether the defendant is eligible for participation in the Criminal Mental Health Court; and

(3) client or patient has consented to the release of the mental health data and a copy of the consent will be provided to the community mental health center, county mental health division, or provider within 72 hours of the release of the data.

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For purposes of this paragraph, "Criminal Mental Health Court" refers to a specialty criminal calendar of the Hennepin County District Court for defendants with mental illness and brain injury where a primary goal of the calendar is to assess the treatment needs of the defendants and to incorporate those treatment needs into voluntary case disposition plans. The data released pursuant to this paragraph may be used for the sole purpose of determining whether the person is eligible for participation in mental health court. This paragraph does not in any way limit or otherwise extend the rights of the court to obtain the release of mental health data pursuant to court order or any other means allowed by law.

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For purposes of this paragraph, "Criminal Mental Health Court" refers to a specialty criminal calendar of the Hennepin County District Court for defendants with mental illness and brain injury where a primary goal of the calendar is to assess the treatment needs of the defendants and to incorporate those treatment needs into voluntary case disposition plans. The data released pursuant to this paragraph may be used for the sole purpose of determining whether the person is eligible for participation in mental health court. This paragraph does not in any way limit or otherwise extend the rights of the court to obtain the release of mental health data pursuant to court order or any other means allowed by law.

Sec. 3. Minnesota Statutes 2014, section 62Q.55, subdivision 3, is amended to read:

Subd. 3. **Emergency services.** As used in this section, "emergency services" means, with respect to an emergency medical condition:

(1) a medical screening examination, as required under section 1867 of the Social Security Act, that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate such emergency medical condition; ~~and~~

(2) within the capabilities of the staff and facilities available at the hospital, such further medical examination and treatment as are required under section 1867 of the Social Security Act to stabilize the patient; and

(3) emergency services as defined in sections 245.462, subdivision 11, and 245.4871, subdivision 14.

Sec. 4. Minnesota Statutes 2014, section 144.293, subdivision 5, is amended to read:

Subd. 5. **Exceptions to consent requirement.** This section does not prohibit the release of health records:

(1) for a medical emergency when the provider is unable to obtain the patient's consent due to the patient's condition or the nature of the medical emergency;

(2) to other providers within related health care entities when necessary for the current treatment of the patient; ~~or~~

(3) to a health care facility licensed by this chapter, chapter 144A, or to the same types of health care facilities licensed by this chapter and chapter 144A that are licensed in another state when a patient:

(i) is returning to the health care facility and unable to provide consent; or

(ii) who resides in the health care facility, has services provided by an outside resource under Code of Federal Regulations, title 42, section 483.75(h), and is unable to provide consent~~.~~; or

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Sec. 3. Minnesota Statutes 2014, section 144.293, subdivision 6, is amended to read:

Subd. 6. **Consent does not expire.** Notwithstanding subdivision 4, if a patient explicitly gives informed consent to the release of health records for the purposes and restrictions in ~~clauses~~ clause (1) ~~and~~, (2), or (3), the consent does not expire after one year for:

(1) the release of health records to a provider who is being advised or consulted with in connection with the releasing provider's current treatment of the patient;

(2) the release of health records to an accident and health insurer, health service plan corporation, health maintenance organization, or third-party administrator for purposes of payment of claims, fraud investigation, or quality of care review and studies, provided that:

(i) the use or release of the records complies with sections 72A.49 to 72A.505;

(ii) further use or release of the records in individually identifiable form to a person other than the patient without the patient's consent is prohibited; and

(iii) the recipient establishes adequate safeguards to protect the records from unauthorized disclosure, including a procedure for removal or destruction of information that identifies the patient; or

(3) the release of health records to a program in the welfare system, as defined in section 13.46, to the extent necessary to coordinate services for the patient.

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(4) to a program in the welfare system, as defined in section 13.46, upon written documentation that access to the data is necessary to coordinate services for an individual who is receiving services from the welfare system.

Sec. 5. Minnesota Statutes 2014, section 145.56, subdivision 2, is amended to read:

Subd. 2. **Community-based programs.** To the extent funds are appropriated for the purposes of this subdivision, the commissioner shall establish a grant program to fund:

(1) community-based programs to provide education, outreach, and advocacy services to populations who may be at risk for suicide;

(2) community-based programs that educate community helpers and gatekeepers, such as family members, spiritual leaders, coaches, and business owners, employers, and coworkers on how to prevent suicide by encouraging help-seeking behaviors;

(3) community-based programs that educate populations at risk for suicide and community helpers and gatekeepers that must include information on the symptoms of depression and other psychiatric illnesses, the warning signs of suicide, skills for preventing suicides, and making or seeking effective referrals to intervention and community resources; ~~and~~

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114.24 Sec. 4. Minnesota Statutes 2014, section 245.4661, subdivision 5, is amended to read:

114.25 Subd. 5. **Planning for pilot projects.** (a) Each local plan for a pilot project, with
114.26 the exception of the placement of a Minnesota specialty treatment facility as defined in
114.27 paragraph (c), must be developed under the direction of the county board, or multiple
114.28 county boards acting jointly, as the local mental health authority. The planning process
114.29 for each pilot shall include, but not be limited to, mental health consumers, families,
114.30 advocates, local mental health advisory councils, local and state providers, representatives
114.31 of state and local public employee bargaining units, and the department of human services.
114.32 As part of the planning process, the county board or boards shall designate a managing
114.33 entity responsible for receipt of funds and management of the pilot project.

115.1 (b) For Minnesota specialty treatment facilities, the commissioner shall issue a
115.2 request for proposal for regions in which a need has been identified for services.

298.6 (4) community-based programs to provide evidence-based suicide prevention and
298.7 intervention education to school staff, parents, and students in grades kindergarten through
298.8 12, and for students attending Minnesota colleges and universities;

298.9 (5) community-based programs to provide evidence-based suicide prevention and
298.10 intervention to public school nurses, teachers, administrators, coaches, school social
298.11 workers, peace officers, firefighters, emergency medical technicians, advanced emergency
298.12 medical technicians, paramedics, primary care providers, and others; and

298.13 (6) community-based, evidence-based postvention training to mental health
298.14 professionals and practitioners in order to provide technical assistance to communities
298.15 after a suicide and to prevent suicide clusters and contagion.

298.16 Sec. 6. Minnesota Statutes 2014, section 145.56, subdivision 4, is amended to read:

298.17 Subd. 4. **Collection and reporting suicide data.** (a) The commissioner shall
298.18 coordinate with federal, regional, local, and other state agencies to collect, analyze, and
298.19 annually issue a public report on Minnesota-specific data on suicide and suicidal behaviors.

298.20 (b) The commissioner, in consultation with stakeholders, shall submit a detailed
298.21 plan identifying proposed methods to improve the timeliness, usefulness, and quality of
298.22 suicide-related data so that the data can help identify the scope of the suicide problem,
298.23 identify high-risk groups, set priority prevention activities, and monitor the effects of
298.24 suicide prevention programs. The report shall include how to improve external cause
298.25 of injury coding, progress on implementing the Minnesota Violent Death Reporting
298.26 System, how to obtain and release data in a timely manner, and how to support the use of
298.27 psychological autopsies.

298.28 (c) The written report must be provided to the chairs and ranking minority members
298.29 of the house of representatives and senate finance and policy divisions and committees
298.30 with jurisdiction over health and human services by February 1, 2016.

Senate Language S1458-2

House Language UES1458-1

(c) For purposes of this section, "Minnesota specialty treatment facility" is defined as an intensive ~~rehabilitative mental health~~ residential treatment service under section 256B.0622, subdivision 2, paragraph (b).

Sec. 5. Minnesota Statutes 2014, section 245.4661, subdivision 6, is amended to read:

Subd. 6. **Duties of commissioner.** (a) For purposes of the pilot projects, the commissioner shall facilitate integration of funds or other resources as needed and requested by each project. These resources may include:

(1) community support services funds administered under Minnesota Rules, parts 9535.1700 to 9535.1760;

(2) other mental health special project funds;

(3) medical assistance, general assistance medical care, MinnesotaCare and group residential housing if requested by the project's managing entity, and if the commissioner determines this would be consistent with the state's overall health care reform efforts; and

(4) regional treatment center resources consistent with section 246.0136, subdivision 1~~; and~~.

~~(5) funds transferred from section 246.18, subdivision 8, for grants to providers to participate in mental health specialty treatment services, awarded to providers through a request for proposal process.~~

(b) The commissioner shall consider the following criteria in awarding start-up and implementation grants for the pilot projects:

(1) the ability of the proposed projects to accomplish the objectives described in subdivision 2;

(2) the size of the target population to be served; and

(3) geographical distribution.

(c) The commissioner shall review overall status of the projects initiatives at least every two years and recommend any legislative changes needed by January 15 of each odd-numbered year.

(d) The commissioner may waive administrative rule requirements which are incompatible with the implementation of the pilot project.

(e) The commissioner may exempt the participating counties from fiscal sanctions for noncompliance with requirements in laws and rules which are incompatible with the implementation of the pilot project.

(f) The commissioner may award grants to an entity designated by a county board or group of county boards to pay for start-up and implementation costs of the pilot project.

Senate Language S1458-2 House Language UES1458-1

Sec. 6. Minnesota Statutes 2014, section 245.4661, is amended by adding a subdivision to read:

Subd. 9. **Services and programs.** (a) The following three distinct grant programs are funded under this section:

(1) mental health crisis services;

(2) housing with supports for adults with serious mental illness; and

(3) projects for assistance in transitioning from homelessness (PATH program).

(b) In addition, the following are eligible for grant funds:

(1) community education and prevention;

(2) client outreach;

(3) early identification and intervention;

(4) adult outpatient diagnostic assessment and psychological testing;

(5) peer support services;

(6) community support program services (CSP);

(7) adult residential crisis stabilization;

(8) supported employment;

(9) assertive community treatment (ACT);

(10) housing subsidies;

(11) basic living, social skills, and community intervention;

(12) emergency response services;

(13) adult outpatient psychotherapy;

(14) adult outpatient medication management;

(15) adult mobile crisis services;

(16) adult day treatment;

(17) partial hospitalization;

(18) adult residential treatment;

(19) adult mental heath targeted case management;

(20) intensive community residential services (IRCS); and

(21) transportation.

Senate Language S1458-2

Sec. 7. Minnesota Statutes 2014, section 245.4661, is amended by adding a subdivision to read:

Subd. 10. **Commissioner duty to report on use of grant funds biennially.** By November 1, 2016, and biennially thereafter, the commissioner of human services shall provide sufficient information to the members of the legislative committees having jurisdiction over mental health funding and policy issues to evaluate the use of funds appropriated under this section of law. The commissioner shall provide, at a minimum, the following information:

(1) the amount of funding to mental health initiatives, what programs and services were funded in the previous two years, gaps in services that each initiative brought to the attention of the commissioner, and outcome data for the programs and services that were funded; and

(2) the amount of funding for other targeted services and the location of services.

Sec. 8. Minnesota Statutes 2014, section 245.467, subdivision 6, is amended to read:

Subd. 6. **Restricted access to data.** The county board shall establish procedures to ensure that the names and addresses of persons receiving mental health services are disclosed only to:

(1) county employees who are specifically responsible for determining county of financial responsibility or making payments to providers; ~~and~~

(2) staff who provide treatment services or case management and their clinical supervisors.~~;~~ and

(3) personnel of the welfare system or health care providers who have access to the data under section 13.46, subdivision 7.

Release of mental health data on individuals submitted under subdivisions 4 and 5, to persons other than those specified in this subdivision, or use of this data for purposes other than those stated in subdivisions 4 and 5, results in civil or criminal liability under the standards in section 13.08 or 13.09.

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Sec. 7. Minnesota Statutes 2014, section 245.467, subdivision 6, is amended to read:

Subd. 6. **Restricted access to data.** The county board shall establish procedures to ensure that the names and addresses of persons receiving mental health services are disclosed only to:

(1) county employees who are specifically responsible for determining county of financial responsibility or making payments to providers; ~~and~~

(2) staff who provide treatment services or case management and their clinical supervisors.~~;~~ and

(3) personnel of the welfare system or health care providers who have access to the data under section 13.46, subdivision 7.

Release of mental health data on individuals submitted under subdivisions 4 and 5, to persons other than those specified in this subdivision, or use of this data for purposes other than those stated in subdivisions 4 and 5, results in civil or criminal liability under the standards in section 13.08 or 13.09.

Senate Language S1458-2

House Language UES1458-1

Sec. 9. Minnesota Statutes 2014, section 245.469, is amended by adding a subdivision to read:

Subd. 3. **Commissioner duties.** By July 1, 2016, unless otherwise specified, the commissioner shall:

(1) enhance oversight and training of the state's mobile crisis services to ensure consistency throughout the state, including the development and implementation of a certification process for mental health emergency telephone lines;

(2) develop standards for crisis services to ensure uniformity in the services that crisis response providers are delivering to clients;

(3) provide specialty telephone consultation 24 hours per day to mobile crisis teams serving persons with traumatic brain injury or an intellectual disability who are experiencing a mental health crisis;

(4) establish a single statewide mental health crisis phone number to immediately connect the person in crisis with the closest crisis response provider; and

(5) by July 1, 2018, provide 24/7 availability of mobile crisis teams throughout the state.

Sec. 10. Minnesota Statutes 2014, section 245.4876, subdivision 7, is amended to read:

Only persons acting consistent with section 13.05 may enter, update, or access mental health data on individuals submitted under subdivisions 4 and 5. The ability of authorized persons to enter, update, or access data must be limited through the use of role-based access that corresponds to the official duties or training level of the person, and the statutory authorization that grants access for that purpose. For data submitted under subdivisions 4 and 5 and stored in an information system not operated by a state agency, all queries and all actions in which records are viewed, accessed, accepted, or exited must be recorded in a data audit trail. Data contained in the audit trail are public data, to the extent that the data are not otherwise classified by law. The authorization of any person determined to have willfully entered, updated, accessed, shared, or disseminated data in violation of this section, or any other provision of law, must be immediately revoked and investigated. If a person is determined to have willfully gained access to data without explicit authorization, the person is subject to civil and criminal liability under sections 13.08 and 13.09.

Sec. 18. **MENTAL HEALTH CRISIS SERVICES.**

The commissioner of human services shall increase access to mental health crisis services for children and adults. In order to increase access, the commissioner must:

(1) develop a central phone number where calls can be routed to the appropriate crisis services;

(2) provide telephone consultation 24 hours a day to mobile crisis teams who are serving people with traumatic brain injury or intellectual disabilities who are experiencing a mental health crisis;

(3) expand crisis services across the state, including rural areas of the state and examining access per population;

(4) establish and implement state standards for crisis services; and

(5) provide grants to adult mental health initiatives, counties, tribes, or community mental health providers to establish new mental health crisis residential service capacity.

Priority will be given to regions that do not have a mental health crisis residential services program, do not have an inpatient psychiatric unit within the region, do not have an inpatient psychiatric unit within 90 miles, or have a demonstrated need based on the number of crisis residential or intensive residential treatment beds available to meet the needs of the residents in the region. At least 50 percent of the funds must be distributed to programs in rural Minnesota. Grant funds may be used for start-up costs, including but not limited to renovations, furnishings, and staff training. Grant applications shall provide details on how the intended service will address identified needs and shall demonstrate collaboration with crisis teams, other mental health providers, hospitals, and police.

Sec. 8. Minnesota Statutes 2014, section 245.4876, subdivision 7, is amended to read:

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Subd. 7. **Restricted access to data.** The county board shall establish procedures to ensure that the names and addresses of children receiving mental health services and their families are disclosed only to:

(1) county employees who are specifically responsible for determining county of financial responsibility or making payments to providers; ~~and~~

(2) staff who provide treatment services or case management and their clinical supervisors~~.~~; and

(3) personnel of the welfare system or health care providers who have access to the data under section 13.46, subdivision 7.

Release of mental health data on individuals submitted under subdivisions 5 and 6, to persons other than those specified in this subdivision, or use of this data for purposes other than those stated in subdivisions 5 and 6, results in civil or criminal liability under section 13.08 or 13.09.

Sec. 11. Minnesota Statutes 2014, section 245.4889, subdivision 1, is amended to read:

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

(1) counties;

(2) Indian tribes;

(3) children's collaboratives under section 124D.23 or 245.493; or

(4) mental health service providers

~~for providing services to children with emotional disturbances as defined in section 245.4871, subdivision 15, and their families. The commissioner may also authorize grants to young adults meeting the criteria for transition services in section 245.4875, subdivision 8, and their families~~.

House Language UES1458-1

Subd. 7. **Restricted access to data.** The county board shall establish procedures to ensure that the names and addresses of children receiving mental health services and their families are disclosed only to:

(1) county employees who are specifically responsible for determining county of financial responsibility or making payments to providers; ~~and~~

(2) staff who provide treatment services or case management and their clinical supervisors~~.~~; and

(3) personnel of the welfare system or health care providers who have access to the data under section 13.46, subdivision 7.

Release of mental health data on individuals submitted under subdivisions 5 and 6, to persons other than those specified in this subdivision, or use of this data for purposes other than those stated in subdivisions 5 and 6, results in civil or criminal liability under section 13.08 or 13.09.

Only persons acting consistent with section 13.05 may enter, update, or access mental health data on individuals submitted under subdivisions 5 and 6. The ability of authorized persons to enter, update, or access data must be limited through the use of role-based access that corresponds to the official duties or training level of the person, and the statutory authorization that grants access for that purpose. For data submitted under subdivisions 5 and 6 and stored in an information system not operated by a state agency, all queries and all actions in which records are viewed, accessed, accepted, or exited must be recorded in a data audit trail. Data contained in the audit trail are public data, to the extent that the data are not otherwise classified by law. The authorization of any person determined to have willfully entered, updated, accessed, shared, or disseminated data in violation of this section, or any other provision of law, must be immediately revoked and investigated. If a person is determined to have willfully gained access to data without explicit authorization, the person is subject to civil and criminal liability under sections 13.08 and 13.09.

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

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

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

(3) respite care services for children with severe emotional disturbances who are at risk of out-of-home placement;

(4) children's mental health crisis services;

(5) mental health services for people from cultural and ethnic minorities;

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

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

(8) school-linked mental health services;

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

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

(11) mental health first aid training;

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

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

(14) early childhood mental health consultation;

(15) 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; and

(16) psychiatric consultation for primary care practitioners.

(c) Services under paragraph ~~(a)~~ (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 paragraph ~~(a)~~ (b) must be designed to foster independent living in the community.

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Sec. 12. Minnesota Statutes 2014, section 245.4889, is amended by adding a subdivision to read:

Subd. 3. **Commissioner duty to report on use of grant funds biennially.** By November 1, 2016, and biennially thereafter, the commissioner of human services shall provide sufficient information to the members of the legislative committees having jurisdiction over mental health funding and policy issues to evaluate the use of funds appropriated under this section. The commissioner shall provide, at a minimum, the following information:

(1) the amount of funding for children's mental health grants, what programs and services were funded in the previous two years, and outcome data for the programs and services that were funded; and

(2) the amount of funding for other targeted services and the location of services.

Sec. 13. **[245.735] EXCELLENCE IN MENTAL HEALTH DEMONSTRATION PROJECT.**

Subdivision 1. **Excellence in Mental Health demonstration project.** The commissioner shall develop and execute projects to reform the mental health system by participating in the Excellence in Mental Health demonstration project.

Subd. 2. **Federal proposal.** The commissioner shall develop and submit to the United States Department of Health and Human Services a proposal for the Excellence in Mental Health demonstration project. The proposal shall include any necessary state plan amendments, waivers, requests for new funding, realignment of existing funding, and other authority necessary to implement the projects specified in subdivision 4.

Subd. 3. **Rules.** By January 15, 2017, the commissioner shall adopt rules that meet the criteria in subdivision 4, paragraph (a), to establish standards for state certification of community behavioral health clinics, and rules that meet the criteria in subdivision 4, paragraph (b), to implement a prospective payment system for medical assistance payment of mental health services delivered in certified community behavioral health clinics. These rules shall comply with federal requirements for certification of community behavioral health clinics and the prospective payment system and shall apply to community mental health centers, mental health clinics, mental health residential treatment centers, essential community providers, federally qualified health centers, and rural health clinics. The commissioner may adopt rules under this subdivision using the expedited process in section 14.389.

Subd. 4. **Reform projects.** (a) The commissioner shall establish standards for state certification of clinics as certified community behavioral health clinics, in accordance with the criteria published on or before September 1, 2015, by the United States Department of Health and Human Services. Certification standards established by the commissioner shall require that:

Sec. 9. **[245.735] EXCELLENCE IN MENTAL HEALTH DEMONSTRATION PROJECT.**

Subdivision 1. **Excellence in Mental Health demonstration project.** The commissioner may develop and execute projects to reform the mental health system by participating in the Excellence in Mental Health demonstration project.

Subd. 2. **Federal proposal.** The commissioner may develop and submit to the United States Department of Health and Human Services a proposal for the Excellence in Mental Health demonstration project. The proposal shall include any necessary state plan amendments, waivers, requests for new funding, realignment of existing funding, and other authority necessary to implement the projects specified in subdivision 3.

Subd. 3. **Reform projects.** (a) The commissioner may establish standards for state certification of a clinic as a certified community behavioral health clinic, in accordance with the criteria published on or before September 1, 2015, by the United States Department of Health and Human Services. Certification standards established by the commissioner shall require that:

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(1) clinic staff have backgrounds in diverse disciplines, include licensed mental health professionals, and are culturally and linguistically trained to serve the needs of the clinic's patient population;

(2) clinic services are available and accessible and that crisis management services are available 24 hours per day;

(3) fees for clinic services are established using a sliding fee scale and services to patients are not denied or limited due to a patient's inability to pay for services;

(4) clinics provide coordination of care across settings and providers to ensure seamless transitions for patients across the full spectrum of health services, including acute, chronic, and behavioral needs. Care coordination may be accomplished through partnerships or formal contracts with federally qualified health centers, inpatient psychiatric facilities, substance use and detoxification facilities, community-based mental health providers, and 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;

(5) services provided by clinics include crisis mental health services, emergency crisis intervention services, and stabilization services; screening, assessment, and diagnosis services, including risk assessments and level of care determinations; patient-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; and

(6) clinics comply with quality assurance reporting requirements and other reporting requirements, including any required reporting of encounter data, clinical outcomes data, and quality data.

(b) The commissioner shall establish standards and methodologies for a prospective payment system for medical assistance payments for mental health services delivered by certified community behavioral health clinics, in accordance with guidance issued on or before September 1, 2015, by the Centers for Medicare and Medicaid Services. During the operation of the demonstration project, payments shall comply with federal requirements for a 90 percent enhanced federal medical assistance percentage.

Subd. 5. **Public participation.** In developing the projects under subdivision 4, the commissioner shall consult with mental health providers, advocacy organizations, licensed mental health professionals, and Minnesota public health care program enrollees who receive mental health services and their families.

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(1) clinic staff have backgrounds in diverse disciplines, include licensed mental health professionals, and are culturally and linguistically trained to serve the needs of the clinic's patient population;

(2) clinic services are available and accessible and crisis management services are available 24 hours per day;

(3) fees for clinic services are established using a sliding fee scale and services to patients are not denied or limited due to a patient's inability to pay for services;

(4) clinics provide coordination of care across settings and providers to ensure seamless transitions for patients across the full spectrum of health services, including acute, chronic, and behavioral needs. Care coordination may be accomplished through partnerships or formal contracts with federally qualified health centers, inpatient psychiatric facilities, substance use and detoxification facilities, community-based mental health providers, and 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; and

(5) services provided by clinics include crisis mental health services, emergency crisis intervention services, and stabilization services; screening, assessment, and diagnosis services, including risk assessments and level of care determinations; patient-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.

(b) The commissioner shall establish standards and methodologies for a prospective payment system for medical assistance payments for mental health services delivered by certified community behavioral health clinics, in accordance with guidance issued on or before September 1, 2015, by the Centers for Medicare and Medicaid Services. During the operation of the demonstration project, payments shall comply with federal requirements for a 90 percent enhanced federal medical assistance percentage.

Subd. 4. **Public participation.** In developing the projects under subdivision 3, the commissioner shall consult with mental health providers, advocacy organizations, licensed mental health professionals, and Minnesota health care program enrollees who receive mental health services and their families.

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Subd. 6. **Information systems support.** The commissioner and the state chief information officer shall provide information systems support to the projects as necessary to comply with federal requirements and the deadlines in subdivision 3.

Sec. 14. Minnesota Statutes 2014, section 246.18, subdivision 8, is amended to read:

Subd. 8. **State-operated services account.** (a) The state-operated services account is established in the special revenue fund. Revenue generated by new state-operated services listed under this section established after July 1, 2010, that are not enterprise activities must be deposited into the state-operated services account, unless otherwise specified in law:

(1) intensive residential treatment services;

(2) foster care services; and

(3) psychiatric extensive recovery treatment services.

(b) Funds deposited in the state-operated services account are ~~available~~ appropriated to the commissioner of human services for the purposes of:

(1) providing services needed to transition individuals from institutional settings within state-operated services to the community when those services have no other adequate funding source; and

(2) ~~grants to providers participating in mental health specialty treatment services under section 245.4661; and~~

~~(3)~~ to fund the operation of the intensive residential treatment service program in Willmar.

Sec. 15. Minnesota Statutes 2014, section 253B.18, subdivision 4c, is amended to read:

Subd. 4c. **Special review board.** (a) The commissioner shall establish one or more panels of a special review board. The board shall consist of three members experienced in the field of mental illness. One member of each special review board panel shall be a psychiatrist or a doctoral level psychologist with forensic experience and one member shall be an attorney. No member shall be affiliated with the Department of Human Services. The special review board shall meet at least every six months and at the call of the commissioner. It shall hear and consider all petitions for a reduction in custody or to appeal a revocation of provisional discharge. A "reduction in custody" means transfer from a secure treatment facility, discharge, and provisional discharge. Patients may be transferred by the commissioner between secure treatment facilities without a special review board hearing.

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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 federal requirements.

ARTICLE 9, SECTIONS 2 AND 3

Sec. 2. Minnesota Statutes 2014, section 253B.18, subdivision 4c, is amended to read:

Subd. 4c. **Special review board.** (a) The commissioner shall establish one or more panels of a special review board. The board shall consist of three members experienced in the field of mental illness. One member of each special review board panel shall be a psychiatrist or a doctoral level psychologist with forensic experience and one member shall be an attorney. No member shall be affiliated with the Department of Human Services. The special review board shall meet at least every six months and at the call of the commissioner. It shall hear and consider all petitions for a reduction in custody or to appeal a revocation of provisional discharge. A "reduction in custody" means transfer from a secure treatment facility, discharge, and provisional discharge. Patients may be transferred by the commissioner between secure treatment facilities without a special review board hearing.

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Members of the special review board shall receive compensation and reimbursement for expenses as established by the commissioner.

(b) The special review board must review each denied petition under subdivision 5 for barriers and obstacles preventing the patient from progressing in treatment. Based on the cases before the board in the previous year, the special review board shall provide to the commissioner an annual summation of the barriers to treatment progress, and recommendations to achieve the common goal of making progress in treatment.

(c) A petition filed by a person committed as mentally ill and dangerous to the public under this section must be heard as provided in subdivision 5 and, as applicable, subdivision 13. A petition filed by a person committed as a sexual psychopathic personality or as a sexually dangerous person under chapter 253D, or committed as both mentally ill and dangerous to the public under this section and as a sexual psychopathic personality or as a sexually dangerous person must be heard as provided in section 253D.27.

EFFECTIVE DATE. This section is effective January 1, 2016.

Sec. 16. Minnesota Statutes 2014, section 253B.18, subdivision 5, is amended to read:

Subd. 5. **Petition; notice of hearing; attendance; order.** (a) A petition for a reduction in custody or revocation of provisional discharge shall be filed with the commissioner and may be filed by the patient or by the head of the treatment facility. A patient may not petition the special review board for six months following commitment under subdivision 3 or following the final disposition of any previous petition and subsequent appeal by the patient. The head of the treatment facility must schedule a hearing before the special review board for any patient who has not appeared before the special review board in the previous three years, and schedule a hearing at least every three years thereafter. The medical director may petition at any time.

(b) Fourteen days prior to the hearing, the committing court, the county attorney of the county of commitment, the designated agency, interested person, the petitioner, and the petitioner's counsel shall be given written notice by the commissioner of the time and place of the hearing before the special review board. Only those entitled to statutory notice of the hearing or those administratively required to attend may be present at the hearing. The patient may designate interested persons to receive notice by providing the names and addresses to the commissioner at least 21 days before the hearing. The board shall provide the commissioner with written findings of fact and recommendations within 21 days of the hearing. The commissioner shall issue an order no later than 14 days after receiving the recommendation of the special review board. A copy of the order shall be mailed to every person entitled to statutory notice of the hearing within five days after it is signed. No order by the commissioner shall be effective sooner than 30 days after the order is signed, unless the county attorney, the patient, and the commissioner agree that it may become effective sooner.

House Language UES1458-1

Members of the special review board shall receive compensation and reimbursement for expenses as established by the commissioner.

(b) The special review board must review each denied petition under subdivision 5 for barriers and obstacles preventing the patient from progressing in treatment. Based on the cases before the board in the previous year, the special review board shall provide to the commissioner an annual summation of the barriers to treatment progress, and recommendations to achieve the common goal of making progress in treatment.

(c) A petition filed by a person committed as mentally ill and dangerous to the public under this section must be heard as provided in subdivision 5 and, as applicable, subdivision 13. A petition filed by a person committed as a sexual psychopathic personality or as a sexually dangerous person under chapter 253D, or committed as both mentally ill and dangerous to the public under this section and as a sexual psychopathic personality or as a sexually dangerous person must be heard as provided in section 253D.27.

Sec. 3. Minnesota Statutes 2014, section 253B.18, subdivision 5, is amended to read:

Subd. 5. **Petition; notice of hearing; attendance; order.** (a) A petition for a reduction in custody or revocation of provisional discharge shall be filed with the commissioner and may be filed by the patient or by the head of the treatment facility. A patient may not petition the special review board for six months following commitment under subdivision 3 or following the final disposition of any previous petition and subsequent appeal by the patient. The head of the treatment facility must schedule a hearing before the special review board for any patient who has not appeared before the special review board in the previous three years, and schedule a hearing at least every three years thereafter. The medical director may petition at any time.

(b) Fourteen days prior to the hearing, the committing court, the county attorney of the county of commitment, the designated agency, interested person, the petitioner, and the petitioner's counsel shall be given written notice by the commissioner of the time and place of the hearing before the special review board. Only those entitled to statutory notice of the hearing or those administratively required to attend may be present at the hearing. The patient may designate interested persons to receive notice by providing the names and addresses to the commissioner at least 21 days before the hearing. The board shall provide the commissioner with written findings of fact and recommendations within 21 days of the hearing. The commissioner shall issue an order no later than 14 days after receiving the recommendation of the special review board. A copy of the order shall be mailed to every person entitled to statutory notice of the hearing within five days after it is signed. No order by the commissioner shall be effective sooner than 30 days after the order is signed, unless the county attorney, the patient, and the commissioner agree that it may become effective sooner.

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(c) The special review board shall hold a hearing on each petition prior to making its recommendation to the commissioner. The special review board proceedings are not contested cases as defined in chapter 14. Any person or agency receiving notice that submits documentary evidence to the special review board prior to the hearing shall also provide copies to the patient, the patient's counsel, the county attorney of the county of commitment, the case manager, and the commissioner.

(d) Prior to the final decision by the commissioner, the special review board may be reconvened to consider events or circumstances that occurred subsequent to the hearing.

(e) In making their recommendations and order, the special review board and commissioner must consider any statements received from victims under subdivision 5a.

EFFECTIVE DATE. This section is effective January 1, 2016, with hearings starting no later than February 1, 2016.

Sec. 17. Minnesota Statutes 2014, section 254B.05, subdivision 5, is amended to read:

Subd. 5. **Rate requirements.** (a) The commissioner shall establish rates for chemical dependency services and service enhancements funded under this chapter.

(b) Eligible chemical dependency treatment services include:

(1) outpatient treatment services that are licensed according to Minnesota Rules, parts 9530.6405 to 9530.6480, or applicable tribal license;

(2) medication-assisted therapy services that are licensed according to Minnesota Rules, parts 9530.6405 to 9530.6480 and 9530.6500, or applicable tribal license;

(3) medication-assisted therapy plus enhanced treatment services that meet the requirements of clause (2) and provide nine hours of clinical services each week;

(4) high, medium, and low intensity residential treatment services that are licensed according to Minnesota Rules, parts 9530.6405 to 9530.6480 and 9530.6505, or applicable tribal license which provide, respectively, 30, 15, and five hours of clinical services each week;

(5) hospital-based treatment services that are licensed according to Minnesota Rules, parts 9530.6405 to 9530.6480, or applicable tribal license and licensed as a hospital under sections 144.50 to 144.56;

(6) adolescent treatment programs that are licensed as outpatient treatment programs according to Minnesota Rules, parts 9530.6405 to 9530.6485, or as residential treatment programs according to Minnesota Rules, parts 2960.0010 to 2960.0220, and 2960.0430 to 2960.0490, or applicable tribal license; ~~and~~

(7) high-intensity residential treatment services that are licensed according to

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(c) The special review board shall hold a hearing on each petition prior to making its recommendation to the commissioner. The special review board proceedings are not contested cases as defined in chapter 14. Any person or agency receiving notice that submits documentary evidence to the special review board prior to the hearing shall also provide copies to the patient, the patient's counsel, the county attorney of the county of commitment, the case manager, and the commissioner.

(d) Prior to the final decision by the commissioner, the special review board may be reconvened to consider events or circumstances that occurred subsequent to the hearing.

(e) In making their recommendations and order, the special review board and commissioner must consider any statements received from victims under subdivision 5a.

SEE HOUSE ARTICLE 9, SECTION 4 REGARDING COMMUNITY ADDICTION RECOVERY ENTERPRISE

Minnesota Rules, parts 9530.6405 to 9530.6480 and 9530.6505, or applicable tribal license, which provide 30 hours of clinical services each week provided by a state-operated vendor or to clients who have been civilly committed to the commissioner, present the most complex and difficult care needs, and are a potential threat to the community; and

(8) room and board facilities that meet the requirements of section 254B.05, subdivision 1a.

(c) The commissioner shall establish higher rates for programs that meet the requirements of paragraph (b) and the following additional requirements:

(1) programs that serve parents with their children if the program:

(i) provides on-site child care during hours of treatment activity that meets the requirements in Minnesota Rules, part 9530.6490, or section 245A.03, subdivision 2; or

(ii) arranges for off-site child care during hours of treatment activity at a facility that is licensed under chapter 245A as:

(A) a child care center under Minnesota Rules, chapter 9503; or

(B) a family child care home under Minnesota Rules, chapter 9502;

(2) culturally specific programs as defined in section 254B.01, subdivision 8, if the program meets the requirements in Minnesota Rules, part 9530.6605, subpart 13;

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

(4) programs that offer services to individuals with co-occurring mental health and chemical dependency problems if:

(i) the program meets the co-occurring requirements in Minnesota Rules, part 9530.6495;

(ii) 25 percent of the counseling staff are licensed mental health professionals, as defined in section 245.462, subdivision 18, clauses (1) to (6), or are students or licensing candidates under the supervision of a licensed alcohol and drug counselor supervisor and licensed mental health professional, except that no more than 50 percent of the mental health staff may be students or licensing candidates with time documented to be directly related to provisions of co-occurring services;

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

(iv) the program has standards for multidisciplinary case review that include a monthly review for each client that, at a minimum, includes a licensed mental health

professional and licensed alcohol and drug counselor, and their involvement in the review is documented;

(v) family education is offered that addresses mental health and substance abuse disorders and the interaction between the two; and

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

(d) In order to be eligible for a higher rate under paragraph (c), clause (1), a program that provides arrangements for off-site child care must maintain current documentation at the chemical dependency facility of the child care provider's current licensure to provide child care services. Programs that provide child care according to paragraph (c), clause (1), must be deemed in compliance with the licensing requirements in Minnesota Rules, part 9530.6490.

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

Sec. 18. Minnesota Statutes 2014, section 254B.12, subdivision 2, is amended to read:

Subd. 2. **Payment methodology for highly specialized vendors.** ~~(a)~~ Notwithstanding subdivision 1, the commissioner shall seek federal authority to develop separate payment methodologies for chemical dependency treatment services provided under the consolidated chemical dependency treatment fund: (1) by a state-operated vendor; or (2) for persons who have been civilly committed to the commissioner, present the most complex and difficult care needs, and are a potential threat to the community. A payment methodology under this subdivision is effective for services provided on or after October 1, 2015, or on or after the receipt of federal approval, whichever is later.

~~(b) Before implementing an approved payment methodology under paragraph (a), the commissioner must also receive any necessary legislative approval of required changes to state law or funding.~~

Sec. 19. Minnesota Statutes 2014, section 256B.0615, subdivision 3, is amended to read:

Subd. 3. **Eligibility.** Peer support services may be made available to consumers of (1) intensive ~~rehabilitative mental health~~ residential treatment services under section 256B.0622; (2) adult rehabilitative mental health services under section 256B.0623; and (3) crisis stabilization and mental health mobile crisis intervention services under section 256B.0624.

Sec. 20. Minnesota Statutes 2014, section 256B.0622, subdivision 1, is amended to read:

Subdivision 1. **Scope.** Subject to federal approval, medical assistance covers medically necessary, ~~intensive nonresidential~~ assertive community treatment and intensive residential ~~rehabilitative mental health~~ treatment services as defined in subdivision 2, for recipients as defined in subdivision 3, when the services are provided by an entity meeting the standards in this section.

Sec. 21. Minnesota Statutes 2014, section 256B.0622, subdivision 2, is amended to read:

Subd. 2. **Definitions.** For purposes of this section, the following terms have the meanings given them.

(a) ~~"Intensive nonresidential rehabilitative mental health services" means adult rehabilitative mental health services as defined in section 256B.0623, subdivision 2, paragraph (a), except that these services are provided by a multidisciplinary staff using a total team approach consistent with assertive community treatment, the Fairweather Lodge treatment model, as defined by the standards established by the National Coalition for Community Living, and other evidence-based practices, and directed to recipients with a serious mental illness who require intensive services.~~ "Assertive community treatment" means intensive nonresidential rehabilitative mental health services provided according to the evidence-based practice of assertive community treatment. Core elements of this service include, but are not limited to:

(1) a multidisciplinary staff who utilize a total team approach and who serve as a fixed point of responsibility for all service delivery;

(2) providing services 24 hours per day and 7 days per week;

(3) providing the majority of services in a community setting;

(4) offering a low ratio of recipients to staff; and

(5) providing service that is not time-limited.

(b) "Intensive residential ~~rehabilitative mental health~~ treatment services" means short-term, time-limited services provided in a residential setting to recipients who are in need of more restrictive settings and are at risk of significant functional deterioration if they do not receive these services. Services are designed to develop and enhance psychiatric stability, personal and emotional adjustment, self-sufficiency, and skills to live in a more independent setting. Services must be directed toward a targeted discharge date with specified client outcomes ~~and must be consistent with the Fairweather Lodge treatment model as defined in paragraph (a), and other evidence-based practices~~.

(c) "Evidence-based practices" are nationally recognized mental health services that are proven by substantial research to be effective in helping individuals with serious mental illness obtain specific treatment goals.

(d) "Overnight staff" means a member of the intensive residential rehabilitative mental health treatment team who is responsible during hours when recipients are typically asleep.

(e) "Treatment team" means all staff who provide services under this section to recipients. At a minimum, this includes the clinical supervisor, mental health professionals as defined in section 245.462, subdivision 18, clauses (1) to (6); mental health practitioners as defined in section 245.462, subdivision 17; mental health rehabilitation workers under section 256B.0623, subdivision 5, clause (3); and certified peer specialists under section 256B.0615.

Sec. 22. Minnesota Statutes 2014, section 256B.0622, subdivision 3, is amended to read:

Subd. 3. **Eligibility.** An eligible recipient is an individual who:

(1) is age 18 or older;

(2) is eligible for medical assistance;

(3) is diagnosed with a mental illness;

(4) because of a mental illness, has substantial disability and functional impairment in three or more of the areas listed in section 245.462, subdivision 11a, so that self-sufficiency is markedly reduced;

(5) has one or more of the following: a history of ~~two or more~~ recurring or prolonged inpatient hospitalizations in the past year, significant independent living instability, homelessness, or very frequent use of mental health and related services yielding poor outcomes; and

(6) in the written opinion of a licensed mental health professional, has the need for mental health services that cannot be met with other available community-based services, or is likely to experience a mental health crisis or require a more restrictive setting if intensive rehabilitative mental health services are not provided.

Sec. 23. Minnesota Statutes 2014, section 256B.0622, subdivision 4, is amended to read:

Subd. 4. **Provider certification and contract requirements.** (a) The ~~intensive nonresidential rehabilitative mental health services~~ assertive community treatment provider must:

(1) have a contract with the host county to provide intensive adult rehabilitative mental health services; and

(2) be certified by the commissioner as being in compliance with this section and section 256B.0623.

(b) The intensive residential ~~rehabilitative mental health~~ treatment services provider must:

(1) be licensed under Minnesota Rules, parts 9520.0500 to 9520.0670;

(2) not exceed 16 beds per site;

(3) comply with the additional standards in this section; and

(4) have a contract with the host county to provide these services.

(c) The commissioner shall develop procedures for counties and providers to submit contracts and other documentation as needed to allow the commissioner to determine whether the standards in this section are met.

Sec. 24. Minnesota Statutes 2014, section 256B.0622, subdivision 5, is amended to read:

Subd. 5. **Standards applicable to both ~~nonresidential~~ assertive community treatment and residential providers.** (a) Services must be provided by qualified staff as defined in section 256B.0623, subdivision 5, who are trained and supervised according to section 256B.0623, subdivision 6, except that mental health rehabilitation workers acting as overnight staff are not required to comply with section 256B.0623, subdivision 5, clause ~~(3)~~ (4), item (iv).

(b) The clinical supervisor must be an active member of the treatment team. The treatment team must meet with the clinical supervisor at least weekly to discuss recipients' progress and make rapid adjustments to meet recipients' needs. The team meeting shall include recipient-specific case reviews and general treatment discussions among team members. Recipient-specific case reviews and planning must be documented in the individual recipient's treatment record.

(c) Treatment staff must have prompt access in person or by telephone to a mental health practitioner or mental health professional. The provider must have the capacity to promptly and appropriately respond to emergent needs and make any necessary staffing adjustments to assure the health and safety of recipients.

(d) The initial functional assessment must be completed within ten days of intake and updated at least every ~~three months~~ 30 days for intensive residential treatment services and every six months for assertive community treatment, or prior to discharge from the service, whichever comes first.

(e) The initial individual treatment plan must be completed within ten days of intake ~~and~~ for assertive community treatment and within 24 hours of admission for intensive residential treatment services. Within ten days of admission, the initial treatment plan must be refined and further developed for intensive residential treatment services, except for providers certified according to Minnesota Rules, parts 9533.0010 to 9533.0180. The individual treatment plan must be reviewed with the recipient and updated at least monthly ~~with the recipient~~ for intensive residential treatment services and at least every six months for assertive community treatment.

Sec. 25. Minnesota Statutes 2014, section 256B.0622, subdivision 7, is amended to read:

Senate Language S1458-2

House Language UES1458-1

Subd. 7. **Additional standards for ~~nonresidential services~~ assertive community treatment.** The standards in this subdivision apply to ~~intensive nonresidential rehabilitative mental health~~ assertive community treatment services.

(1) The treatment team must use team treatment, not an individual treatment model.

(2) The clinical supervisor must function as a practicing clinician at least on a part-time basis.

(3) The staffing ratio must not exceed ten recipients to one full-time equivalent treatment team position.

(4) Services must be available at times that meet client needs.

(5) The treatment team must actively and assertively engage and reach out to the recipient's family members and significant others, after obtaining the recipient's permission.

(6) The treatment team must establish ongoing communication and collaboration between the team, family, and significant others and educate the family and significant others about mental illness, symptom management, and the family's role in treatment.

(7) The treatment team must provide interventions to promote positive interpersonal relationships.

Sec. 26. Minnesota Statutes 2014, section 256B.0622, subdivision 8, is amended to read:

Subd. 8. **Medical assistance payment for intensive rehabilitative mental health services.** (a) Payment for intensive residential ~~and nonresidential~~ treatment services and assertive community treatment in this section shall be based on one daily rate per provider inclusive of the following services received by an eligible recipient in a given calendar day: all rehabilitative services under this section, staff travel time to provide rehabilitative services under this section, and nonresidential crisis stabilization services under section 256B.0624.

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

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

~~(1) the cost for similar services in the local trade area;~~

Senate Language S1458-2

House Language UES1458-1

~~(2)~~ (1) the provider's cost for services shall include direct services costs, other program costs, and other costs determined as follows:

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

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

(iii) ~~in situations where a provider of intensive residential services can demonstrate actual program-related physical plant costs in excess of the group residential housing reimbursement, the commissioner may include these costs in the program rate, so long as the additional reimbursement does not subsidize the room and board expenses of the program~~ physical plant costs calculated based on the percentage of space within the program that is entirely devoted to treatment and programming. This does not include administrative or residential space;

(iv) ~~intensive nonresidential services~~ assertive community treatment physical plant costs must be reimbursed as part of the costs described in item (ii); and

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

~~(3)~~ (2) actual cost is defined as costs which are allowable, allocable, and reasonable, and consistent with federal reimbursement requirements under Code of Federal Regulations, title 48, chapter 1, part 31, relating to for-profit entities, and Office of Management and Budget Circular Number A-122, relating to nonprofit entities;

~~(4)~~ (3) the number of service units;

~~(5)~~ (4) the degree to which recipients will receive services other than services under this section; and

~~(6)~~ (5) the costs of other services that will be separately reimbursed~~; and~~.

~~(7) input from the local planning process authorized by the adult mental health initiative under section 245.4661, regarding recipients' service needs.~~

(d) The rate for intensive ~~rehabilitative mental health~~ residential treatment services and assertive community treatment must exclude room and board, as defined in section 256I.03, subdivision 6, and services not covered under this section, such as partial hospitalization, home care, and inpatient services.

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

~~(e)~~ (f) When services under this section are provided by an ~~intensive nonresidential service~~ assertive community treatment provider, case management functions must be an integral part of the team.

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

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

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

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

Sec. 27. Minnesota Statutes 2014, section 256B.0622, subdivision 9, is amended to read:

Subd. 9. **Provider enrollment; rate setting for county-operated entities.** Counties that employ their own staff to provide services under this section shall apply directly to the commissioner for enrollment and rate setting. In this case, a county contract is not required ~~and the commissioner shall perform the program review and rate setting duties which would otherwise be required of counties under this section~~.

Sec. 28. Minnesota Statutes 2014, section 256B.0622, subdivision 10, is amended to read:

Subd. 10. **Provider enrollment; rate setting for specialized program.** A county contract is not required for a provider proposing to serve a subpopulation of eligible recipients ~~may bypass the county approval procedures in this section and receive approval for provider enrollment and rate setting directly from the commissioner~~ under the following circumstances:

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

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

~~For providers meeting the criteria in clauses (1) and (2), the commissioner shall perform the program review and rate setting duties which would otherwise be required of counties under this section.~~

Sec. 29. Minnesota Statutes 2014, section 256B.0622, is amended by adding a subdivision to read:

Subd. 11. **Sustainability grants.** The commissioner may disburse grant funds directly to intensive residential treatment services providers and assertive community treatment providers to maintain access to these services.

Sec. 30. Minnesota Statutes 2014, section 256B.0624, subdivision 7, is amended to read:

Subd. 7. **Crisis stabilization services.** (a) Crisis stabilization services must be provided by qualified staff of a crisis stabilization services provider entity and must meet the following standards:

(1) a crisis stabilization treatment plan must be developed which meets the criteria in subdivision 11;

(2) staff must be qualified as defined in subdivision 8; and

(3) services must be delivered according to the treatment plan and include face-to-face contact with the recipient by qualified staff for further assessment, help with referrals, updating of the crisis stabilization treatment plan, supportive counseling, skills training, and collaboration with other service providers in the community.

(b) If crisis stabilization services are provided in a supervised, licensed residential setting, the recipient must be contacted face-to-face daily by a qualified mental health practitioner or mental health professional. The program must have 24-hour-a-day residential staffing which may include staff who do not meet the qualifications in subdivision 8. The residential staff must have 24-hour-a-day immediate direct or telephone access to a qualified mental health professional or practitioner.

Senate Language S1458-2

(c) If crisis stabilization services are provided in a supervised, licensed residential setting that serves no more than four adult residents, and ~~no more than two are recipients of crisis stabilization services~~ one or more individuals are present at the setting to receive residential crisis stabilization services, the residential staff must include, for at least eight hours per day, at least one individual who meets the qualifications in subdivision 8, paragraph (a), clause (1) or (2).

(d) If crisis stabilization services are provided in a supervised, licensed residential setting that serves more than four adult residents, and one or more are recipients of crisis stabilization services, the residential staff must include, for 24 hours a day, at least one individual who meets the qualifications in subdivision 8. During the first 48 hours that a recipient is in the residential program, the residential program must have at least two staff working 24 hours a day. Staffing levels may be adjusted thereafter according to the needs of the recipient as specified in the crisis stabilization treatment plan.

Sec. 31. Minnesota Statutes 2014, section 256B.0625, is amended by adding a subdivision to read:

Subd. 45a. **Psychiatric residential treatment facility services for persons under 21 years of age.** (a) Medical assistance covers psychiatric residential treatment facility services for persons under 21 years of age. Individuals who reach age 21 at the time they are receiving services are eligible to continue receiving services until they no longer require services or until they reach age 22, whichever occurs first.

(b) For purposes of this subdivision, "psychiatric residential treatment facility" means a facility other than a hospital that provides psychiatric services, as described in Code of Federal Regulations, title 42, sections 441.151 to 441.182, to individuals under age 21 in an inpatient setting.

(c) The commissioner shall develop admissions and discharge procedures and establish rates consistent with guidelines from the federal Centers for Medicare and Medicaid Services.

(d) The commissioner shall enroll up to 150 certified psychiatric residential treatment facility services beds at up to six sites. The commissioner shall select psychiatric residential treatment facility services providers through a request for proposals process. Providers of state-operated services may respond to the request for proposals.

EFFECTIVE DATE. This section is effective July 1, 2017, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 32. Minnesota Statutes 2014, section 256B.0625, subdivision 48, is amended to read:

House Language UES1458-1

Sec. 10. Minnesota Statutes 2014, section 256B.0625, is amended by adding a subdivision to read:

Subd. 45a. **Psychiatric residential treatment facility services for persons under 21 years of age.** (a) Medical assistance covers psychiatric residential treatment facility services for persons under 21 years of age. Individuals who reach age 21 at the time they are receiving services are eligible to continue receiving services until they no longer require services or until they reach age 22, whichever occurs first.

(b) For purposes of this subdivision, "psychiatric residential treatment facility" means a facility other than a hospital that provides psychiatric services, as described in Code of Federal Regulations, title 42, sections 441.151 to 441.182, to individuals under age 21 in an inpatient setting.

(c) The commissioner shall develop admissions and discharge procedures and establish rates consistent with guidelines from the federal Centers for Medicare and Medicaid Services.

(d) The commissioner shall enroll up to 150 certified psychiatric residential treatment facility services beds at up to six sites. The commissioner shall select psychiatric residential treatment facility services providers through a request for proposals process. Providers of state-operated services may respond to the request for proposals.

EFFECTIVE DATE. This section is effective July 1, 2016, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Senate Language S1458-2

House Language UES1458-1

Subd. 48. **Psychiatric consultation to primary care practitioners.** Medical assistance covers consultation provided by a psychiatrist, a psychologist, ~~or~~ an advanced practice registered nurse certified in psychiatric mental health, a licensed independent clinical social worker, as defined in section 245.462, subdivision 18, clause (2), or a licensed marriage and family therapist, as defined in section 245.462, subdivision 18, clause (5), via telephone, e-mail, facsimile, or other means of communication to primary care practitioners, including pediatricians. The need for consultation and the receipt of the consultation must be documented in the patient record maintained by the primary care practitioner. If the patient consents, and subject to federal limitations and data privacy provisions, the consultation may be provided without the patient present.

Sec. 33. **[256B.7631] CHEMICAL DEPENDENCY PROVIDER RATE INCREASE.**

For the chemical dependency services listed in section 254B.05, subdivision 5, and provided on or after July 1, 2015, payment rates shall be increased by two percent over the rates in effect on January 1, 2014, for vendors who meet the requirements of section 254B.05.

Sec. 34. **CLUBHOUSE PROGRAM SERVICES.**

The commissioner of human services, in consultation with stakeholders, shall develop service standards and a payment methodology for Clubhouse program services to be covered under medical assistance when provided by a Clubhouse International accredited provider or a provider meeting equivalent standards. The commissioner shall seek federal approval for the service standards and payment methodology. Upon federal approval, the commissioner must seek and obtain legislative approval of the services standards and funding methodology allowing medical assistance coverage of the service.

Sec. 35. **EXCELLENCE IN MENTAL HEALTH DEMONSTRATION PROJECT.**

Sec. 11. **[256B.7631] CHEMICAL DEPENDENCY PROVIDER RATE INCREASE.**

For the chemical dependency services listed in section 254B.05, subdivision 5, and provided on or after July 1, 2015, payment rates shall be increased by 2.5 percent over the rates in effect on January 1, 2014, for vendors who meet the requirements of section 254B.05.

Sec. 12. **REPORT TO LEGISLATURE; PERFORMANCE MEASURES FOR CHEMICAL DEPENDENCY TREATMENT SERVICES.**

The commissioner of human services, in consultation with members of the Minnesota State Substance Abuse Strategy and representatives of counties, tribes, health plan companies, and chemical dependency treatment providers, shall develop performance measures to assess the outcomes of chemical dependency treatment services. The commissioner shall report these performance measures to the members of the health and human services policy and finance committees in the house of representatives and senate on or before January 15, 2016.

Sec. 15. **CLUBHOUSE PROGRAM SERVICES.**

The commissioner of human services, in consultation with stakeholders, may develop service standards and a payment methodology for Clubhouse program services to be covered under medical assistance when provided by a Clubhouse International accredited provider or a provider meeting equivalent standards. The commissioner may seek federal approval for the service standards and payment methodology. Upon federal approval, the commissioner must seek and obtain legislative approval of the services standards and funding methodology allowing medical assistance coverage of the service.

Sec. 14. **EXCELLENCE IN MENTAL HEALTH DEMONSTRATION PROJECT.**

Senate Language S1458-2

By January 15, 2016, the commissioner of human services shall report to the legislative committees in the house of representatives and senate with jurisdiction over human services issues on the progress of the Excellence in Mental Health demonstration project under Minnesota Statutes, section 245.735. The commissioner shall include in the report any recommendations for legislative changes needed to implement the reform projects specified in Minnesota Statutes, section 245.735, subdivision 4.

Sec. 36. **RATE-SETTING METHODOLOGY FOR COMMUNITY-BASED MENTAL HEALTH SERVICES.**

The commissioner of human services shall conduct a comprehensive analysis of the current rate-setting methodology for all community-based mental health services for children and adults. The report shall include an assessment of alternative payment structures, consistent with the intent and direction of the federal Centers for Medicare and Medicaid Services, that could provide adequate reimbursement to sustain community-based mental health services regardless of geographic location. The report shall also include recommendations for establishing pay-for-performance measures for providers delivering services consistent with evidence-based practices. In developing the report, the commissioner shall consult with stakeholders and with outside experts in Medicaid financing. The commissioner shall provide a report on the analysis to the chairs of the legislative committees with jurisdiction over health and human services finance by January 1, 2017.

Sec. 37. **REPORT ON HUMAN SERVICES DATA SHARING TO COORDINATE SERVICES AND CARE OF A PATIENT.**

The commissioner of human services, in coordination with Hennepin County, shall report to the legislative committees with jurisdiction over health care financing on the fiscal impact, including the estimated savings, resulting from the modifications to the Data Practices Act in the 2015 legislative session, permitting the sharing of public welfare data and allowing the exchange of health records between providers to the extent necessary to coordinate services and care for clients enrolled in public health care programs. Counties shall provide information regarding the number of clients receiving care coordination, and improved outcomes achieved due to data sharing, to the commissioner of human services to include in the report. The report is due January 1, 2017.

Sec. 38. **COMPREHENSIVE MENTAL HEALTH PROGRAM IN BELTRAMI COUNTY.**

House Language UES1458-1

By January 15, 2016, the commissioner of human services shall report to the legislative committees in the house of representatives and senate with jurisdiction over human services issues on the progress of the Excellence in Mental Health demonstration project under Minnesota Statutes, section 245.735. The commissioner shall include in the report any recommendations for legislative changes needed to implement the reform projects specified in Minnesota Statutes, section 245.735, subdivision 3.

Sec. 13. **RATE-SETTING METHODOLOGY FOR COMMUNITY-BASED MENTAL HEALTH SERVICES.**

The commissioner of human services shall conduct a comprehensive analysis of the current rate-setting methodology for all community-based mental health services for children and adults. The report shall also include recommendations for establishing pay-for-performance measures for providers delivering services consistent with evidence-based practices. In developing the report, the commissioner shall consult with stakeholders and with outside experts in Medicaid financing. The commissioner shall provide a report on the analysis to the chairs of the legislative committees with jurisdiction over health and human services finance by January 1, 2017.

Sec. 19. **COMPREHENSIVE MENTAL HEALTH CENTER.**

Senate Language S1458-2

(a) The $500,000 appropriated to the commissioner of human services for a grant to Beltrami County to fund the planning and development of a comprehensive mental health program is contingent upon Beltrami County providing to the commissioner of human services a formal commitment and plan to fund, operate, and sustain the program and services after the onetime state grant is expended. The county must provide evidence of the funding stream or mechanism, and a sufficient local funding commitment, that will ensure that the onetime state investment in the program will result in a sustainable program without future state grants. The funding stream may include state funding for programs and services for which the individuals served under this section may be eligible. The grant under this section cannot be used for any purpose that could be funded with state bond proceeds. This is a onetime appropriation.

(b) The planning and development of the program by the county must include an integrated care model for the provision of mental health and substance use disorder treatment for the individuals served under paragraph (c), in collaboration with existing services. The model may include mobile crisis services, crisis residential services, outpatient services, and community-based services. The model must be patient-centered, culturally competent, and based on evidence-based practices.

(c) The comprehensive mental health program will serve individuals who are:

(1) under arrest or subject to arrest who are experiencing a mental health crisis;

(2) under a transport hold under Minnesota Statutes, section 253B.05, subdivision 2; or

(3) in immediate need of mental health crisis services.

(d) The commissioner of human services may encourage the commissioners of the Minnesota Housing Finance Agency, corrections, and health to provide technical assistance and support in the planning and development of the mental health program under paragraph (a). The commissioners of the Minnesota Housing Finance Agency and human services may explore a plan to develop short-term and long-term housing for individuals served by the program, and the possibility of using existing appropriations available in the housing finance budget for low-income housing or homelessness.

(e) The commissioner of human services, in consultation with Beltrami County, shall report to the senate and house of representatives committees having jurisdiction over mental health issues the status of the planning and development of the mental health program, and the plan to financially support the program and services after the state grant is expended, by November 1, 2017.

House Language UES1458-1

(a) To the extent funds are appropriated for the purposes of this section, the commissioner of human services shall establish a grant for Beltrami County to fund the planning and development of a comprehensive mental health center for individuals who are under arrest or subject to arrest, individuals who are experiencing a mental health crisis, or individuals who are under a transport hold under Minnesota Statutes, section 253B.05, subdivision 2, in Beltrami County and northwestern Minnesota. The program must be a sustainable, integrated care model for the provision of mental health and substance use disorder treatment for the population served in collaboration with existing services. The model may include mobile crisis services, crisis residential services, outpatient services, and community-based services. The model must be patient-centered, culturally competent, and based on evidence-based practices.

(b) The program shall maintain data on the extent to which the center reduces incarceration and hospitalization rates for individuals with mental illness or co-occurring disorders, and the extent to which the center impacts service utilization for these individuals. In order to have the capacity to be replicated in other areas of the state, the center must report outcomes to the commissioner, at a time and in a manner determined by the commissioner. The commissioner shall use the data to evaluate the effect the program has on incarceration rates and services utilization, and report to the chairs and ranking minority members of the senate and house of representatives committees having jurisdiction over health and human services and corrections issues every two years, beginning February 1, 2017.

(c) The commissioner shall encourage the commissioners of the Minnesota Housing Finance Agency, corrections, and health to provide technical assistance and support to this program. The commissioner, together with the commissioner of health, shall determine the most appropriate model for licensure of the proposed services and which agency will regulate the services of the center. The commissioners of the Minnesota Housing Finance Agency and human services shall work with the center to provide short-term and long-term housing for individuals served by the center within the limits of existing appropriations available for low-income housing or homelessness.

Senate Language S1458-2

House Language UES1458-1

SECTION 16 MOVED TO APPROPRIATIONS, SENATE ARTICLE 12/HOUSE ARTICLE 14

Sec. 17. **INSTRUCTIONS TO THE COMMISSIONER.**

The commissioner of human services shall, in consultation with stakeholders, develop recommendations on funding for children's mental health crisis residential services that will allow for timely access without requiring county authorization or child welfare placement.

Sec. 20. **REPORT ON INTENSIVE COMMUNITY REHABILITATION SERVICES.**

(a) The commissioner of human services shall issue a report to the chairs and ranking minority members of the house and senate committees with jurisdiction over health and human services programs that contains recommendations on the intensive community rehabilitation services program, including options for sustainable funding models. The report shall:

(1) analyze how the intensive community rehabilitation services program provides needed mental health services and supports that are not currently covered by medical assistance;

(2) identify similar program models that are used in other states to fill similar service gaps and the program funding sources used by those states;

(3) analyze how the intensive community rehabilitation services model differs between rural and metro areas;

(4) make recommendations for expanding services; and

(5) analyze potential sources for sustainable funding, including inclusion as a medical assistance benefit.

(b) The commissioner shall include stakeholders in developing recommendations and developing the legislative report. The commissioner shall submit the report no later than January 15, 2016.

Sec. 21. **COMMISSIONER'S DUTIES RELATED TO PEER SPECIALIST TRAINING AND OUTREACH.**

The commissioner shall collaborate with the Minnesota State Colleges and Universities system to identify coursework to fulfill the peer specialist training requirements. In addition, the commissioner shall provide outreach to community mental health providers to increase their knowledge on how peer specialists can be utilized, best practices on hiring peer specialists, how peer specialist activities can be billed, and the benefits of hiring peer specialists.

Senate Language S1458-2

House Language UES1458-1

SECTION 22 MOVED TO CONTINUING CARE, SENATE ARTICLE 6/HOUSE ARTICLE 4.