Senate Language UEH2749-1

House Language H3467-3

ARTICLE 22
MENTAL HEALTH

Section 1. Minnesota Statutes 2015 Supplement, section 245.735, subdivision 3, is amended to read:

Subd. 3. **~~Reform projects~~ Certified community behavioral health clinics.** (a) The commissioner shall establish ~~standards for~~ a state certification ~~of clinics as~~ process for certified community behavioral health clinics~~, in accordance~~ (CCBHCs) to be eligible for the prospective payment system in paragraph (f). Entities that choose to be CCBHCs must:

(1) comply with the CCBHC 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:~~;

~~(1)~~ (2) employ or contract for clinic staff who have backgrounds in diverse disciplines, ~~include~~ including licensed mental health professionals, and staff who are culturally and linguistically trained to serve the needs of the clinic's patient population;

~~(2)~~ (3) ensure that clinic services are available and accessible to patients of all ages and genders and that crisis management services are available 24 hours per day;

~~(3)~~ (4) establish fees for clinic services ~~are established~~ for non-medical assistance patients using a sliding fee scale ~~and~~ that ensures that 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) comply with quality assurance reporting requirements and other reporting requirements, including any required reporting of encounter data, clinical outcomes data, and quality data;

ARTICLE 5
CHEMICAL AND MENTAL HEALTH

Section 1. Minnesota Statutes 2015 Supplement, section 245.735, subdivision 3, is amended to read:

Subd. 3. **~~Reform projects~~ Certified community behavioral health clinics.** (a) The commissioner shall establish ~~standards for~~ a state certification ~~of clinics as~~ process for certified community behavioral health clinics~~, in accordance~~ (CCBHCs) to be eligible for the prospective payment system in paragraph (f). Entities that choose to be CCBHCs must:

(1) comply with the CCBHC 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:~~;

~~(1)~~ (2) employ or contract for clinic staff who have backgrounds in diverse disciplines, ~~include~~ including licensed mental health professionals, and staff who are culturally and linguistically trained to serve the needs of the clinic's patient population;

~~(2)~~ (3) ensure that clinic services are available and accessible to patients of all ages and genders and that crisis management services are available 24 hours per day;

~~(3)~~ (4) establish fees for clinic services ~~are established~~ for non-medical assistance patients using a sliding fee scale ~~and~~ that ensures that 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) comply with quality assurance reporting requirements and other reporting requirements, including any required reporting of encounter data, clinical outcomes data, and quality data;

Senate Language UEH2749-1

~~(5) services provided by clinics include~~ (6) provide crisis mental health services, withdrawal management 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.~~ (7) 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:

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

(ii) other community services, supports, and providers, including schools, child welfare agencies, juvenile and criminal justice agencies, Indian health services clinics, tribally licensed health care and mental health facilities, urban Indian health clinics, Department of Veterans Affairs medical centers, outpatient clinics, drop-in centers, acute care hospitals, and hospital outpatient clinics;

(8) be certified as mental health clinics under section 245.69, subdivision 2;

(9) comply with standards relating to integrated treatment for co-occurring mental illness and substance use disorders in adults or children under Minnesota Rules, chapter 9533;

(10) comply with standards relating to mental health services in Minnesota Rules, parts 9505.0370 to 9505.0372;

(11) be licensed to provide chemical dependency treatment under Minnesota Rules, parts 9530.6405 to 9530.6505;

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

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

House Language H3467-3

~~(5) services provided by clinics include~~ (6) provide crisis mental health services, withdrawal management 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.~~

(7) 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:

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

(ii) other community services, supports, and providers including schools, child welfare agencies, juvenile and criminal justice agencies, Indian Health Services clinics, tribally licensed health care and mental health facilities, urban Indian health clinics, Department of Veterans Affairs medical centers, outpatient clinics, drop-in centers, acute care hospitals, and hospital outpatient clinics;

(8) be certified as mental health clinics under section 245.69, subdivision 2;

(9) comply with standards relating to integrated treatment for co-occurring mental illness and substance use disorders in adults or children under Minnesota Rules, chapter 9533;

(10) comply with standards relating to mental health services in Minnesota Rules, parts 9505.0370 to 9505.0372;

(11) be licensed to provide chemical dependency treatment under Minnesota Rules, parts 9530.6405 to 9530.6505;

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

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

Senate Language UEH2749-1

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

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

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

(17) provide services that comply with the evidence-based practices described in paragraph (e).

(b) If an entity is unable to provide one or more of the services listed in paragraph (a), clauses (6) to (17), the commissioner may certify the entity as a CCBHC if it has a current contract with another entity that has the required authority to provide that service and that meets federal CCBHC criteria as a designated collaborating organization; or, to the extent allowed by the federal CCBHC criteria, the commissioner may approve a referral arrangement. The CCBHC must meet federal requirements regarding the type and scope of services to be provided directly by the CCBHC.

(c) Notwithstanding other law that requires a county contract or other form of county approval for certain services listed in paragraph (a), clause (6), a clinic that otherwise meets CCBHC requirements may receive the prospective payment under paragraph (f) for those services without a county contract or county approval. There is no county share when medical assistance pays the CCBHC prospective payment. As part of the certification process in paragraph (a), the commissioner shall require a letter of support from the CCBHC's host county confirming that the CCBHC and the county or counties it serves have an ongoing relationship to facilitate access and continuity of care, especially for individuals who are uninsured or who may go on and off medical assistance.

(d) When the standards listed in paragraph (a) or other applicable standards conflict or address similar issues in duplicative or incompatible ways, the commissioner may grant variances to state requirements if the variances do not conflict with federal requirements. If standards overlap, the commissioner may substitute all or a part of a licensure or certification that is substantially the same as another licensure or certification. The commissioner shall consult with stakeholders, as described in subdivision 4, before granting variances under this provision.

House Language H3467-3

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

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

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

(17) provide services that comply with the evidence-based practices described in paragraph (e).

(b) If an entity is unable to provide one or more of the services listed in paragraph (a), clauses (6) to (17), the commissioner may certify the entity as a CCBHC, if the entity has a current contract with another entity that has the required authority to provide that service and that meets federal CCBHC criteria as a designated collaborating organization, or, to the extent allowed by the federal CCBHC criteria, the commissioner may approve a referral arrangement. The CCBHC must meet federal requirements regarding the type and scope of services to be provided directly by the CCBHC.

(c) Notwithstanding other law that requires a county contract or other form of county approval for certain services listed in paragraph (a), clause (6), a clinic that otherwise meets CCBHC requirements may receive the prospective payment under paragraph (f) for those services without a county contract or county approval. There is no county share when medical assistance pays the CCBHC prospective payment. As part of the certification process in paragraph (a), the commissioner shall require a letter of support from the CCBHC's host county confirming that the CCBHC and the counties it serves have an ongoing relationship to facilitate access and continuity of care, especially for individuals who are uninsured or who may go on and off medical assistance.

(d) In situations where the standards in paragraph (a) or other applicable standards conflict or address similar issues in duplicative or incompatible ways, the commissioner may grant variances to state requirements as long as the variances do not conflict with federal requirements. In situations where standards overlap, the commissioner may decide to substitute all or a part of a licensure or certification that is substantially the same as another licensure or certification. The commissioner shall consult with stakeholders, as described in subdivision 4, before granting variances under this provision.

Senate Language UEH2749-1

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

~~(b)~~ (f) 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~~ an enhanced federal medical assistance percentage. The commissioner may include quality bonus payments in the prospective payment system based on federal criteria and on a clinic's provision of the evidence-based practices in paragraph (e). The prospective payments system does not apply to MinnesotaCare. Implementation of the prospective payment system is effective July 1, 2017, or upon federal approval, whichever is later.

(g) The commissioner shall seek federal approval to continue federal financial participation in payment for CCBHC services after the federal demonstration period ends for clinics that were certified as CCBHCs during the demonstration period and that continue to meet the CCBHC certification standards in paragraph (a). Payment for CCBHC services shall cease effective July 1, 2019, if continued federal financial participation for the payment of CCBHC services cannot be obtained.

(h) To the extent allowed by federal law, the commissioner may limit the number of certified clinics so that the projected claims for certified clinics will not exceed the funds budgeted for this purpose. The commissioner shall give preference to clinics that:

(1) are located in both rural and urban areas, with at least one in each area, as defined by federal criteria;

(2) provide a comprehensive range of services and evidence-based practices for all age groups, with services being fully coordinated and integrated; and

(3) enhance the state's ability to meet the federal priorities to be selected as a CCBHC demonstration state.

House Language H3467-3

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

~~(b)~~ (f) 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~~ an enhanced federal medical assistance percentage. The commissioner may include quality bonus payments in the prospective payment system based on federal criteria and on a clinic's provision of the evidence-based practices in paragraph (e). The prospective payments system does not apply to MinnesotaCare. Implementation of the prospective payment system is effective July 1, 2017, or upon federal approval, whichever is later.

(g) The commissioner shall seek federal approval to continue federal financial participation in payment for CCBHC services after the federal demonstration period ends for clinics that were certified as CCBHCs during the demonstration period and that continue to meet the CCBHC certification standards in paragraph (a). Payment for CCBHC services shall cease effective July 1, 2019, if continued federal financial participation for the payment of CCBHC services cannot be obtained.

(h) To the extent allowed by federal law, the commissioner may limit the number of certified clinics so that the projected claims for certified clinics will not exceed the funds budgeted for this purpose. The commissioner shall give preference to clinics that:

(1) are located in both rural and urban areas, with at least one in each, as defined by federal criteria;

(2) provide a comprehensive range of services and evidence-based practices for all age groups, with services being fully coordinated and integrated; and

(3) enhance the state's ability to meet the federal priorities to be selected as a CCBHC demonstration state.

Senate Language UEH2749-1

(i) The commissioner shall recertify CCBHCs at least every three years. The commissioner shall establish a process for decertification and shall require corrective action, medical assistance repayment, or decertification of a CCBHC that no longer meets the requirements in this section or that fails to meet the standards provided by the commissioner in the application and certification process.

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

Sec. 2. Minnesota Statutes 2015 Supplement, section 245.735, subdivision 4, is amended to read:

Subd. 4. **Public participation.** In developing ~~the projects~~ and implementing certified community behavioral health clinics under subdivision 3, the commissioner shall consult, collaborate, and partner with stakeholders, including but not limited to mental health providers, substance use disorder treatment providers, advocacy organizations, licensed mental health professionals, counties, tribes, hospitals, other health care providers, and Minnesota public health care program enrollees who receive mental health services and their families.

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

Sec. 3. Minnesota Statutes 2014, section 245.99, subdivision 2, is amended to read:

Subd. 2. **Rental assistance.** The program shall pay up to 90 days of housing assistance for persons with a serious ~~and persistent~~ mental illness who require inpatient or residential care for stabilization. The commissioner of human services may extend the length of assistance on a case-by-case basis.

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

Sec. 4. Minnesota Statutes 2014, section 254B.01, subdivision 4a, is amended to read:

Subd. 4a. **Culturally specific program.** (a) "Culturally specific program" means a substance use disorder treatment service program or subprogram that is recovery-focused and culturally specific when the program:

(1) improves service quality to and outcomes of a specific population by advancing health equity to help eliminate health disparities; and

(2) ensures effective, equitable, comprehensive, and respectful quality care services that are responsive to an individual within a specific population's values, beliefs and practices, health literacy, preferred language, and other communication needs.

House Language H3467-3

(i) The commissioner shall recertify CCBHCs at least every three years. The commissioner shall establish a process for decertification and shall require corrective action, medical assistance repayment, or decertification of a CCBHC that no longer meets the requirements in this section or that fails to meet the standards provided by the commissioner in the application and certification process.

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

Sec. 2. Minnesota Statutes 2015 Supplement, section 245.735, subdivision 4, is amended to read:

Subd. 4. **Public participation.** In developing ~~the projects~~ and implementing certified community behavioral health clinics under subdivision 3, the commissioner shall consult, collaborate, and partner with stakeholders, including but not limited to mental health providers, substance use disorder treatment providers, advocacy organizations, licensed mental health professionals, counties, tribes, hospitals, other health care providers, and Minnesota public health care program enrollees who receive mental health services and their families.

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Sec. 3. Minnesota Statutes 2014, section 245.99, subdivision 2, is amended to read:

Subd. 2. **Rental assistance.** The program shall pay up to 90 days of housing assistance for persons with a serious ~~and persistent~~ mental illness who require inpatient or residential care for stabilization. The commissioner of human services may extend the length of assistance on a case-by-case basis.

Senate Language UEH2749-1

(b) A tribally licensed substance use disorder program that is designated as serving a culturally specific population by the applicable tribal government is deemed to satisfy this subdivision.

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

Sec. 5. Minnesota Statutes 2014, section 254B.03, subdivision 4, is amended to read:

Subd. 4. **Division of costs.** (a) Except for services provided by a county under section 254B.09, subdivision 1, or services provided under section 256B.69 ~~or 256D.03, subdivision 4, paragraph (b)~~, the county shall, out of local money, pay the state for 22.95 percent of the cost of chemical dependency services, including those services provided to persons eligible for medical assistance under chapter 256B and general assistance medical care under chapter 256D. Counties may use the indigent hospitalization levy for treatment and hospital payments made under this section.

(b) 22.95 percent of any state collections from private or third-party pay, less 15 percent for the cost of payment and collections, must be distributed to the county that paid for a portion of the treatment under this section.

(c) For fiscal year 2017 only, the 22.95 percentages under paragraphs (a) and (b) are equal to 15 percent.

Sec. 6. Minnesota Statutes 2014, section 254B.04, subdivision 2a, is amended to read:

Subd. 2a. **Eligibility for treatment in residential settings.** Notwithstanding provisions of Minnesota Rules, part 9530.6622, subparts 5 and 6, related to an assessor's discretion in making placements to residential treatment settings, a person eligible for services under this section must score at level 4 on assessment dimensions related to relapse, continued use, or recovery environment in order to be assigned to services with a room and board component reimbursed under this section. Whether a treatment facility has been designated an institution for mental diseases under United States Code, title 42, section 1396d, shall not be a factor in making placements.

Sec. 7. Minnesota Statutes 2015 Supplement, 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.

House Language H3467-3

Sec. 4. Minnesota Statutes 2014, section 254B.03, subdivision 4, is amended to read:

Subd. 4. **Division of costs.** (a) Except for services provided by a county under section 254B.09, subdivision 1, or services provided under section 256B.69 or 256D.03, subdivision 4, paragraph (b), the county shall, out of local money, pay the state for 22.95 percent of the cost of chemical dependency services, including those services provided to persons eligible for medical assistance under chapter 256B and general assistance medical care under chapter 256D. Counties may use the indigent hospitalization levy for treatment and hospital payments made under this section. 22.95 percent of any state collections from private or third-party pay, less 15 percent for the cost of payment and collections, must be distributed to the county that paid for a portion of the treatment under this section.

(b) For fiscal year 2017 only, the county percent of cost of chemical dependency services shall be reduced from 22.95 percent to 15 percent.

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

Sec. 5. Minnesota Statutes 2014, section 254B.04, subdivision 2a, is amended to read:

Subd. 2a. **Eligibility for treatment in residential settings.** Notwithstanding provisions of Minnesota Rules, part 9530.6622, subparts 5 and 6, related to an assessor's discretion in making placements to residential treatment settings, a person eligible for services under this section must score at level 4 on assessment dimensions related to relapse, continued use, or recovery environment in order to be assigned to services with a room and board component reimbursed under this section. Whether a treatment facility has been designated an institution for mental diseases under United States Code, title 42, section 1396d, shall not be a factor in making placements.

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

Senate Language UEH2749-1

House Language H3467-3

(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;

(7) high-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 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 subdivision 1a.

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

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

(i) provides on-site child care during the hours of treatment activity that:

(A) is licensed under chapter 245A as a child care center under Minnesota Rules, chapter 9503; or

(B) meets the licensure exclusion criteria of section 245A.03, subdivision 2, paragraph (a), clause (6), and meets the requirements under Minnesota Rules, part 9530.6490, subpart 4; 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 4a, or programs or subprograms serving special populations, if the program or subprogram meets the following requirements ~~in Minnesota Rules, part~~ 9530.6605~~, subpart 13~~;:

(i) is designed to address the unique needs of individuals who share a common language, racial, ethnic, or social background;

(ii) is governed with significant input from individuals of that specific background; and

(iii) employs individuals to provide individual or group therapy, at least 50 percent of whom are of that specific background, except when the common social background of the individuals served is a traumatic brain injury or cognitive disability and the program employs treatment staff who have the necessary professional training, as approved by the commissioner, to serve clients with the specific disabilities that the program is designed to serve;

(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;

Senate Language UEH2749-1

(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~~ shall 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).

(f) Subject to federal approval, chemical dependency services that are otherwise covered as direct face-to-face services may be provided via two-way interactive video. The use of two-way interactive video must be medically appropriate to the condition and needs of the person being served. Reimbursement shall be at the same rates and under the same conditions that would otherwise apply to direct face-to-face services. The interactive video equipment and connection must comply with Medicare standards in effect at the time the service is provided.

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

Sec. 8. Minnesota Statutes 2014, section 254B.06, subdivision 2, is amended to read:

Subd. 2. **Allocation of collections.** (a) The commissioner shall allocate all federal financial participation collections to a special revenue account. The commissioner shall allocate 77.05 percent of patient payments and third-party payments to the special revenue account and 22.95 percent to the county financially responsible for the patient.

(b) For fiscal year 2017 only, the percentage under paragraph (a) that the commissioner shall pay is 85 percent, and the percentage the county shall pay is 15 percent.

Sec. 9. Minnesota Statutes 2014, section 254B.06, is amended by adding a subdivision to read:

House Language H3467-3

Sec. 6. Minnesota Statutes 2014, section 254B.06, subdivision 2, is amended to read:

Subd. 2. **Allocation of collections.** (a) The commissioner shall allocate all federal financial participation collections to a special revenue account. The commissioner shall allocate 77.05 percent of patient payments and third-party payments to the special revenue account and 22.95 percent to the county financially responsible for the patient.

(b) For fiscal year 2017 only, the commissioner's allocation to the special revenue account shall be increased from 77.05 percent to 85 percent and the county financial responsibility shall be reduced from 22.95 percent to 15 percent.

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

Sec. 7. Minnesota Statutes 2014, section 254B.06, is amended by adding a subdivision to read:

Senate Language UEH2749-1

Subd. 4. **Reimbursement for institutions for mental diseases.** The commissioner shall not deny reimbursement to a program designated as an institution for mental diseases under United States Code, title 42, section 1396d, due to a reduction in federal financial participation and the addition of new residential beds.

Sec. 10. Minnesota Statutes 2014, section 256B.0621, subdivision 10, is amended to read:

Subd. 10. **Payment rates.** The commissioner shall set payment rates for targeted case management under this subdivision. Case managers may bill according to the following criteria:

(1) for relocation targeted case management, case managers may bill for direct case management activities, including face-to-face ~~and~~, telephone contacts, and interactive video contact in accordance with section 256B.0924, subdivision 4a, in the lesser of:

(i) 180 days preceding an eligible recipient's discharge from an institution; or

(ii) the limits and conditions which apply to federal Medicaid funding for this service;

House Language H3467-3

Subd. 4. **Reimbursement for institutions for mental diseases.** The commissioner shall not deny reimbursement to a program designated as an institution for mental diseases under United States Code, title 42, section 1396d, due to a reduction in federal financial participation and the addition of new residential beds.

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

Sec. 8. **[254B.15] PILOT PROJECTS; TREATMENT FOR PREGNANT AND POSTPARTUM WOMEN WITH SUBSTANCE USE DISORDER.**

Subdivision 1. **Pilot projects established.** (a) Within the limits of federal funds available specifically for this purpose, the commissioner of human services shall establish pilot projects to provide substance use disorder treatment and services to pregnant and postpartum women with a primary diagnosis of substance use disorder, including opioid use disorder. Pilot projects funded under this section must:

(1) promote flexible uses of funds to provide treatment and services to pregnant and postpartum women with substance use disorders;

(2) fund family-based treatment and services for pregnant and postpartum women with substance use disorders;

(3) identify gaps in services along the continuum of care that are provided to pregnant and postpartum women with substance use disorders; and

(4) encourage new approaches to service delivery and service delivery models.

(b) A pilot project funded under this section must provide at least a portion of its treatment and services to women who receive services on an outpatient basis.

Subd. 2. **Federal funds.** The commissioner shall apply for any available grant funds from the federal Center for Substance Abuse Treatment for these pilot projects.

Sec. 9. Minnesota Statutes 2014, section 256B.0621, subdivision 10, is amended to read:

Subd. 10. **Payment rates.** The commissioner shall set payment rates for targeted case management under this subdivision. Case managers may bill according to the following criteria:

(1) for relocation targeted case management, case managers may bill for direct case management activities, including face-to-face ~~and~~, telephone contacts, and interactive video contact in accordance with section 256B.0924, subdivision 4a, in the lesser of:

(i) 180 days preceding an eligible recipient's discharge from an institution; or

(ii) the limits and conditions which apply to federal Medicaid funding for this service;

Senate Language UEH2749-1

(2) for home care targeted case management, case managers may bill for direct case management activities, including face-to-face and telephone contacts; and

(3) billings for targeted case management services under this subdivision shall not duplicate payments made under other program authorities for the same purpose.

Sec. 11. Minnesota Statutes 2014, section 256B.0622, is amended by adding a subdivision to read:

Subd. 12. **Start-up grants.** The commissioner may, within available appropriations, disburse grant funding to counties, Indian tribes, or mental health service providers to establish additional assertive community treatment teams, intensive residential treatment services, or crisis residential services.

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

Sec. 12. Minnesota Statutes 2015 Supplement, section 256B.0625, subdivision 20, is amended to read:

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

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

(c) Medical assistance and MinnesotaCare payment for mental health case management shall be made on a monthly basis. In order to receive payment for an eligible child, the provider must document at least a face-to-face contact with the child, the child's parents, or the child's legal representative. To receive payment for an eligible adult, the provider must document:

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

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

House Language H3467-3

(2) for home care targeted case management, case managers may bill for direct case management activities, including face-to-face and telephone contacts; and

(3) billings for targeted case management services under this subdivision shall not duplicate payments made under other program authorities for the same purpose.

Sec. 10. Minnesota Statutes 2015 Supplement, section 256B.0625, subdivision 20, is amended to read:

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

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

(c) Medical assistance and MinnesotaCare payment for mental health case management shall be made on a monthly basis. In order to receive payment for an eligible child, the provider must document at least a face-to-face contact with the child, the child's parents, or the child's legal representative. To receive payment for an eligible adult, the provider must document:

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

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

Senate Language UEH2749-1

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

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

(f) Payment for mental health case management provided by vendors who contract with a county or Indian tribe shall be based on a monthly rate negotiated by the host county or tribe. The negotiated rate must not exceed the rate charged by the vendor for the same service to other payers. If the service is provided by a team of contracted vendors, the county or tribe may negotiate a team rate with a vendor who is a member of the team. The team shall determine how to distribute the rate among its members. No reimbursement received by contracted vendors shall be returned to the county or tribe, except to reimburse the county or tribe for advance funding provided by the county or tribe to the vendor.

(g) If the service is provided by a team which includes contracted vendors, tribal staff, and county or state staff, the costs for county or state staff participation in the team shall be included in the rate for county-provided services. In this case, the contracted vendor, the tribal agency, and the county may each receive separate payment for services provided by each entity in the same month. In order to prevent duplication of services, each entity must document, in the recipient's file, the need for team case management and a description of the roles of the team members.

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

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

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

House Language H3467-3

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

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

(f) Payment for mental health case management provided by vendors who contract with a county or Indian tribe shall be based on a monthly rate negotiated by the host county or tribe. The negotiated rate must not exceed the rate charged by the vendor for the same service to other payers. If the service is provided by a team of contracted vendors, the county or tribe may negotiate a team rate with a vendor who is a member of the team. The team shall determine how to distribute the rate among its members. No reimbursement received by contracted vendors shall be returned to the county or tribe, except to reimburse the county or tribe for advance funding provided by the county or tribe to the vendor.

(g) If the service is provided by a team which includes contracted vendors, tribal staff, and county or state staff, the costs for county or state staff participation in the team shall be included in the rate for county-provided services. In this case, the contracted vendor, the tribal agency, and the county may each receive separate payment for services provided by each entity in the same month. In order to prevent duplication of services, each entity must document, in the recipient's file, the need for team case management and a description of the roles of the team members.

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

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

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

Senate Language UEH2749-1

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

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

(2) programming the information systems.

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

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

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

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

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

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

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

Sec. 13. Minnesota Statutes 2014, section 256B.0625, is amended by adding a subdivision to read:

Subd. 20b. **Mental health targeted case management through interactive video.**

(a) Subject to federal approval, contact made for targeted case management by interactive video shall be eligible for payment if:

(1) the person receiving targeted case management services is residing in:

(i) a hospital;

(ii) a nursing facility; or

House Language H3467-3

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

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

(2) programming the information systems.

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

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

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

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

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

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

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

Sec. 11. Minnesota Statutes 2014, section 256B.0625, is amended by adding a subdivision to read:

Subd. 20b. **Mental health targeted case management through interactive video.**

(a) Subject to federal approval, contact made for targeted case management by interactive video shall be eligible for payment under section 256B.0924, subdivision 6, if:

(1) the person receiving targeted case management services is residing in:

(i) a hospital;

(ii) a nursing facility; or

Senate Language UEH2749-1

(iii) a residential setting licensed under chapter 245A or 245D, or a boarding and lodging establishment or lodging establishment that provides supportive services or health supervision services according to section 157.17, which is staffed 24 hours per day, seven days per week;

(2) interactive video is in the best interests of the person and is deemed appropriate by the person receiving targeted case management or their legal guardian, the case management provider, and the provider operating the setting where the person is residing;

(3) the use of interactive video is approved as part of the person's written personal service or case plan taking into consideration the person's vulnerability and active personal relationships; and

(4) interactive video is used for up to, but not more than, 50 percent of the minimum required face-to-face contacts.

(b) The person receiving targeted case management or their legal guardian has the right to choose and consent to the use of interactive video under this subdivision, and has the right to refuse the use of interactive video at any time.

(c) The commissioner shall establish criteria that a targeted case management provider must attest to in order to demonstrate the safety or efficacy of delivering the service via interactive video. The attestation may include that the case management provider:

(1) has written policies and procedures specific to interactive video services that are regularly reviewed and updated;

(2) has polices and procedures that adequately address client safety before, during, and after the interactive video service is rendered;

(3) has established protocols addressing how and when to discontinue interactive video services; and

(4) has an established quality assurance process related to interactive video services.

(d) As a condition of payment, the targeted case management provider must document each occurrence of targeted case management provided by interactive video and must document:

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

(2) the basis for determining that interactive video is an appropriate and effective means for delivering the service to the enrollees;

(3) the mode of transmission of the interactive video service and records evidencing that a particular mode of transmission was utilized;

(4) the location of the originating site and the distant site; and

House Language H3467-3

(iii) a residential setting licensed under chapter 245A or 245D, or a boarding and lodging establishment or a lodging establishment that provides supportive services or health supervision services according to section 157.17, that is staffed 24 hours per day, seven days per week;

(2) interactive video is in the best interests of the person and is deemed appropriate by the person receiving targeted case management or the person's legal guardian, the case management provider, and the provider operating the setting where the person is residing;

(3) the use of interactive video is approved as part of the person's written personal service or case plan taking into consideration the person's vulnerability and active personal relationships; and

(4) interactive video is used for up to, but not more than, 50 percent of the minimum required face-to-face contacts.

(b) The person receiving targeted case management or the person's legal guardian has the right to choose and consent to the use of interactive video under this subdivision and has the right to refuse the use of interactive video at any time.

(c) The commissioner shall establish criteria that a targeted case management provider must attest to in order to demonstrate the safety or efficacy of delivering the service via interactive video. The attestation may include that the case management provider has:

(1) written policies and procedures specific to interactive video services that are regularly reviewed and updated;

(2) policies and procedures that adequately address client safety before, during, and after the interactive video services are rendered;

(3) established protocols addressing how and when to discontinue interactive video services; and

(4) established a quality assurance process related to interactive video services.

(d) As a condition of payment, the targeted case management provider must document the following for each occurrence of targeted case management provided by interactive video:

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

(2) the basis for determining that interactive video is an appropriate and effective means for delivering the service to the person receiving case management services;

(3) the mode of transmission of the interactive video services and records evidencing that a particular mode of transmission was utilized;

(4) the location of the originating site and the distant site; and

Senate Language UEH2749-1

(5) compliance with the criteria attested to by the health care provider in accordance with paragraph (c).

Sec. 14. Minnesota Statutes 2014, section 256B.0924, is amended by adding a subdivision to read:

Subd. 4a. **Targeted case management through interactive video.** (a) Subject to federal approval, contact made for targeted case management by interactive video shall be eligible for payment if:

(1) the person receiving targeted case management services is residing in:

(i) a hospital;

(ii) a nursing facility; or

(iii) a residential setting licensed under chapter 245A or 245D, or a boarding and lodging establishment or lodging establishment that provides supportive services or health supervision services according to section 157.17, and that is staffed 24 hours per day, seven days per week;

(2) interactive video is in the best interests of the person and is deemed appropriate by the person receiving targeted case management or their legal guardian, the case management provider, and the provider operating the setting where the person is residing;

(3) the use of interactive video is approved as part of the person's written personal service or case plan; and

(4) interactive video is used for up to, but not more than, 50 percent of the minimum required face-to-face contacts.

(b) The person receiving targeted case management or their legal guardian has the right to choose and consent to the use of interactive video under this subdivision, and has the right to refuse the use of interactive video at any time.

(c) The commissioner shall establish criteria that a targeted case management provider must attest to in order to demonstrate the safety or efficacy of delivering the service via interactive video. The attestation may include that the case management provider:

(1) has written policies and procedures specific to interactive video services that are regularly reviewed and updated;

(2) has polices and procedures that adequately address client safety before, during, and after the interactive video service is rendered;

(3) has established protocols addressing how and when to discontinue interactive video services; and

(4) has an established quality assurance process related to interactive video services.

House Language H3467-3

(5) compliance with the criteria attested to by the targeted case management provider as provided in paragraph (c).

Sec. 12. Minnesota Statutes 2014, section 256B.0924, is amended by adding a subdivision to read:

Subd. 4a. **Targeted case management through interactive video.** (a) Subject to federal approval, contact made for targeted case management by interactive video shall be eligible for payment under subdivision 6 if:

(1) the person receiving targeted case management services is residing in:

(i) a hospital;

(ii) a nursing facility;

(iii) a residential setting licensed under chapter 245A or 245D, or a boarding and lodging establishment or a lodging establishment that provides supportive services or health supervision services according to section 157.17, that is staffed 24 hours per day, seven days per week;

(2) interactive video is in the best interests of the person and is deemed appropriate by the person receiving targeted case management or the person's legal guardian, the case management provider, and the provider operating the setting where the person is residing;

(3) the use of interactive video is approved as part of the person's written personal service or case plan; and

(4) interactive video is used for up to, but not more than, 50 percent of the minimum required face-to-face contacts.

(b) The person receiving targeted case management or the person's legal guardian has the right to choose and consent to the use of interactive video under this subdivision and has the right to refuse the use of interactive video at any time.

(c) The commissioner shall establish criteria that a targeted case management provider must attest to in order to demonstrate the safety or efficacy of delivering the service via interactive video. The attestation may include that the case management provider has:

(1) written policies and procedures specific to interactive video services that are regularly reviewed and updated;

(2) policies and procedures that adequately address client safety before, during, and after the interactive video services are rendered;

(3) established protocols addressing how and when to discontinue interactive video services; and

(4) established a quality assurance process related to interactive video services.

Senate Language UEH2749-1

(d) As a condition of payment, the targeted case management provider must document each occurrence of targeted case management provided by interactive video and must document:

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

(2) the basis for determining that interactive video is an appropriate and effective means for delivering the service to the enrollees;

(3) the mode of transmission of the interactive video service and records evidencing that a particular mode of transmission was utilized;

(4) the location of the originating site and the distant site; and

(5) compliance with the criteria attested to by the health care provider in accordance with paragraph (c).

Sec. 15. **CHILDREN'S MENTAL HEALTH COLLABORATIVE; YOUTH AND YOUNG ADULT MENTAL HEALTH DEMONSTRATION PROJECT.**

(a) The commissioner of human services shall grant funds to a children's mental health collaborative for a rural demonstration project to assist transition-aged youth and young adults with emotional behavioral disturbance (EBD) or mental illnesses in making a successful transition into adulthood.

(b) The demonstration project must:

(1) build on and streamline transition services by identifying rural youth ages 15 to 25 currently in the mental health system or with emerging mental health conditions;

(2) support youth to achieve, within their potential, their personal goals in employment, education, housing, and community life functioning;

(3) provide individualized motivational coaching;

(4) build on needed social supports;

(5) demonstrate how services can be enhanced for youth to successfully navigate the complexities associated with their unique needs;

(6) utilize all available funding streams;

(7) demonstrate collaboration with the local children's mental health collaborative in designing and implementing the demonstration project;

(8) evaluate the effectiveness of the project by specifying and measuring outcomes showing the level of progress for involved youth; and

House Language H3467-3

(d) As a condition of payment, the targeted case management provider must document the following for each occurrence of targeted case management provided by interactive video:

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

(2) the basis for determining that interactive video is an appropriate and effective means for delivering the service to the person receiving case management services;

(3) the mode of transmission of the interactive video services and records evidencing that a particular mode of transmission was utilized;

(4) the location of the originating site and the distant site; and

(5) compliance with the criteria attested to by the targeted case management provider as provided in paragraph (c).

Sec. 14. **RURAL DEMONSTRATION PROJECT.**

(a) Children's mental health collaboratives under Minnesota Statutes, section 245.493, are eligible to apply for grant funding under this section. The commissioner shall solicit proposals and select the proposal that best meets the requirements under paragraph (c). Only one demonstration project may be funded under this section.

(b) The demonstration project must:

(1) support youth served to achieve, within their potential, their personal goals in employment, education, living situation, personal effectiveness, and community life functioning;

(2) build on and streamline transition services by identifying rural youth ages 15 to 25 currently in the mental health system or with emerging mental health conditions;

(3) provide individualized motivational coaching;

(4) build needed social supports;

(5) demonstrate how services can be enhanced for youth to successfully navigate the complexities associated with their unique needs;

(6) utilize all available funding streams;

(7) evaluate the effectiveness of the project; and

(8) compare differences in outcomes and costs to youth without previous access to this project.

Senate Language UEH2749-1

(9) compare differences in outcomes and costs to youth without previous access to this project.

(c) The commissioner shall report to the committee members of the senate and house of representatives committees with jurisdiction over mental health issues on the status and outcomes of the demonstration project by January 15, 2019. The children's mental health collaborative administering the demonstration project shall collect and report outcome data, as outlined by the commissioner, to support the development of this report.

Sec. 16. **COMMISSIONER DUTY TO SEEK FEDERAL APPROVAL FOR INTERACTIVE VIDEO CONTACT.**

The commissioner of human services shall seek federal approval that is necessary to implement the sections of this article related to reimbursement for interactive video contact.

House Language H3467-3

(c) The commissioner shall report to the chairs and ranking minority members of the house of representatives and senate committees with jurisdiction over mental health issues on the status and outcomes of the demonstration project by January 15, 2019. The children's mental health collaboratives administering the demonstration project shall collect and report outcome data, per guidelines approved by the commissioner, to support the development of this report.

Sec. 13. **COMMISSIONER DUTY TO SEEK FEDERAL APPROVAL.**

The commissioner of human services shall seek federal approval that is necessary to implement Minnesota Statutes, sections 256B.0621, subdivision 10, and 256B.0625, subdivision 20, for interactive video contact.