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State of Minnesota

HOUSE OF REPRESENTATIVES

NINETY-FOURTH SESSION

H. F. No. 98

02/10/2025 Authored by Fischer, Gillman, Baker, Frederick, Schomacker and others
The bill was read for the first time and referred to the Committee on Human Services Finance and Policy

1.1 A bill for an act
1.2 relating to behavioral health; modifying case management associate, mental health
1.3 behavioral aide, and mental health rehabilitation worker supervision requirements;
1.4 exempting intensive residential treatment services or residential crisis stabilization
1.5 services providers from specified client rights; modifying mental health residential
1.6 program critical incident reporting requirements; modifying timeline for intensive
1.7 residential treatment services level of care assessments; modifying assertive
1.8 community treatment team leader requirements; allowing payment for adult mental
1.9 health case management contact conducted via secure electronic message; amending
1.10 Minnesota Statutes 2024, sections 245.462, subdivision 4; 245I.06, subdivision
1.11 3; 245I.12, subdivisions 1, 5; 245I.13; 245I.23, subdivision 7; 256B.0622,
1.12 subdivision 7a; 256B.0625, subdivision 20.

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

1.14 Section 1. Minnesota Statutes 2024, section 245.462, subdivision 4, is amended to read:

1.15 Subd. 4. Case management service provider. (a) "Case management service provider"
1.16 means a case manager or case manager associate employed by the county or other entity
1.17 authorized by the county board to provide case management services specified in section
1.18 245.4711.

1.19 (b) A case manager must:

1.20 (1) be skilled in the process of identifying and assessing a wide range of client needs;

1.21 (2) be knowledgeable about local community resources and how to use those resources
1.22 for the benefit of the client;

1.23 (3) be a mental health practitioner as defined in section 245I.04, subdivision 4, or have
1.24 a bachelor's degree in one of the behavioral sciences or related fields including, but not
1.25 limited to, social work, psychology, or nursing from an accredited college or university. A

2.1 case manager who is not a mental health practitioner and who does not have a bachelor's
2.2 degree in one of the behavioral sciences or related fields must meet the requirements of
2.3 paragraph (c); and

2.4 (4) meet the supervision and continuing education requirements described in paragraphs
2.5 (d), (e), and (f), as applicable.

2.6 (c) Case managers without a bachelor's degree must meet one of the requirements in
2.7 clauses (1) to (3):

2.8 (1) have three or four years of experience as a case manager associate as defined in this
2.9 section;

2.10 (2) be a registered nurse without a bachelor's degree and have a combination of
2.11 specialized training in psychiatry and work experience consisting of community interaction
2.12 and involvement or community discharge planning in a mental health setting totaling three
2.13 years; or

2.14 (3) be a person who qualified as a case manager under the 1998 Department of Human
2.15 Service waiver provision and meet the continuing education and mentoring requirements
2.16 in this section.

2.17 (d) A case manager with at least 2,000 hours of supervised experience in the delivery
2.18 of services to adults with mental illness must receive regular ongoing supervision and clinical
2.19 supervision totaling 38 hours per year of which at least one hour per month must be clinical
2.20 supervision regarding individual service delivery with a case management supervisor. The
2.21 remaining 26 hours of supervision may be provided by a case manager with two years of
2.22 experience. Group supervision may not constitute more than one-half of the required
2.23 supervision hours. Clinical supervision must be documented in the client record.

2.24 (e) A case manager without 2,000 hours of supervised experience in the delivery of
2.25 services to adults with mental illness must:

2.26 (1) receive clinical supervision regarding individual service delivery from a mental
2.27 health professional at least one hour per week until the requirement of 2,000 hours of
2.28 experience is met; and

2.29 (2) complete 40 hours of training approved by the commissioner in case management
2.30 skills and the characteristics and needs of adults with serious and persistent mental illness.

2.31 (f) A case manager who is not licensed, registered, or certified by a health-related
2.32 licensing board must receive 30 hours of continuing education and training in mental illness
2.33 and mental health services every two years.

3.1 (g) A case manager associate (CMA) must:

3.2 (1) work under the direction of a case manager or case management supervisor;

3.3 (2) be at least 21 years of age;

3.4 (3) have at least a high school diploma or its equivalent; and

3.5 (4) meet one of the following criteria:

3.6 (i) have an associate of arts degree in one of the behavioral sciences or human services;

3.7 (ii) be a certified peer specialist under section 256B.0615;

3.8 (iii) be a registered nurse without a bachelor's degree;

3.9 (iv) within the previous ten years, have three years of life experience with serious and
 3.10 persistent mental illness as defined in subdivision 20; or as a child had severe emotional
 3.11 disturbance as defined in section 245.4871, subdivision 6; or have three years life experience
 3.12 as a primary caregiver to an adult with serious and persistent mental illness within the
 3.13 previous ten years;

3.14 (v) have 6,000 hours work experience as a nondegreed state hospital technician; or

3.15 (vi) have at least 6,000 hours of supervised experience in the delivery of services to
 3.16 persons with mental illness.

3.17 Individuals meeting one of the criteria in items (i) to (v) may qualify as a case manager
 3.18 after four years of supervised work experience as a case manager associate. Individuals
 3.19 meeting the criteria in item (vi) may qualify as a case manager after three years of supervised
 3.20 experience as a case manager associate.

3.21 (h) A case management associate must meet the following supervision, mentoring, and
 3.22 continuing education requirements:

3.23 (1) have 40 hours of preservice training described under paragraph (e), clause (2);

3.24 (2) receive at least ~~40~~ 20 hours of continuing education in mental illness and mental
 3.25 health services annually; and

3.26 (3) receive at least ~~five~~ four hours of ~~mentoring supervision per week~~ supervision per month from a case
 3.27 management ~~mentor~~ supervisor.

3.28 A "case management mentor" means a qualified, practicing case manager or case management
 3.29 supervisor who teaches or advises and provides intensive training and clinical supervision
 3.30 to one or more case manager associates. Mentoring may occur while providing direct services
 3.31 to consumers in the office or in the field and may be provided to individuals or groups of

4.1 ~~case manager associates. At least two mentoring hours per week must be individual and~~
4.2 ~~face-to-face.~~

4.3 (i) A case management supervisor must meet the criteria for mental health professionals,
4.4 as specified in subdivision 18.

4.5 (j) An immigrant who does not have the qualifications specified in this subdivision may
4.6 provide case management services to adult immigrants with serious and persistent mental
4.7 illness who are members of the same ethnic group as the case manager if the person:

4.8 (1) is currently enrolled in and is actively pursuing credits toward the completion of a
4.9 bachelor's degree in one of the behavioral sciences or a related field including, but not
4.10 limited to, social work, psychology, or nursing from an accredited college or university;

4.11 (2) completes 40 hours of training as specified in this subdivision; and

4.12 (3) receives clinical supervision at least once a week until the requirements of this
4.13 subdivision are met.

4.14 Sec. 2. Minnesota Statutes 2024, section 245I.06, subdivision 3, is amended to read:

4.15 Subd. 3. **Treatment supervision and direct observation of mental health**
4.16 **rehabilitation workers and mental health behavioral aides.** (a) A mental health behavioral
4.17 aide or a mental health rehabilitation worker must receive direct observation from a mental
4.18 health professional, clinical trainee, certified rehabilitation specialist, or mental health
4.19 practitioner while the mental health behavioral aide or mental health rehabilitation worker
4.20 provides treatment services to clients, no less than twice per month for the first six months
4.21 of employment and once per month thereafter. ~~The staff person performing the direct~~
4.22 ~~observation must approve of the progress note for the observed treatment service.~~

4.23 (b) For a mental health rehabilitation worker qualified under section 245I.04, subdivision
4.24 14, paragraph (a), clause (2), item (i), treatment supervision in the first 2,000 hours of work
4.25 must at a minimum consist of:

4.26 (1) monthly individual supervision; and

4.27 (2) direct observation twice per month.

4.28 Sec. 3. Minnesota Statutes 2024, section 245I.12, subdivision 1, is amended to read:

4.29 Subdivision 1. **Client rights.** A license holder must ensure that all clients have the
4.30 following rights:

5.1 (1) the rights listed in the health care bill of rights in section 144.651. Section 144.651,
5.2 subdivisions 20, 25, 29, 32, and 33, do not apply to intensive residential treatment services
5.3 or residential crisis stabilization services;

5.4 (2) the right to be free from discrimination based on age, race, color, creed, religion,
5.5 national origin, sex, gender identity, marital status, disability, sexual orientation, and status
5.6 with regard to public assistance. The license holder must follow all applicable state and
5.7 federal laws including the Minnesota Human Rights Act, chapter 363A; and

5.8 (3) the right to be informed prior to a photograph or audio or video recording being made
5.9 of the client. The client has the right to refuse to allow any recording or photograph of the
5.10 client that is not for the purposes of identification or supervision by the license holder.

5.11 Sec. 4. Minnesota Statutes 2024, section 245I.12, subdivision 5, is amended to read:

5.12 Subd. 5. **Client grievances.** (a) The license holder must have a grievance procedure
5.13 that:

5.14 (1) describes to clients how the license holder will meet the requirements in this
5.15 subdivision; and

5.16 (2) contains the current public contact information of the Department of Human Services,
5.17 Licensing Division; the Office of Ombudsman for Mental Health and Developmental
5.18 Disabilities; the Department of Health, Office of Health Facilities Complaints; and all
5.19 applicable health-related licensing boards.

5.20 (b) On the day of each client's admission, the license holder must explain the grievance
5.21 procedure to the client.

5.22 (c) The license holder must:

5.23 (1) post the grievance procedure in a place visible to clients and provide a copy of the
5.24 grievance procedure upon request;

5.25 (2) allow clients, former clients, and their authorized representatives to submit a grievance
5.26 to the license holder;

5.27 (3) within three business days of receiving a client's grievance, acknowledge in writing
5.28 that the license holder received the client's grievance. If applicable, the license holder must
5.29 include a notice of the client's separate appeal rights for a managed care organization's
5.30 reduction, termination, or denial of a covered service;

6.1 (4) within 15 business days of receiving a client's grievance, provide a written final
 6.2 response to the client's grievance containing the license holder's official response to the
 6.3 grievance; and

6.4 (5) allow the client to bring a grievance to the person with the highest level of authority
 6.5 in the program.

6.6 (d) Clients may voice grievances and recommend changes in policies and services to
 6.7 staff and others of their choice, free from restraint, interference, coercion, discrimination,
 6.8 or reprisal, including threat of discharge.

6.9 Sec. 5. Minnesota Statutes 2024, section 245I.13, is amended to read:

6.10 **245I.13 CRITICAL INCIDENTS.**

6.11 If a license holder is licensed as a residential program, the license holder must report all
 6.12 critical incidents to the commissioner within ten days of learning of the incident on a form
 6.13 approved by the commissioner. The license holder is not required to report critical incidents
 6.14 to the commissioner if the license holder is required to report those critical incidents to the
 6.15 Office of Ombudsman for Mental Health and Developmental Disabilities or the Minnesota
 6.16 Adult Abuse Reporting Center. The license holder must keep a record of critical incidents
 6.17 in a central location that is readily accessible to the commissioner for review upon the
 6.18 commissioner's request for a minimum of two licensing periods.

6.19 Sec. 6. Minnesota Statutes 2024, section 245I.23, subdivision 7, is amended to read:

6.20 Subd. 7. **Intensive residential treatment services assessment and treatment**
 6.21 **planning.** (a) Within 12 hours of a client's admission, the license holder must evaluate and
 6.22 document the client's immediate needs, including the client's:

6.23 (1) health and safety, including the client's need for crisis assistance;

6.24 (2) responsibilities for children, family and other natural supports, and employers; and

6.25 (3) housing and legal issues.

6.26 (b) Within 24 hours of the client's admission, the license holder must complete an initial
 6.27 treatment plan for the client. The license holder must:

6.28 (1) base the client's initial treatment plan on the client's referral information and an
 6.29 assessment of the client's immediate needs;

6.30 (2) consider crisis assistance strategies that have been effective for the client in the past;

7.1 (3) identify the client's initial treatment goals, measurable treatment objectives, and
7.2 specific interventions that the license holder will use to help the client engage in treatment;

7.3 (4) identify the participants involved in the client's treatment planning. The client must
7.4 be a participant; and

7.5 (5) ensure that a treatment supervisor approves of the client's initial treatment plan if a
7.6 mental health practitioner or clinical trainee completes the client's treatment plan,
7.7 notwithstanding section 245I.08, subdivision 3.

7.8 (c) According to section 245A.65, subdivision 2, paragraph (b), the license holder must
7.9 complete an individual abuse prevention plan as part of a client's initial treatment plan.

7.10 (d) Within ~~five~~ ten days of the client's admission and again within 60 days after the
7.11 client's admission, the license holder must complete a level of care assessment of the client.
7.12 If the license holder determines that a client does not need a medically monitored level of
7.13 service, a treatment supervisor must document how the client's admission to and continued
7.14 services in intensive residential treatment services are medically necessary for the client.

7.15 (e) Within ten days of a client's admission, the license holder must complete or review
7.16 and update the client's standard diagnostic assessment.

7.17 (f) Within ten days of a client's admission, the license holder must complete the client's
7.18 individual treatment plan, notwithstanding section 245I.10, subdivision 8. Within 40 days
7.19 after the client's admission and again within 70 days after the client's admission, the license
7.20 holder must update the client's individual treatment plan. The license holder must focus the
7.21 client's treatment planning on preparing the client for a successful transition from intensive
7.22 residential treatment services to another setting. In addition to the required elements of an
7.23 individual treatment plan under section 245I.10, subdivision 8, the license holder must
7.24 identify the following information in the client's individual treatment plan: (1) the client's
7.25 referrals and resources for the client's health and safety; and (2) the staff persons who are
7.26 responsible for following up with the client's referrals and resources. If the client does not
7.27 receive a referral or resource that the client needs, the license holder must document the
7.28 reason that the license holder did not make the referral or did not connect the client to a
7.29 particular resource. The license holder is responsible for determining whether additional
7.30 follow-up is required on behalf of the client.

7.31 (g) Within 30 days of the client's admission, the license holder must complete a functional
7.32 assessment of the client. Within 60 days after the client's admission, the license holder must
7.33 update the client's functional assessment to include any changes in the client's functioning
7.34 and symptoms.

8.1 (h) For a client with a current substance use disorder diagnosis and for a client whose
8.2 substance use disorder screening in the client's standard diagnostic assessment indicates the
8.3 possibility that the client has a substance use disorder, the license holder must complete a
8.4 written assessment of the client's substance use within 30 days of the client's admission. In
8.5 the substance use assessment, the license holder must: (1) evaluate the client's history of
8.6 substance use, relapses, and hospitalizations related to substance use; (2) assess the effects
8.7 of the client's substance use on the client's relationships including with family member and
8.8 others; (3) identify financial problems, health issues, housing instability, and unemployment;
8.9 (4) assess the client's legal problems, past and pending incarceration, violence, and
8.10 victimization; and (5) evaluate the client's suicide attempts, noncompliance with taking
8.11 prescribed medications, and noncompliance with psychosocial treatment.

8.12 (i) On a weekly basis, a mental health professional or certified rehabilitation specialist
8.13 must review each client's treatment plan and individual abuse prevention plan. The license
8.14 holder must document in the client's file each weekly review of the client's treatment plan
8.15 and individual abuse prevention plan.

8.16 Sec. 7. Minnesota Statutes 2024, section 256B.0622, subdivision 7a, is amended to read:

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

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

8.19 (1) the team leader:

8.20 (i) shall be a mental health professional. Individuals who are not licensed but who ~~are~~
8.21 ~~eligible for licensure and~~ are otherwise qualified may also fulfill this role;

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

8.24 (iii) must be a single full-time staff member, dedicated to the ACT team, who is
8.25 responsible for overseeing the administrative operations of the team and supervising team
8.26 members to ensure delivery of best and ethical practices; and

8.27 (iv) must be available to ensure that overall treatment supervision to the ACT team is
8.28 available after regular business hours and on weekends and holidays and is provided by a
8.29 qualified member of the ACT team;

8.30 (2) the psychiatric care provider:

8.31 (i) must be a mental health professional permitted to prescribe psychiatric medications
8.32 as part of the mental health professional's scope of practice. The psychiatric care provider

9.1 must have demonstrated clinical experience working with individuals with serious and
9.2 persistent mental illness;

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

9.8 (iii) shall fulfill the following functions for assertive community treatment clients:
9.9 provide assessment and treatment of clients' symptoms and response to medications, including
9.10 side effects; provide brief therapy to clients; provide diagnostic and medication education
9.11 to clients, with medication decisions based on shared decision making; monitor clients'
9.12 nonpsychiatric medical conditions and nonpsychiatric medications; and conduct home and
9.13 community visits;

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

9.17 (v) shall have a minimum full-time equivalency that is prorated at a rate of 16 hours per
9.18 50 clients. Part-time psychiatric care providers shall have designated hours to work on the
9.19 team, with sufficient blocks of time on consistent days to carry out the provider's clinical,
9.20 supervisory, and administrative responsibilities. No more than two psychiatric care providers
9.21 may share this role; and

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

9.25 (3) the nursing staff:

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

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

9.32 (iii) shall develop strategies, in collaboration with clients, to maximize taking medications
9.33 as prescribed; screen and monitor clients' mental and physical health conditions and

10.1 medication side effects; engage in health promotion, prevention, and education activities;
10.2 communicate and coordinate services with other medical providers; facilitate the development
10.3 of the individual treatment plan for clients assigned; and educate the ACT team in monitoring
10.4 psychiatric and physical health symptoms and medication side effects;

10.5 (4) the co-occurring disorder specialist:

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

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

10.19 (5) the vocational specialist:

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

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

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

10.30 (6) the mental health certified peer specialist:

10.31 (i) shall be a full-time equivalent. No more than two individuals can share this position.
10.32 The mental health certified peer specialist is a fully integrated team member who provides
10.33 highly individualized services in the community and promotes the self-determination and

11.1 shared decision-making abilities of clients. This requirement may be waived due to workforce
11.2 shortages upon approval of the commissioner;

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

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

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

11.13 (8) additional staff:

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

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

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

11.21 (c) Each ACT team member must serve as a primary team member for clients assigned
11.22 by the team leader and are responsible for facilitating the individual treatment plan process
11.23 for those clients. The primary team member for a client is the responsible team member
11.24 knowledgeable about the client's life and circumstances and writes the individual treatment
11.25 plan. The primary team member provides individual supportive therapy or counseling, and
11.26 provides primary support and education to the client's family and support system.

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

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

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

12.5 Sec. 8. Minnesota Statutes 2024, section 256B.0625, subdivision 20, is amended to read:

12.6 Subd. 20. **Mental health case management.** (a) To the extent authorized by rule of the
12.7 state agency, medical assistance covers case management services to persons with serious
12.8 and persistent mental illness and children with severe emotional disturbance. Services
12.9 provided under this section must meet the relevant standards in sections 245.461 to 245.4887,
12.10 the Comprehensive Adult and Children's Mental Health Acts, Minnesota Rules, parts
12.11 9520.0900 to 9520.0926, and 9505.0322, excluding subpart 10.

12.12 (b) Entities meeting program standards set out in rules governing family community
12.13 support services as defined in section 245.4871, subdivision 17, are eligible for medical
12.14 assistance reimbursement for case management services for children with severe emotional
12.15 disturbance when these services meet the program standards in Minnesota Rules, parts
12.16 9520.0900 to 9520.0926 and 9505.0322, excluding subparts 6 and 10.

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

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

12.25 (2) at least a telephone contact with the adult or the adult's legal representative and
12.26 document a face-to-face contact either in person or by interactive video that meets the
12.27 requirements of subdivision 20b with the adult or the adult's legal representative within the
12.28 preceding two months; or

12.29 (3) at least a contact via secure electronic message with the adult or the adult's legal
12.30 representative, if requested by the adult or the adult's legal representative, and a face-to-face
12.31 contact either in person or by interactive video that meets the requirements of subdivision
12.32 20b with the adult or the adult's legal representative within the preceding two months. To

13.1 receive payment for an eligible adult under this clause, contact via secure electronic message

13.2 must:

13.3 (i) be limited to reminders, verbal cues, prompts, and coordinating and supporting

13.4 referrals within the scope of adult mental health case management;

13.5 (ii) directly relate to targeted case management service activities listed in section

13.6 256B.0924, subdivision 4;

13.7 (iii) align with the individual goals identified in the adult's individual community support

13.8 plan;

13.9 (iv) be conducted using a platform that complies with the requirements of the federal

13.10 Health Insurance Portability and Accountability Act of 1996 (HIPAA); and

13.11 (v) document the adult's or adult's legal representative's request for contact to be

13.12 conducted via secure electronic message and the verbatim content of each secure electronic

13.13 message.

13.14 (d) Payment for mental health case management provided by county or state staff shall

13.15 be based on the monthly rate methodology under section 256B.094, subdivision 6, paragraph

13.16 (b), with separate rates calculated for child welfare and mental health, and within mental

13.17 health, separate rates for children and adults.

13.18 (e) Payment for mental health case management provided by Indian health services or

13.19 by agencies operated by Indian tribes may be made according to this section or other relevant

13.20 federally approved rate setting methodology.

13.21 (f) Payment for mental health case management provided by vendors who contract with

13.22 a county must be calculated in accordance with section 256B.076, subdivision 2. Payment

13.23 for mental health case management provided by vendors who contract with a Tribe must

13.24 be based on a monthly rate negotiated by the Tribe. The rate must not exceed the rate charged

13.25 by the vendor for the same service to other payers. If the service is provided by a team of

13.26 contracted vendors, the team shall determine how to distribute the rate among its members.

13.27 No reimbursement received by contracted vendors shall be returned to the county or tribe,

13.28 except to reimburse the county or tribe for advance funding provided by the county or tribe

13.29 to the vendor.

13.30 (g) If the service is provided by a team which includes contracted vendors, tribal staff,

13.31 and county or state staff, the costs for county or state staff participation in the team shall be

13.32 included in the rate for county-provided services. In this case, the contracted vendor, the

13.33 tribal agency, and the county may each receive separate payment for services provided by

14.1 each entity in the same month. In order to prevent duplication of services, each entity must
14.2 document, in the recipient's file, the need for team case management and a description of
14.3 the roles of the team members.

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

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

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

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

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

14.24 (2) programming the information systems.

14.25 (l) Payments to counties and tribal agencies for case management expenditures under
14.26 this section shall only be made from federal earnings from services provided under this
14.27 section. When this service is paid by the state without a federal share through fee-for-service,
14.28 50 percent of the cost shall be provided by the state. Payments to county-contracted vendors
14.29 shall include the federal earnings, the state share, and the county share.

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

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

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

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

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

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

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