..... moves to amend H.F. No. 4366 as follows:

Delete everything after the enacting clause and insert:

"ARTICLE 1

PRIORITY ADMISSIONS TO STATE-OPERATED TREATMENT PROGRAMS

Section 1. Minnesota Statutes 2023 Supplement, section 253B.10, subdivision 1, is amended to read:

Subdivision 1. **Administrative requirements.** (a) When a person is committed, the court shall issue a warrant or an order committing the patient to the custody of the head of the treatment facility, state-operated treatment program, or community-based treatment program. The warrant or order shall state that the patient meets the statutory criteria for civil commitment.

(b) ~~The commissioner shall prioritize patients being admitted from jail or a correctional institution who are~~ A person committed to the commissioner will be prioritized for admission to a medically appropriate direct care and treatment program based on the decisions of physicians in the executive medical director's office, using a priority admissions framework. The framework must account for a range of factors for priority admission, including but not limited to:

(1) ~~ordered confined in a state-operated treatment program for an examination under Minnesota Rules of Criminal Procedure, rules 20.01, subdivision 4, paragraph (a), and 20.02, subdivision 2~~ the length of time the person has been on a waiting list for admission to a direct care and treatment program;

(2) ~~under civil commitment for competency treatment and continuing supervision under Minnesota Rules of Criminal Procedure, rule 20.01, subdivision 7~~ the intensity of the treatment the person needs, based on medical acuity;

(3) ~~found not guilty by reason of mental illness under Minnesota Rules of Criminal Procedure, rule 20.02, subdivision 8, and under civil commitment or are ordered to be detained in a state-operated treatment program pending completion of the civil commitment proceedings; or~~ the person's provisional discharge status;

(4) ~~committed under this chapter to the commissioner after dismissal of the patient's criminal charges.~~ the person's safety and safety of others in the person's current environment;

(5) whether the person has access to necessary treatment in a program that is not a direct care and treatment program;

(6) negative impacts of an admission delay on the facility referring the individual for treatment; and

(7) any relevant federal prioritization requirements.

~~Patients described in this paragraph must be admitted to a state-operated treatment program within 48 hours. The commitment must be ordered by the court as provided in section 253B.09, subdivision 1, paragraph (d).~~

(c) Upon the arrival of a patient at the designated treatment facility, state-operated treatment program, or community-based treatment program, the head of the facility or program shall retain the duplicate of the warrant and endorse receipt upon the original warrant or acknowledge receipt of the order. The endorsed receipt or acknowledgment must be filed in the court of commitment. After arrival, the patient shall be under the control and custody of the head of the facility or program.

(d) Copies of the petition for commitment, the court's findings of fact and conclusions of law, the court order committing the patient, the report of the court examiners, and the prepetition report, and any medical and behavioral information available shall be provided at the time of admission of a patient to the designated treatment facility or program to which the patient is committed. Upon a patient's referral to the commissioner of human services for admission pursuant to subdivision 1, paragraph (b), any inpatient hospital, treatment facility, jail, or correctional facility that has provided care or supervision to the patient in the previous two years shall, when requested by the treatment facility or commissioner, provide copies of the patient's medical and behavioral records to the Department of Human Services for purposes of preadmission planning. This information shall be provided by the head of the treatment facility to treatment facility staff in a consistent and timely manner and pursuant to all applicable laws.

(e) Patients described in paragraph (b) must be admitted to a state-operated treatment program within 48 hours of the Office of Medical Director, under section 246.018, or a designee determining that a medically appropriate bed is available. This paragraph expires on June 30, 2025.

(f) A panel appointed by the commissioner, consisting of all members who served on the Task Force on Priority Admissions to State-Operated Treatment Programs under Minnesota Laws 2023, chapter 61, article 8, section 13, subdivision 2, must review de-identified data quarterly for one year following the implementation of the priority admissions framework to ensure that the framework is implemented and applied equitably. If the panel requests to review data that is classified as private or confidential and the commissioner determines the data requested is necessary for the scope of the panel's review, the commissioner is authorized to disclose private or confidential data to the panel under this paragraph and pursuant to section 13.05, subdivision 4, paragraph (b), for private or confidential data collected prior to the effective date of this paragraph. The panel must also advise the commissioner on the effectiveness of the framework and priority admissions generally. After the panel completes its year of review, a quality committee established by the Department of Direct Care and Treatment executive board will continue to review data and provide a routine report to the executive board on the effectiveness of the framework and priority admissions.

(g) The commissioner may immediately approve an exception to add up to ten civilly committed patients who are awaiting admission in hospital settings to the priority admissions waiting list for admission to medically appropriate direct care and treatment programs. Admissions of these patients must be managed according to the priority admissions framework under paragraph (b). This paragraph expires upon the commissioner's approval of the exception, or on August 1, 2024, whichever is sooner.

ARTICLE 2
COMMUNITY BEHAVIORAL HEALTH SERVICES

Section 1. Minnesota Statutes 2022, section 245.4905, is amended to read:

245.4905 FIRST EPISODE OF PSYCHOSIS GRANT PROGRAM.

Subdivision 1. **Creation.** The first episode of psychosis grant program is established in the Department of Human Services to fund evidence-based interventions for youth and young adults at risk of developing or experiencing ~~a~~ an early or first episode of psychosis ~~and a public awareness campaign on the signs and symptoms of psychosis~~. First episode of psychosis services are eligible for children's mental health grants as specified in section

245.4889, subdivision 1, paragraph (b), clause (15). The Department of Human Services must seek to fund eligible providers of first episode of psychosis services and assist with program establishment throughout the state.

Subd. 2. **Activities.** (a) All first episode of psychosis grant programs must:

(1) provide intensive treatment and support for adolescents and young adults experiencing or at risk of experiencing ~~a~~ an early or first psychotic episode. Intensive treatment and support includes medication management, psychoeducation for an individual and an individual's family, case management, employment support, education support, cognitive behavioral approaches, social skills training, peer support, family peer support, crisis planning, and stress management;

(2) conduct outreach and provide training and guidance to mental health and health care professionals, including postsecondary health clinicians, on early psychosis symptoms, screening tools, the first episode of psychosis program, and best practices;

(3) ensure access for individuals to first psychotic episode services under this section~~, including access for individuals who live in rural areas~~; and

(4) use all available funding streams.

(b) Grant money may also be used to pay for housing or travel expenses for individuals receiving services or to address other barriers preventing individuals and their families from participating in first psychotic episode services.

Subd. 3. **Eligibility.** Program activities must be provided to people 15 to 40 years old ~~with~~ who have early signs of psychosis or who have experienced an early or first episode of psychosis.

Subd. 4. **Outcomes.** Evaluation of program activities must utilize evidence-based practices and must include the following outcome evaluation criteria:

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

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

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

Subd. 5. **Federal aid or grants.** (a) The commissioner of human services must comply with all conditions and requirements necessary to receive federal aid or grants.

(b) The commissioner must provide an annual report to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services

policy and finance, the senate Finance Committee, and the house of representatives Ways and Means Committee detailing the use of state and federal funds for the first episode of psychosis grant program, the number of programs funded, the number of individuals served across all grant-funded programs, and outcome and evaluation data.

Sec. 2. **[245.4908] EARLY EPISODE OF BIPOLAR DISORDER GRANT PROGRAM.**

Subdivision 1. **Creation.** The early episode of bipolar disorder grant program is established in the Department of Human Services, to fund evidence-based interventions for youth and young adults at risk of developing or experiencing an early episode of bipolar disorder. Early episode of bipolar disorder services are eligible for children's mental health grants as specified in section 245.4889, subdivision 1, paragraph (b), clause (15). The Department of Human Services must seek to fund eligible programs throughout the state.

Subd. 2. **Activities.** (a) All early episode of bipolar grant program recipients must:

(1) provide intensive treatment and support for adolescents and young adults experiencing or at risk of experiencing early episode of bipolar disorder. Intensive treatment and support includes medication management, psychoeducation for an individual and an individual's family, case management, employment support, education support, cognitive behavioral approaches, social skills training, peer and family peer support, crisis planning, and stress management;

(2) conduct outreach and provide training and guidance to mental health and health care professionals, including postsecondary health clinicians, on bipolar disorder symptoms, screening tools, the recipient's program, and best practices; and

(3) use all available funding streams.

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

Subd. 3. **Service eligibility.** A grant recipient's program activities must be provided to individuals between 15 and 40 years of age who have early signs of or are experiencing bipolar disorder.

Subd. 4. **Outcomes.** Evaluation of program activities must utilize evidence-based practices and must include the following outcome evaluation criteria:

(1) whether individuals experience a reduction in symptoms;

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

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

Subd. 5. **Federal aid or grants.** (a) The commissioner of human services must comply with all conditions and requirements necessary to receive federal aid or grants.

(b) The commissioner must provide an annual report to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services policy and finance, the senate Finance Committee, and the house of representatives Ways and Means Committee detailing the use of state and federal funds for the early episode of bipolar disorder grant program, the number of programs funded, the number of individuals served across all grant-funded programs, and outcome and evaluation data.

Sec. 3. **[253B.042] ENGAGEMENT SERVICES PILOT GRANTS.**

Subdivision 1. **Creation.** The engagement services pilot grant program is established in the Department of Human Services, to provide grants to counties or certified community behavioral health centers to provide engagement services under section 253B.041. Engagement services provide early interventions to prevent an individual from meeting the criteria for civil commitment and promote positive outcomes.

Subd. 2. **Allowable grant activities.** (a) Grantees must use grant funding to:

(1) develop a system to respond to requests for engagement services;

(2) provide the following engagement services, taking into account an individual's preferences for treatment services and supports:

(i) assertive attempts to engage an individual in voluntary treatment for mental illness for at least 90 days;

(ii) efforts to engage an individual's existing support systems and interested persons, including but not limited to providing education on restricting means of harm and suicide prevention, when the provider determines that such engagement would be helpful; and

(iii) collaboration with the individual to meet the individual's immediate needs, including but not limited to housing access, food and income assistance, disability verification, medication management, and medical treatment;

(3) conduct outreach to families and providers; and

(4) evaluate the impact of engagement services on decreasing civil commitments, increasing engagement in treatment, decreasing police involvement with individuals exhibiting symptoms of serious mental illness, and other measures.

(b) Engagement services staff must have completed training on person-centered care. Staff may include but are not limited to mobile crisis providers under section 256B.0624, certified peer specialists under section 256B.0615, community-based treatment programs staff, and homeless outreach workers.

Subd. 3. **Outcome evaluation.** The commissioner of management and budget must formally evaluate outcomes of grants awarded under this section, using an experimental or quasi-experimental design. The commissioner shall consult with the commissioner of management and budget to ensure that grants are administered to facilitate this evaluation. Grantees must collect and provide the information needed to the commissioner of human services to complete the evaluation. The commissioner must provide the information collected to the commissioner of management and budget to conduct the evaluation. The commissioner of management and budget may obtain additional relevant data to support the evaluation study pursuant to section 15.08.

Sec. 4. Minnesota Statutes 2023 Supplement, section 254B.04, subdivision 1a, is amended to read:

Subd. 1a. **Client eligibility.** (a) Persons eligible for benefits under Code of Federal Regulations, title 25, part 20, who meet the income standards of section 256B.056, subdivision 4, and are not enrolled in medical assistance, are entitled to behavioral health fund services. State money appropriated for this paragraph must be placed in a separate account established for this purpose.

(b) Persons with dependent children who are determined to be in need of substance use disorder treatment pursuant to an assessment under section 260E.20, subdivision 1, or in need of chemical dependency treatment pursuant to a case plan under section 260C.201, subdivision 6, or 260C.212, shall be assisted by the local agency to access needed treatment services. Treatment services must be appropriate for the individual or family, which may include long-term care treatment or treatment in a facility that allows the dependent children to stay in the treatment facility. The county shall pay for out-of-home placement costs, if applicable.

(c) Notwithstanding paragraph (a), persons enrolled in medical assistance are eligible for room and board services under section 254B.05, subdivision 5, paragraph (b), clause (12).

(d) A client is eligible to have substance use disorder treatment paid for with funds from the behavioral health fund when the client:

(1) is eligible for MFIP as determined under chapter 256J;

(2) is eligible for medical assistance as determined under Minnesota Rules, parts 9505.0010 to 9505.0150;

(3) is eligible for general assistance, general assistance medical care, or work readiness as determined under Minnesota Rules, parts 9500.1200 to 9500.1318; or

(4) has income that is within current household size and income guidelines for entitled persons, as defined in this subdivision and subdivision 7.

(e) Clients who meet the financial eligibility requirement in paragraph (a) and who have a third-party payment source are eligible for the behavioral health fund if the third-party payment source pays less than 100 percent of the cost of treatment services for eligible clients.

(f) A client is ineligible to have substance use disorder treatment services paid for with behavioral health fund money if the client:

(1) has an income that exceeds current household size and income guidelines for entitled persons as defined in this subdivision and subdivision 7; or

(2) has an available third-party payment source that will pay the total cost of the client's treatment.

(g) A client who is disenrolled from a state prepaid health plan during a treatment episode is eligible for continued treatment service that is paid for by the behavioral health fund until the treatment episode is completed or the client is re-enrolled in a state prepaid health plan if the client:

(1) continues to be enrolled in MinnesotaCare, medical assistance, or general assistance medical care; or

(2) is eligible according to paragraphs (a) and (b) and is determined eligible by a local agency under section 254B.04.

(h) When a county commits a client under chapter 253B to a regional treatment center for substance use disorder services and the client is ineligible for the behavioral health fund, the county is responsible for the payment to the regional treatment center according to section 254B.05, subdivision 4.

(i) Notwithstanding paragraph (a), persons enrolled in MinnesotaCare are eligible for room and board services under section 254B.05, subdivision 1a, paragraph (d).

EFFECTIVE DATE. This section is effective January 1, 2025, or upon federal approval, whichever is later. The commissioner of human services shall inform the revisor of statutes when federal approval is obtained.

Sec. 5. Minnesota Statutes 2023 Supplement, section 254B.05, subdivision 5, is amended to read:

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

(b) Effective for services rendered on or after January 1, 2025, the commissioner shall increase rates for residential services subject to this section by ... percent. The commissioner shall adjust rates for such services annually according to the change from the midpoint of the previous rate year to the midpoint of the rate year for which the rate is being determined using the Centers for Medicare and Medicaid Services Medicare Economic Index as forecasted in the fourth quarter of the calendar year before the rate year. This paragraph does not apply to federally qualified health centers, rural health centers, Indian health services, certified community behavioral health clinics, cost-based rates, and rates that are negotiated with the county.

(c) For payments made under paragraph (b), if and to the extent that the commissioner identifies that the state has received federal financial participation for behavioral health services in excess of the amount allowed under Code of Federal Regulations, title 42, section 447.321, the state shall repay the excess amount to the Centers for Medicare and Medicaid Services with state money and maintain the full payment rate under paragraph (b).

(d) Effective for services rendered on or after January 1, 2025, the commissioner shall increase capitation payments made to managed care plans and county-based purchasing plans to reflect the rate increase for residential services provided in paragraph (b). Managed care and county-based purchasing plans must use the capitation rate increase provided under this paragraph to increase payment rates to behavioral health services providers. The commissioner must monitor the effect of this rate increase on enrollee access to services provided under paragraph (b). If for any contract year federal approval is not received for this paragraph, the commissioner must adjust the capitation rates paid to managed care plans and county-based purchasing plans for that contract year to reflect the removal of this provision. Contracts between managed care plans and county-based purchasing plans and providers to whom this paragraph applies must allow recovery of payments from those

providers if capitation rates are adjusted in accordance with this paragraph. Payment recoveries must not exceed the amount equal to any increase in rates that results from this provision.

~~(b)~~ (e) Eligible substance use disorder treatment services include:

(1) those licensed, as applicable, according to chapter 245G or applicable Tribal license and provided according to the following ASAM levels of care:

(i) ASAM level 0.5 early intervention services provided according to section 254B.19, subdivision 1, clause (1);

(ii) ASAM level 1.0 outpatient services provided according to section 254B.19, subdivision 1, clause (2);

(iii) ASAM level 2.1 intensive outpatient services provided according to section 254B.19, subdivision 1, clause (3);

(iv) ASAM level 2.5 partial hospitalization services provided according to section 254B.19, subdivision 1, clause (4);

(v) ASAM level 3.1 clinically managed low-intensity residential services provided according to section 254B.19, subdivision 1, clause (5);

(vi) ASAM level 3.3 clinically managed population-specific high-intensity residential services provided according to section 254B.19, subdivision 1, clause (6); and

(vii) ASAM level 3.5 clinically managed high-intensity residential services provided according to section 254B.19, subdivision 1, clause (7);

(2) comprehensive assessments provided according to sections 245.4863, paragraph (a), and 245G.05;

(3) treatment coordination services provided according to section 245G.07, subdivision 1, paragraph (a), clause (5);

(4) peer recovery support services provided according to section 245G.07, subdivision 2, clause (8);

(5) withdrawal management services provided according to chapter 245F;

(6) hospital-based treatment services that are licensed according to sections 245G.01 to 245G.17 or applicable tribal license and licensed as a hospital under sections 144.50 to 144.56;

(7) adolescent treatment programs that are licensed as outpatient treatment programs according to sections 245G.01 to 245G.18 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;

(8) ASAM 3.5 clinically managed high-intensity residential services that are licensed according to sections 245G.01 to 245G.17 and 245G.21 or applicable tribal license, which provide ASAM level of care 3.5 according to section 254B.19, subdivision 1, clause (7), and are 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

(9) room and board facilities that meet the requirements of subdivision 1a.

~~(c)~~ (f) The commissioner shall establish higher rates for programs that meet the requirements of paragraph ~~(b)~~ (e) 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) is licensed under chapter 245A and sections 245G.01 to 245G.19; 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 or culturally responsive programs as defined in section 254B.01, subdivision 4a;

(3) disability responsive programs as defined in section 254B.01, subdivision 4b;

(4) 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; or

(5) programs that offer services to individuals with co-occurring mental health and substance use disorder problems if:

(i) the program meets the co-occurring requirements in section 245G.20;

(ii) 25 percent of the counseling staff are licensed mental health professionals under section 245I.04, subdivision 2, or are students or licensing candidates under the supervision of a licensed alcohol and drug counselor supervisor and mental health professional under section 245I.04, subdivision 2, except that no more than 50 percent of the mental health staff may be students or licensing candidates with time documented to be directly related to provisions of co-occurring services;

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

(iv) the program has standards for multidisciplinary case review that include a monthly review for each client that, at a minimum, includes a licensed mental health professional and licensed alcohol and drug counselor, and their involvement in the review is documented;

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

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

~~(d)~~ (g) In order to be eligible for a higher rate under paragraph ~~(c)~~ (f), clause (1), a program that provides arrangements for off-site child care must maintain current documentation at the substance use disorder facility of the child care provider's current licensure to provide child care services.

~~(e)~~ (h) 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)~~ (f), clause (4), items (i) to (iv).

~~(f)~~ (i) Subject to federal approval, substance use disorder services that are otherwise covered as direct face-to-face services may be provided via telehealth as defined in section 256B.0625, subdivision 3b. The use of telehealth to deliver services 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.

~~(g)~~ (j) For the purpose of reimbursement under this section, substance use disorder treatment services provided in a group setting without a group participant maximum or maximum client to staff ratio under chapter 245G shall not exceed a client to staff ratio of 48 to one. At least one of the attending staff must meet the qualifications as established

under this chapter for the type of treatment service provided. A recovery peer may not be included as part of the staff ratio.

~~(h)~~ (k) Payment for outpatient substance use disorder services that are licensed according to sections 245G.01 to 245G.17 is limited to six hours per day or 30 hours per week unless prior authorization of a greater number of hours is obtained from the commissioner.

~~(i)~~ (l) Payment for substance use disorder services under this section must start from the day of service initiation, when the comprehensive assessment is completed within the required timelines.

Sec. 6. Minnesota Statutes 2023 Supplement, section 256.969, subdivision 2b, is amended to read:

Subd. 2b. **Hospital payment rates.** (a) For discharges occurring on or after November 1, 2014, hospital inpatient services for hospitals located in Minnesota shall be paid according to the following:

(1) critical access hospitals as defined by Medicare shall be paid using a cost-based methodology;

(2) long-term hospitals as defined by Medicare shall be paid on a per diem methodology under subdivision 25;

(3) rehabilitation hospitals or units of hospitals that are recognized as rehabilitation distinct parts as defined by Medicare shall be paid according to the methodology under subdivision 12; and

(4) all other hospitals shall be paid on a diagnosis-related group (DRG) methodology.

(b) For the period beginning January 1, 2011, through October 31, 2014, rates shall not be rebased, except that a Minnesota long-term hospital shall be rebased effective January 1, 2011, based on its most recent Medicare cost report ending on or before September 1, 2008, with the provisions under subdivisions 9 and 23, based on the rates in effect on December 31, 2010. For rate setting periods after November 1, 2014, in which the base years are updated, a Minnesota long-term hospital's base year shall remain within the same period as other hospitals.

(c) Effective for discharges occurring on and after November 1, 2014, payment rates for hospital inpatient services provided by hospitals located in Minnesota or the local trade area, except for the hospitals paid under the methodologies described in paragraph (a), clauses (2) and (3), shall be rebased, incorporating cost and payment methodologies in a

manner similar to Medicare. The base year or years for the rates effective November 1, 2014, shall be calendar year 2012. The rebasing under this paragraph shall be budget neutral, ensuring that the total aggregate payments under the rebased system are equal to the total aggregate payments that were made for the same number and types of services in the base year. Separate budget neutrality calculations shall be determined for payments made to critical access hospitals and payments made to hospitals paid under the DRG system. Only the rate increases or decreases under subdivision 3a or 3c that applied to the hospitals being rebased during the entire base period shall be incorporated into the budget neutrality calculation.

(d) For discharges occurring on or after November 1, 2014, through the next rebasing that occurs, the rebased rates under paragraph (c) that apply to hospitals under paragraph (a), clause (4), shall include adjustments to the projected rates that result in no greater than a five percent increase or decrease from the base year payments for any hospital. Any adjustments to the rates made by the commissioner under this paragraph and paragraph (e) shall maintain budget neutrality as described in paragraph (c).

(e) For discharges occurring on or after November 1, 2014, the commissioner may make additional adjustments to the rebased rates, and when evaluating whether additional adjustments should be made, the commissioner shall consider the impact of the rates on the following:

(1) pediatric services;

(2) behavioral health services;

(3) trauma services as defined by the National Uniform Billing Committee;

(4) transplant services;

(5) obstetric services, newborn services, and behavioral health services provided by hospitals outside the seven-county metropolitan area;

(6) outlier admissions;

(7) low-volume providers; and

(8) services provided by small rural hospitals that are not critical access hospitals.

(f) Hospital payment rates established under paragraph (c) must incorporate the following:

(1) for hospitals paid under the DRG methodology, the base year payment rate per admission is standardized by the applicable Medicare wage index and adjusted by the hospital's disproportionate population adjustment;

(2) for critical access hospitals, payment rates for discharges between November 1, 2014, and June 30, 2015, shall be set to the same rate of payment that applied for discharges on October 31, 2014;

(3) the cost and charge data used to establish hospital payment rates must only reflect inpatient services covered by medical assistance; and

(4) in determining hospital payment rates for discharges occurring on or after the rate year beginning January 1, 2011, through December 31, 2012, the hospital payment rate per discharge shall be based on the cost-finding methods and allowable costs of the Medicare program in effect during the base year or years. In determining hospital payment rates for discharges in subsequent base years, the per discharge rates shall be based on the cost-finding methods and allowable costs of the Medicare program in effect during the base year or years.

(g) The commissioner shall validate the rates effective November 1, 2014, by applying the rates established under paragraph (c), and any adjustments made to the rates under paragraph (d) or (e), to hospital claims paid in calendar year 2013 to determine whether the total aggregate payments for the same number and types of services under the rebased rates are equal to the total aggregate payments made during calendar year 2013.

(h) Effective for discharges occurring on or after July 1, 2017, and every two years thereafter, payment rates under this section shall be rebased to reflect only those changes in hospital costs between the existing base year or years and the next base year or years. In any year that inpatient claims volume falls below the threshold required to ensure a statistically valid sample of claims, the commissioner may combine claims data from two consecutive years to serve as the base year. Years in which inpatient claims volume is reduced or altered due to a pandemic or other public health emergency shall not be used as a base year or part of a base year if the base year includes more than one year. Changes in costs between base years shall be measured using the lower of the hospital cost index defined in subdivision 1, paragraph (a), or the percentage change in the case mix adjusted cost per claim. The commissioner shall establish the base year for each rebasing period considering the most recent year or years for which filed Medicare cost reports are available, except that the base years for the rebasing effective July 1, 2023, are calendar years 2018 and 2019. The estimated change in the average payment per hospital discharge resulting from a scheduled rebasing must be calculated and made available to the legislature by January 15 of each year in which rebasing is scheduled to occur, and must include by hospital the differential in payment rates compared to the individual hospital's costs.

(i) Effective for discharges occurring on or after July 1, 2015, inpatient payment rates for critical access hospitals located in Minnesota or the local trade area shall be determined using a new cost-based methodology. The commissioner shall establish within the methodology tiers of payment designed to promote efficiency and cost-effectiveness. Payment rates for hospitals under this paragraph shall be set at a level that does not exceed the total cost for critical access hospitals as reflected in base year cost reports. Until the next rebasing that occurs, the new methodology shall result in no greater than a five percent decrease from the base year payments for any hospital, except a hospital that had payments that were greater than 100 percent of the hospital's costs in the base year shall have their rate set equal to 100 percent of costs in the base year. The rates paid for discharges on and after July 1, 2016, covered under this paragraph shall be increased by the inflation factor in subdivision 1, paragraph (a). The new cost-based rate shall be the final rate and shall not be settled to actual incurred costs. Hospitals shall be assigned a payment tier based on the following criteria:

(1) hospitals that had payments at or below 80 percent of their costs in the base year shall have a rate set that equals 85 percent of their base year costs;

(2) hospitals that had payments that were above 80 percent, up to and including 90 percent of their costs in the base year shall have a rate set that equals 95 percent of their base year costs; and

(3) hospitals that had payments that were above 90 percent of their costs in the base year shall have a rate set that equals 100 percent of their base year costs.

(j) The commissioner may refine the payment tiers and criteria for critical access hospitals to coincide with the next rebasing under paragraph (h). The factors used to develop the new methodology may include, but are not limited to:

(1) the ratio between the hospital's costs for treating medical assistance patients and the hospital's charges to the medical assistance program;

(2) the ratio between the hospital's costs for treating medical assistance patients and the hospital's payments received from the medical assistance program for the care of medical assistance patients;

(3) the ratio between the hospital's charges to the medical assistance program and the hospital's payments received from the medical assistance program for the care of medical assistance patients;

(4) the statewide average increases in the ratios identified in clauses (1), (2), and (3);

(5) the proportion of that hospital's costs that are administrative and trends in administrative costs; and

(6) geographic location.

(k) Effective for discharges occurring on or after January 1, 2024, the rates paid to hospitals described in paragraph (a), clauses (2) to (4), must include a rate factor specific to each hospital that qualifies for a medical education and research cost distribution under section 62J.692, subdivision 4, paragraph (a).

(l) Effective for services rendered on or after January 1, 2025, the commissioner shall increase payments for behavioral health services provided by hospitals paid on a diagnosis-related group methodology for hospital inpatient services by increasing the adjustment for behavioral health services under section 256.969, subdivision 2b, paragraph (e).

(m) Effective for services rendered on or after January 1, 2025, the commissioner shall increase capitation payments made to managed care plans and county-based purchasing plans to reflect the rate increase provided under paragraph (l). Managed care and county-based purchasing plans must use the capitation rate increase provided under this paragraph to increase payment rates to behavioral health services providers. The commissioner must monitor the effect of this rate increase on enrollee access to services described in paragraph (l). If for any contract year federal approval is not received for this paragraph, the commissioner must adjust the capitation rates paid to managed care plans and county-based purchasing plans for that contract year to reflect the removal of this provision. Contracts between managed care plans and county-based purchasing plans and providers to whom this paragraph applies must allow recovery of payments from those providers if capitation rates are adjusted in accordance with this paragraph. Payment recoveries must not exceed the amount equal to any increase in rates that results from this provision.

Sec. 7. Minnesota Statutes 2022, section 256B.0622, subdivision 2a, is amended to read:

Subd. 2a. **Eligibility for assertive community treatment.** An eligible client for assertive community treatment is an individual who meets the following criteria as assessed by an ACT team:

(1) is age 18 or older. Individuals ages 16 and 17 may be eligible upon approval by the commissioner;

(2) has a primary diagnosis of schizophrenia, schizoaffective disorder, major depressive disorder with psychotic features, other psychotic disorders, or bipolar disorder. Individuals with other psychiatric illnesses may qualify for assertive community treatment if they have a serious mental illness and meet the criteria outlined in clauses (3) and (4), but no more than ten percent of an ACT team's clients may be eligible based on this criteria. Individuals with a primary diagnosis of a substance use disorder, intellectual developmental disabilities, borderline personality disorder, antisocial personality disorder, traumatic brain injury, or an autism spectrum disorder are not eligible for assertive community treatment;

(3) has significant functional impairment as demonstrated by at least one of the following conditions:

(i) significant difficulty consistently performing the range of routine tasks required for basic adult functioning in the community or persistent difficulty performing daily living tasks without significant support or assistance;

(ii) significant difficulty maintaining employment at a self-sustaining level or significant difficulty consistently carrying out the head-of-household responsibilities; or

(iii) significant difficulty maintaining a safe living situation;

(4) has a need for continuous high-intensity services as evidenced by at least two of the following:

(i) two or more psychiatric hospitalizations or residential crisis stabilization services in the previous 12 months;

(ii) frequent utilization of mental health crisis services in the previous six months;

(iii) 30 or more consecutive days of psychiatric hospitalization in the previous 24 months;

(iv) intractable, persistent, or prolonged severe psychiatric symptoms;

(v) coexisting mental health and substance use disorders lasting at least six months;

(vi) recent history of involvement with the criminal justice system or demonstrated risk of future involvement;

(vii) significant difficulty meeting basic survival needs;

(viii) residing in substandard housing, experiencing homelessness, or facing imminent risk of homelessness;

(ix) significant impairment with social and interpersonal functioning such that basic needs are in jeopardy;

(x) coexisting mental health and physical health disorders lasting at least six months;

(xi) residing in an inpatient or supervised community residence but clinically assessed to be able to live in a more independent living situation if intensive services are provided;

(xii) requiring a residential placement if more intensive services are not available; ~~or~~

(xiii) difficulty effectively using traditional office-based outpatient services; or

(xiv) receiving services through a program that meets the requirements for the first episode of psychosis grant program under section 245.4905 and having been determined to need an ACT team;

(5) there are no indications that other available community-based services would be equally or more effective as evidenced by consistent and extensive efforts to treat the individual; and

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

Sec. 8. Minnesota Statutes 2022, section 256B.0622, subdivision 3a, is amended to read:

Subd. 3a. **Provider certification and contract requirements for assertive community treatment.** (a) The assertive community treatment provider must~~:~~

~~(1) have a contract with the host county to provide assertive community treatment services; and~~

~~(2)~~ have each ACT team be certified by the state following the certification process and procedures developed by the commissioner. The certification process determines whether the ACT team meets the standards for assertive community treatment under this section, the standards in chapter 245I as required in section 245I.011, subdivision 5, and minimum program fidelity standards as measured by a nationally recognized fidelity tool approved by the commissioner. Recertification must occur at least every three years.

(b) An ACT team certified under this subdivision must meet the following standards:

(1) have capacity to recruit, hire, manage, and train required ACT team members;

(2) have adequate administrative ability to ensure availability of services;

(3) ensure flexibility in service delivery to respond to the changing and intermittent care needs of a client as identified by the client and the individual treatment plan;

(4) keep all necessary records required by law;

(5) be an enrolled Medicaid provider; and

(6) establish and maintain a quality assurance plan to determine specific service outcomes and the client's satisfaction with services.

(c) The commissioner may intervene at any time and decertify an ACT team with cause. The commissioner shall establish a process for decertification of an ACT team and shall require corrective action, medical assistance repayment, or decertification of an ACT team that no longer meets the requirements in this section or that fails to meet the clinical quality standards or administrative standards provided by the commissioner in the application and certification process. The decertification is subject to appeal to the state.

Sec. 9. Minnesota Statutes 2022, section 256B.0622, subdivision 7a, is amended to read:

Subd. 7a. **Assertive community treatment team staff requirements and roles.** (a) The required treatment staff qualifications and roles for an ACT team are:

(1) the team leader:

(i) shall be a mental health professional. Individuals who are not licensed but who are eligible for licensure and are otherwise qualified may also fulfill this role ~~but must obtain full licensure within 24 months of assuming the role of team leader~~;

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

(iii) must be a single full-time staff member, dedicated to the ACT team, who is responsible for overseeing the administrative operations of the team~~, providing treatment supervision of services in conjunction with the psychiatrist or psychiatric care provider,~~ and supervising team members to ensure delivery of best and ethical practices; and

(iv) must be available to ~~provide~~ ensure that overall treatment supervision to the ACT team is available after regular business hours and on weekends and holidays~~. The team leader may delegate this duty to another~~, and is provided by a qualified member of the ACT team;

(2) the psychiatric care provider:

(i) must be a mental health professional permitted to prescribe psychiatric medications as part of the mental health professional's scope of practice. The psychiatric care provider must have demonstrated clinical experience working with individuals with serious and persistent mental illness;

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

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

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

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

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

(3) the nursing staff:

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

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

(iii) shall develop strategies, in collaboration with clients, to maximize taking medications as prescribed; screen and monitor clients' mental and physical health conditions and medication side effects; engage in health promotion, prevention, and education activities; communicate and coordinate services with other medical providers; facilitate the development

of the individual treatment plan for clients assigned; and educate the ACT team in monitoring psychiatric and physical health symptoms and medication side effects;

(4) the co-occurring disorder specialist:

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

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

(5) the vocational specialist:

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

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

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

(6) the mental health certified peer specialist:

(i) shall be a full-time equivalent. No more than two individuals can share this position. The mental health certified peer specialist is a fully integrated team member who provides highly individualized services in the community and promotes the self-determination and shared decision-making abilities of clients. This requirement may be waived due to workforce shortages upon approval of the commissioner;

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

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

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

(8) additional staff:

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

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

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

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

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

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

Sec. 10. Minnesota Statutes 2023 Supplement, section 256B.0622, subdivision 7b, is amended to read:

Subd. 7b. **Assertive community treatment program ~~size and opportunities~~ scores.** ~~(a)~~ Each ACT team ~~shall maintain an annual average caseload that does not exceed 100 clients. Staff-to-client ratios shall be based on team size as follows:~~ must demonstrate that the team attained a passing score according to the most recently issued Tool for Measurement of Assertive Community Treatment (TMACT).

~~(1) a small ACT team must:~~

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

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

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

~~(iv) schedule ACT team staff on weekdays and on-call duty to provide crisis services and deliver services after hours when staff are not working;~~

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

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

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

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

~~health professional, certified rehabilitation specialist, clinical trainee, or mental health practitioner status; and~~

~~(2) a midsize ACT team shall:~~

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

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

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

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

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

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

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

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

~~(3) a large ACT team must:~~

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

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

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

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

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

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

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

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

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

Subd. 7d. **Assertive community treatment assessment and individual treatment plan.** (a) An initial assessment shall be completed the day of the client's admission to assertive community treatment by the ACT team leader or the psychiatric care provider, with participation by designated ACT team members and the client. The initial assessment must include obtaining or completing a standard diagnostic assessment according to section 245I.10, subdivision 6, and completing a 30-day individual treatment plan. The team leader, psychiatric care provider, or other mental health professional designated by the team leader

or psychiatric care provider, must update the client's diagnostic assessment ~~at least annually~~ as required under section 245I.10, subdivision 2, paragraphs (f) and (g).

(b) A functional assessment must be completed according to section 245I.10, subdivision 9. Each part of the functional assessment areas shall be completed by each respective team specialist or an ACT team member with skill and knowledge in the area being assessed.

(c) Between 30 and 45 days after the client's admission to assertive community treatment, the entire ACT team must hold a comprehensive case conference, where all team members, including the psychiatric provider, present information discovered from the completed assessments and provide treatment recommendations. The conference must serve as the basis for the first individual treatment plan, which must be written by the primary team member.

(d) The client's psychiatric care provider, primary team member, and individual treatment team members shall assume responsibility for preparing the written narrative of the results from the psychiatric and social functioning history timeline and the comprehensive assessment.

(e) The primary team member and individual treatment team members shall be assigned by the team leader in collaboration with the psychiatric care provider by the time of the first treatment planning meeting or 30 days after admission, whichever occurs first.

(f) Individual treatment plans must be developed through the following treatment planning process:

(1) The individual treatment plan shall be developed in collaboration with the client and the client's preferred natural supports, and guardian, if applicable and appropriate. The ACT team shall evaluate, together with each client, the client's needs, strengths, and preferences and develop the individual treatment plan collaboratively. The ACT team shall make every effort to ensure that the client and the client's family and natural supports, with the client's consent, are in attendance at the treatment planning meeting, are involved in ongoing meetings related to treatment, and have the necessary supports to fully participate. The client's participation in the development of the individual treatment plan shall be documented.

(2) The client and the ACT team shall work together to formulate and prioritize the issues, set goals, research approaches and interventions, and establish the plan. The plan is individually tailored so that the treatment, rehabilitation, and support approaches and interventions achieve optimum symptom reduction, help fulfill the personal needs and aspirations of the client, take into account the cultural beliefs and realities of the individual,

and improve all the aspects of psychosocial functioning that are important to the client. The process supports strengths, rehabilitation, and recovery.

(3) Each client's individual treatment plan shall identify service needs, strengths and capacities, and barriers, and set specific and measurable short- and long-term goals for each service need. The individual treatment plan must clearly specify the approaches and interventions necessary for the client to achieve the individual goals, when the interventions shall happen, and identify which ACT team member shall carry out the approaches and interventions.

(4) The primary team member and the individual treatment team, together with the client and the client's family and natural supports with the client's consent, are responsible for reviewing and rewriting the treatment goals and individual treatment plan whenever there is a major decision point in the client's course of treatment or at least every six months.

(5) The primary team member shall prepare a summary that thoroughly describes in writing the client's and the individual treatment team's evaluation of the client's progress and goal attainment, the effectiveness of the interventions, and the satisfaction with services since the last individual treatment plan. The client's most recent diagnostic assessment must be included with the treatment plan summary.

(6) The individual treatment plan and review must be approved or acknowledged by the client, the primary team member, the team leader, the psychiatric care provider, and all individual treatment team members. A copy of the approved individual treatment plan must be made available to the client.

Sec. 12. Minnesota Statutes 2022, section 256B.0757, subdivision 5, is amended to read:

Subd. 5. **Payments.** (a) The commissioner shall ~~make payments to each designated provider for the provision of health home services described in subdivision 3 to each eligible individual under subdivision 2 that selects the health home as a provider~~ determine and implement a single statewide reimbursement rate for behavioral health home services under this section. The rate must be no less than $408 per member per month. The commissioner must adjust the statewide reimbursement rate annually according to the change from the midpoint of the previous rate year to the midpoint of the rate year for which the rate is being determined using the Centers for Medicare and Medicaid Services Medicare Economic Index as forecasted in the fourth quarter of the calendar year before the rate year.

(b) The commissioner must review and update the behavioral health home service rate under paragraph (a) at least every four years. The updated rate must account for the average

hours required for behavioral health home team members spent providing services and the Department of Labor prevailing wage for required behavioral health home team members. The updated rate must ensure that behavioral health home services rates are sufficient to allow providers to meet required certifications, training, and practice transformation standards, staff qualification requirements, and service delivery standards.

EFFECTIVE DATE. This section is effective January 1, 2025, or upon federal approval, whichever is later. The commissioner of human services shall inform the revisor of statutes when federal approval is obtained.

Sec. 13. Minnesota Statutes 2023 Supplement, section 256B.76, subdivision 1, is amended to read:

Subdivision 1. **Physician and professional services reimbursement.** ~~(a) Effective for services rendered on or after October 1, 1992, the commissioner shall make payments for physician services as follows:~~

~~(1) payment for level one Centers for Medicare and Medicaid Services' common procedural coding system codes titled "office and other outpatient services," "preventive medicine new and established patient," "delivery, antepartum, and postpartum care," "critical care," cesarean delivery and pharmacologic management provided to psychiatric patients, and level three codes for enhanced services for prenatal high risk, shall be paid at the lower of (i) submitted charges, or (ii) 25 percent above the rate in effect on June 30, 1992;~~

~~(2) payments for all other services shall be paid at the lower of (i) submitted charges, or (ii) 15.4 percent above the rate in effect on June 30, 1992; and~~

~~(3) all physician rates shall be converted from the 50th percentile of 1982 to the 50th percentile of 1989, less the percent in aggregate necessary to equal the above increases except that payment rates for home health agency services shall be the rates in effect on September 30, 1992.~~

~~(b)~~ (a) Effective for services rendered on or after January 1, 2000, through December 31, 2024, payment rates for physician and professional services shall be increased by three percent over the rates in effect on December 31, 1999, except for home health agency and family planning agency services. The increases in this paragraph shall be implemented January 1, 2000, for managed care.

~~(c)~~ (b) Effective for services rendered on or after July 1, 2009, through December 31, 2024, payment rates for physician and professional services shall be reduced by five percent, except that for the period July 1, 2009, through June 30, 2010, payment rates shall be reduced

by 6.5 percent for the medical assistance and general assistance medical care programs, over the rates in effect on June 30, 2009. This reduction and the reductions in paragraph (d) do not apply to office or other outpatient visits, preventive medicine visits and family planning visits billed by physicians, advanced practice registered nurses, or physician assistants in a family planning agency or in one of the following primary care practices: general practice, general internal medicine, general pediatrics, general geriatrics, and family medicine. This reduction and the reductions in paragraph (d) do not apply to federally qualified health centers, rural health centers, and Indian health services. Effective October 1, 2009, payments made to managed care plans and county-based purchasing plans under sections 256B.69, 256B.692, and 256L.12 shall reflect the payment reduction described in this paragraph.

~~(d)~~ (c) Effective for services rendered on or after July 1, 2010, through December 31, 2024, payment rates for physician and professional services shall be reduced an additional seven percent over the five percent reduction in rates described in paragraph (c). This additional reduction does not apply to physical therapy services, occupational therapy services, and speech pathology and related services provided on or after July 1, 2010. This additional reduction does not apply to physician services billed by a psychiatrist or an advanced practice registered nurse with a specialty in mental health. Effective October 1, 2010, payments made to managed care plans and county-based purchasing plans under sections 256B.69, 256B.692, and 256L.12 shall reflect the payment reduction described in this paragraph.

~~(e) Effective for services rendered on or after September 1, 2011, through June 30, 2013, payment rates for physician and professional services shall be reduced three percent from the rates in effect on August 31, 2011. This reduction does not apply to physical therapy services, occupational therapy services, and speech pathology and related services.~~

~~(f)~~ (d) Effective for services rendered on or after September 1, 2014, through December 31, 2024, payment rates for physician and professional services, including physical therapy, occupational therapy, speech pathology, and mental health services shall be increased by five percent from the rates in effect on August 31, 2014. In calculating this rate increase, the commissioner shall not include in the base rate for August 31, 2014, the rate increase provided under section 256B.76, subdivision 7. This increase does not apply to federally qualified health centers, rural health centers, and Indian health services. Payments made to managed care plans and county-based purchasing plans shall not be adjusted to reflect payments under this paragraph.

~~(g)~~ (e) Effective for services rendered on or after July 1, 2015, payment rates for physical therapy, occupational therapy, and speech pathology and related services provided by a hospital meeting the criteria specified in section 62Q.19, subdivision 1, paragraph (a), clause (4), shall be increased by 90 percent from the rates in effect on June 30, 2015. Payments made to managed care plans and county-based purchasing plans shall not be adjusted to reflect payments under this paragraph.

~~(h)~~ (f) Any ratables effective before July 1, 2015, do not apply to early intensive developmental and behavioral intervention (EIDBI) benefits described in section 256B.0949.

~~(i)~~ (g) The commissioner may reimburse physicians and other licensed professionals for costs incurred to pay the fee for testing newborns who are medical assistance enrollees for heritable and congenital disorders under section 144.125, subdivision 1, paragraph (c), when the sample is collected outside of an inpatient hospital or freestanding birth center and the cost is not recognized by another payment source.

Sec. 14. Minnesota Statutes 2022, section 256B.76, subdivision 6, is amended to read:

Subd. 6. **Medicare relative value units.** ~~Effective for services rendered on or after January 1, 2007, the commissioner shall make payments for physician and professional services based on the Medicare relative value units (RVU's). This change shall be budget neutral and the cost of implementing RVU's will be incorporated in the established conversion factor~~ (a) Effective for physician and professional services included in the Medicare Physician Fee Schedule and rendered on or after January 1, 2025, the commissioner shall make payments at rates at least equal to 100 percent of the corresponding rates in the Medicare Physician Fee Schedule. Payment rates set under this paragraph must use Medicare relative value units (RVU's) and conversion factors, at least equal to those in the Medicare Physician Fee Schedule, to implement the resource-based relative value scale.

(b) The commissioner shall revise fee-for-service payment methodologies under this section, upon the issuance of a Medicare Physician Fee Schedule final rule by the Centers for Medicare and Medicaid Services, to ensure the payment rates under this subdivision are at least equal to the corresponding rates in such final rule.

(c) The commissioner must revise and implement payment rates for mental health services based on RVU's and rendered on or after January 1, 2025, such that the payment rates are at least equal to 100 percent of the Medicare Physician Fee Schedule in accordance with paragraph (a), before or at the same time as when the commissioner revises and implements payment rates for other services under paragraph (a).

(d) All mental health services and substance use disorder services performed in a primary care or mental health care health professional shortage area, medically underserved area, or medically underserved population, as maintained and updated by the United States Department of Health and Human Services, are eligible for a ten percent bonus payment. Such services are eligible for a bonus based upon the performance of the service in a health professional shortage area if (1) the services were rendered in a health professional shortage area, or (2) the provider maintains an office in a health professional shortage area.

(e) Effective for services rendered on or after January 1, 2025, the commissioner shall increase capitation payments made to managed care plans and county-based purchasing plans to reflect the rate increases provided under this subdivision. Managed care and county-based purchasing plans must use the capitation rate increase provided under this paragraph to increase payment rates to the providers corresponding to the rate increases. The commissioner must monitor the effect of this rate increase on enrollee access to services under this subdivision. If for any contract year federal approval is not received for this paragraph, the commissioner must adjust the capitation rates paid to managed care plans and county-based purchasing plans for that contract year to reflect the removal of this provision. Contracts between managed care plans and county-based purchasing plans and providers to whom this paragraph applies must allow recovery of payments from those providers if capitation rates are adjusted in accordance with this paragraph. Payment recoveries must not exceed the amount equal to any increase in rates that results from this provision.

Sec. 15. Minnesota Statutes 2023 Supplement, section 256B.761, is amended to read:

256B.761 REIMBURSEMENT FOR MENTAL HEALTH SERVICES.

(a) Effective for services rendered on or after July 1, 2001, payment for medication management provided to psychiatric patients, outpatient mental health services, day treatment services, home-based mental health services, and family community support services shall be paid at the lower of (1) submitted charges, or (2) 75.6 percent of the 50th percentile of 1999 charges.

(b) Effective July 1, 2001, the medical assistance rates for outpatient mental health services provided by an entity that operates: (1) a Medicare-certified comprehensive outpatient rehabilitation facility; and (2) a facility that was certified prior to January 1, 1993, with at least 33 percent of the clients receiving rehabilitation services in the most recent calendar year who are medical assistance recipients, will be increased by 38 percent, when

those services are provided within the comprehensive outpatient rehabilitation facility and provided to residents of nursing facilities owned by the entity.

(c) In addition to rate increases otherwise provided, the commissioner may restructure coverage policy and rates to improve access to adult rehabilitative mental health services under section 256B.0623 and related mental health support services under section 256B.021, subdivision 4, paragraph (f), clause (2). For state fiscal years 2015 and 2016, the projected state share of increased costs due to this paragraph is transferred from adult mental health grants under sections 245.4661 and 256E.12. The transfer for fiscal year 2016 is a permanent base adjustment for subsequent fiscal years. Payments made to managed care plans and county-based purchasing plans under sections 256B.69, 256B.692, and 256L.12 shall reflect the rate changes described in this paragraph.

(d) Any ratables effective before July 1, 2015, do not apply to early intensive developmental and behavioral intervention (EIDBI) benefits described in section 256B.0949.

(e) Effective for services rendered on or after January 1, 2024, payment rates for behavioral health services included in the rate analysis required by Laws 2021, First Special Session chapter 7, article 17, section 18, except for adult day treatment services under section 256B.0671, subdivision 3; early intensive developmental and behavioral intervention services under section 256B.0949; and substance use disorder services under chapter 254B, must be increased by three percent from the rates in effect on December 31, 2023. Effective for services rendered on or after January 1, 2025, payment rates for behavioral health services included in the rate analysis required by Laws 2021, First Special Session chapter 7, article 17, section 18, except for adult day treatment services under section 256B.0671, subdivision 3; early intensive developmental behavioral intervention services under section 256B.0949; and substance use disorder services under chapter 254B, must be annually adjusted according to the change from the midpoint of the previous rate year to the midpoint of the rate year for which the rate is being determined using the Centers for Medicare and Medicaid Services Medicare Economic Index as forecasted in the fourth quarter of the calendar year before the rate year. For payments made in accordance with this paragraph, if and to the extent that the commissioner identifies that the state has received federal financial participation for behavioral health services in excess of the amount allowed under United States Code, title 42, section 447.321, the state shall repay the excess amount to the Centers for Medicare and Medicaid Services with state money and maintain the full payment rate under this paragraph. This paragraph does not apply to federally qualified health centers, rural health centers, Indian health services, certified community behavioral health clinics, cost-based rates, and rates that are negotiated with the county. This paragraph expires upon legislative

implementation of the new rate methodology resulting from the rate analysis required by Laws 2021, First Special Session chapter 7, article 17, section 18.

(f) Effective January 1, 2024, the commissioner shall increase capitation payments made to managed care plans and county-based purchasing plans to reflect the behavioral health service rate increase provided in paragraph (e). Managed care and county-based purchasing plans must use the capitation rate increase provided under this paragraph to increase payment rates to behavioral health services providers. The commissioner must monitor the effect of this rate increase on enrollee access to behavioral health services. If for any contract year federal approval is not received for this paragraph, the commissioner must adjust the capitation rates paid to managed care plans and county-based purchasing plans for that contract year to reflect the removal of this provision. Contracts between managed care plans and county-based purchasing plans and providers to whom this paragraph applies must allow recovery of payments from those providers if capitation rates are adjusted in accordance with this paragraph. Payment recoveries must not exceed the amount equal to any increase in rates that results from this provision.

(g) Effective for services under this section billed and coded under HCPCS H, S, and T codes and rendered on or after January 1, 2025, the payment rates shall be increased as necessary to align with the Medicare Physician Fee Schedule.

(h) The commissioner shall revise fee-for-service payment methodologies under paragraph (g), upon the issuance of a Medicare Physician Fee Schedule final rule by the Centers for Medicare and Medicaid Services, as necessary to ensure the payments rates under paragraph (g) align with the corresponding payment rates in such final rule.

Sec. 16. **DIRECTION TO COMMISSIONER OF HUMAN SERVICES; MEDICAID REENTRY SECTION 1115 DEMONSTRATION OPPORTUNITY WAIVER.**

(a) The commissioner of human services shall apply to the secretary of health and human services for a Medicaid Reentry Section 1115 Demonstration Opportunity waiver to provide short term medical assistance enrollment assistance and prerelease coverage for care transition services to incarcerated individuals who are soon to be released from incarceration, consistent with the statutory directive in section 5032 of the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act (Public Law 115-271) and federal guidance. The commissioner's application must request coverage for at least the services under Minnesota Statutes, section 256B.0625, subdivision 72, for at least 30 days prior to an eligible incarcerated individual's expected release date.

(b) When preparing the application for the Section 1115 Demonstration Opportunity waiver, the commissioner of human services must consult with the commissioner of corrections, sheriffs, lead agencies, and individuals with lived experience of incarceration.

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

Sec. 17. **REVISOR INSTRUCTION.**

The revisor of statutes, in consultation with the Office of Senate Counsel, Research and Fiscal Analysis; the House Research Department; and the commissioner of human services, shall prepare legislation for the 2025 legislative session to recodify Minnesota Statutes, section 256B.0622, to move provisions related to assertive community treatment and intensive residential treatment services into separate sections of statute. The revisor shall correct any cross-references made necessary by this recodification.

Sec. 18. **REPEALER.**

Minnesota Statutes 2022, section 256B.0625, subdivision 38, is repealed.

ARTICLE 3
MISCELLANEOUS

Section 1. Minnesota Statutes 2022, section 246.18, subdivision 4a, is amended to read:

Subd. 4a. **Mental health innovation account.** The mental health innovation account is established in the special revenue fund. ~~Beginning in fiscal year 2018, $1,000,000 of~~ The revenue generated by collection efforts from the Anoka-Metro Regional Treatment Center and community behavioral health hospitals under section 246.54 must annually be deposited into the mental health innovation account. Money deposited in the mental health innovation account is appropriated to the commissioner of human services for the mental health innovation grant program under section 245.4662.

Sec. 2. Minnesota Statutes 2023 Supplement, section 246.54, subdivision 1a, is amended to read:

Subd. 1a. **Anoka-Metro Regional Treatment Center.** (a) A county's payment of the cost of care provided at Anoka-Metro Regional Treatment Center shall be according to the following schedule:

(1) zero percent for the first 30 days;

(2) 20 percent for days 31 and over if the stay is determined to be clinically appropriate for the client; and

(3) 100 percent for each day during the stay, including the day of admission, when the facility determines that it is clinically appropriate for the client to be discharged.

(b) If payments received by the state under sections 246.50 to 246.53 exceed 80 percent of the cost of care for days over 31 for clients who meet the criteria in paragraph (a), clause (2), the county shall be responsible for paying the state only the remaining amount. The county shall not be entitled to reimbursement from the client, the client's estate, or from the client's relatives, except as provided in section 246.53.

~~(c) Between July 1, 2023, and June 30, 2025, the county is not responsible for the cost of care under paragraph (a), clause (3), for a person who is committed as a person who has a mental illness and is dangerous to the public under section 253B.18 and who is awaiting transfer to another state-operated facility or program. This paragraph expires June 30, 2025.~~

~~(d)~~ (c) Notwithstanding any law to the contrary, the client is not responsible for payment of the cost of care under this subdivision.

(d) The county is not responsible for the cost of care under paragraph (a), clause (3), for a client who is civilly committed, if the client:

(1) is awaiting transfer to a facility operated by the Department of Corrections; or

(2) is awaiting transfer to another state-operated facility or program, and the direct care and treatment executive medical director's office has determined that:

(i) the client meets criteria for admission to that state-operated facility or program; and

(ii) the state-operated facility or program is the only facility or program that can reasonably serve the client.

Sec. 3. Minnesota Statutes 2023 Supplement, section 246.54, subdivision 1b, is amended to read:

Subd. 1b. **Community behavioral health hospitals.** (a) A county's payment of the cost of care provided at state-operated community-based behavioral health hospitals for adults and children shall be according to the following schedule:

(1) 100 percent for each day during the stay, including the day of admission, when the facility determines that it is clinically appropriate for the client to be discharged; and

(2) the county shall not be entitled to reimbursement from the client, the client's estate, or from the client's relatives, except as provided in section 246.53.

~~(b) Between July 1, 2023, and June 30, 2025, the county is not responsible for the cost of care under paragraph (a), clause (1), for a person committed as a person who has a mental illness and is dangerous to the public under section 253B.18 and who is awaiting transfer to another state-operated facility or program. This paragraph expires June 30, 2025.~~

~~(c)~~ (b) Notwithstanding any law to the contrary, the client is not responsible for payment of the cost of care under this subdivision.

(c) The county is not responsible for the cost of care under paragraph (a), clause (1), for a client who is civilly committed, if the client:

(1) is awaiting transfer to a facility operated by the Department of Corrections; or

(2) is awaiting transfer to another state-operated facility or program, and the direct care and treatment executive medical director's office has determined that:

(i) the client meets criteria for admission to that state-operated facility or program; and

(ii) the state-operated facility or program is the only facility or program that can reasonably serve the client.

Sec. 4. Minnesota Statutes 2023 Supplement, section 641.15, subdivision 2, is amended to read:

Subd. 2. **Medical aid.** Except as provided in section 466.101, the county board shall pay the costs of medical services provided to prisoners pursuant to this section. The amount paid by the county board for a medical service shall not exceed the maximum allowed medical assistance payment rate for the service, as determined by the commissioner of human services. In the absence of a health or medical insurance or health plan that has a contractual obligation with the provider or the prisoner, medical providers shall charge no higher than the rate negotiated between the county and the provider. In the absence of an agreement between the county and the provider, the provider may not charge an amount that exceeds the maximum allowed medical assistance payment rate for the service, as determined by the commissioner of human services. The county is entitled to reimbursement from the prisoner for payment of medical bills to the extent that the prisoner to whom the medical aid was provided has the ability to pay the bills. The prisoner shall, at a minimum, incur co-payment obligations for health care services provided by a county correctional facility. The county board shall determine the co-payment amount. A prisoner shall not have a co-payment obligation for receiving a medication for mental health treatment in a

county correctional facility. The county board may seek reimbursement for mental health medication co-payment costs from the commissioner of human services. Notwithstanding any law to the contrary, the co-payment shall be deducted from any of the prisoner's funds held by the county, to the extent possible. If there is a disagreement between the county and a prisoner concerning the prisoner's ability to pay, the court with jurisdiction over the defendant shall determine the extent, if any, of the prisoner's ability to pay for the medical services. If a prisoner is covered by health or medical insurance or other health plan when medical services are provided, the medical provider shall bill that health or medical insurance or other plan. If the county providing the medical services for a prisoner that has coverage under health or medical insurance or other plan, that county has a right of subrogation to be reimbursed by the insurance carrier for all sums spent by it for medical services to the prisoner that are covered by the policy of insurance or health plan, in accordance with the benefits, limitations, exclusions, provider restrictions, and other provisions of the policy or health plan. The county may maintain an action to enforce this subrogation right. The county does not have a right of subrogation against the medical assistance program. The county shall not charge prisoners for telephone calls to MNsure navigators, the Minnesota Warmline, a mental health provider, or calls for the purpose of providing case management or mental health services as defined in section 245.462 to prisoners.

Sec. 5. **JOINT INCIDENT COLLABORATION; DIRECTION TO COMMISSIONER OF HUMAN SERVICES.**

The commissioner of human services and the Department of Direct Care and Treatment executive board, once operational, shall coordinate to implement a joint incident collaboration model with counties and community mental health treatment providers, to actively arrange discharges of direct care and treatment patients to appropriate community treatment settings when the patients are medically stable for discharge.

ARTICLE 4
APPROPRIATIONS

Section 1. **CORRECTIONAL FACILITY MENTAL HEALTH COSTS AND SERVICES.**

$..... in fiscal year 2025 is appropriated from the general fund to the commissioner of human services for services and costs for prisoners receiving mental health medications in county correctional facilities. The commissioner must use these funds to:

(1) pay for injectable medications or neuroleptic medications used for mental health treatment of prisoners in county correctional facilities, and related billable provider costs; and

(2) reimburse county boards for co-payment costs incurred for mental health medications provided in county correctional facilities, pursuant to Minnesota Statutes, section 641.15, subdivision 2.

Sec. 2. **DIRECT CARE AND TREATMENT; COUNTY CORRECTIONAL FACILITY MENTAL HEALTH MEDICATIONS.**

$..... in fiscal year 2025 is appropriated from the general fund to commissioner of human services to create a staff position within direct care and treatment to provide education, support, and technical assistance to counties and county correctional facilities on the provision of medications for mental health treatment, and assist with finding providers to deliver the medications.

Sec. 3. **FORENSIC EXAMINER SERVICES.**

$9,230,000 in fiscal year 2025 is appropriated from the general fund to the supreme court for the psychological and psychiatric forensic examiner services program, to deliver statutorily mandated psychological examinations for civil commitment, criminal competency, and criminal responsibility evaluations. This appropriation must be used to increase forensic examiner pay rates from $125 to $225 per hour.

Sec. 4. **DIRECT CARE AND TREATMENT CAPACITY AND UTILIZATION.**

$..... in fiscal year 2025 is appropriated from the general fund to the commissioner of human services to increase capacity and access to direct care and treatment services for all levels of care. The commissioner must prioritize expanding capacity within the Forensic Mental Health Program by ten to 20 percent, and Anoka Metro Regional Treatment Center and community behavioral health hospitals by 20 percent, through renovation, construction, reallocation of beds and staff, addition of beds and staff, or a combination of these activities. The commissioner must also use money appropriated under this section to examine the utilization of beds at the Forensic Mental Health Program to identify opportunities for most effective utilization of secured programming, and to develop and fund direct care and treatment transitional support resources.

Sec. 5. **HOSPITAL PAYMENT RATE INCREASES.**

$8,785,000 in fiscal year 2025 is appropriated from the general fund to the commissioner of human services for the hospital payment rate increases under Minnesota Statutes, section 256.969, subdivision 2b, paragraphs (l) and (m). The aggregate amount of the increased payments under Minnesota Statutes, section 256.969, subdivision 2b, paragraphs (l) and (m), must at least equal the amount of this appropriation.

Sec. 6. **ENGAGEMENT SERVICES PILOT GRANTS.**

$2,000,000 in fiscal year 2025 is appropriated from the general fund to the commissioner of human services for engagement services pilot grants under Minnesota Statutes, section 253B.042. This funding is added to the base.

Sec. 7. **EARLY EPISODE OF BIPOLAR GRANT PROGRAM.**

$..... in fiscal year 2025 is appropriated from the general fund to the commissioner of human services for the early episode of bipolar grant program under Minnesota Statutes, section 245.4908. This funding is added to the base.

Sec. 8. **FIRST EPISODE OF PSYCHOSIS GRANT PROGRAM.**

$2,000,000 in fiscal year 2025 is appropriated from the general fund to the commissioner of human services for the first episode of psychosis grant program under Minnesota Statutes, section 245.4905. This funding is added to the base. The commissioner may distribute this funding to fully fund current grantee programs, increase a current grantee program's capacity, and to expand grants for programs to outside the seven-county metropolitan area. The commissioner must continue to fund current grantee programs to ensure stability and continuity of care, if the current grantee programs have met requirements for usage of grant funds previously received."

Amend the title accordingly