A bill for an act

relating to human services; amending mental health provisions; changing medical assistance reimbursement and eligibility; changing provider qualification and training requirements; amending mental health behavioral aide services; changing special contracts with bordering states; amending Minnesota Statutes 2008, sections 148C.11, subdivision 1; 245.4835, subdivisions 1, 2; 245.4871, subdivision 26; 245.4885, subdivision 1; 245.50, subdivision 5; 256B.0615, subdivisions 1, 3; 256B.0622, subdivision 8, by adding a subdivision; 256B.0623, subdivision 5; 256B.0624, subdivision 8; 256B.0625, subdivision 49; 256B.0943, subdivisions 1, 2, 4, 5, 6, 7, 9; 256B.0944, subdivision 5.

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

Section 1. Minnesota Statutes 2008, section 148C.11, subdivision 1, is amended to read:

Subdivision 1. **Other professionals.** (a) Nothing in this chapter prevents members of other professions or occupations from performing functions for which they are qualified or licensed. This exception includes, but is not limited to: licensed physicians; registered nurses; licensed practical nurses; licensed psychological practitioners; members of the clergy; American Indian medicine men and women; licensed attorneys; probation officers; licensed marriage and family therapists; licensed social workers; social workers employed by city, county, or state agencies; licensed professional counselors; licensed school counselors; registered occupational therapists or occupational therapy assistants; city, county, or state employees when providing assessments or case management under Minnesota Rules, chapter 9530; and ~~until July 1, 2009,~~ individuals providing integrated dual-diagnosis treatment in adult mental health rehabilitative programs certified by the Department of Human Services under section 256B.0622 or 256B.0623.

(b) Nothing in this chapter prohibits technicians and resident managers in programs licensed by the Department of Human Services from discharging their duties as provided in Minnesota Rules, chapter 9530.

(c) Any person who is exempt under this subdivision but who elects to obtain a license under this chapter is subject to this chapter to the same extent as other licensees. The board shall issue a license without examination to an applicant who is licensed or registered in a profession identified in paragraph (a) if the applicant:

(1) shows evidence of current licensure or registration; and

(2) has submitted to the board a plan for supervision during the first 2,000 hours of professional practice or has submitted proof of supervised professional practice that is acceptable to the board.

(d) Any person who is exempt from licensure under this section must not use a title incorporating the words "alcohol and drug counselor" or "licensed alcohol and drug counselor" or otherwise hold themselves out to the public by any title or description stating or implying that they are engaged in the practice of alcohol and drug counseling, or that they are licensed to engage in the practice of alcohol and drug counseling unless that person is also licensed as an alcohol and drug counselor. Persons engaged in the practice of alcohol and drug counseling are not exempt from the board's jurisdiction solely by the use of one of the above titles.

Sec. 2. Minnesota Statutes 2008, section 245.4835, subdivision 1, is amended to read:

Subdivision 1. **Required expenditures.** (a) Counties must maintain a level of expenditures for mental health services under sections 245.461 to 245.484 and 245.487 to 245.4889 so that each year's county expenditures are at least equal to that county's average expenditures for those services for calendar years 2004 and 2005. The commissioner will adjust each county's base level for minimum expenditures in each year by the amount of any increase or decrease in that county's state grants or other noncounty revenues for mental health services under sections 245.461 to 245.484 and 245.487 to 245.4889.

(b) In order to simplify administration and improve budgeting predictability, the commissioner:

(1) shall use each county's actual prior year revenues to adjust the county's minimum required expenditures for the coming year;

(2) may use more current information regarding major changes in revenues if the change is known early enough to allow counties time to adjust their budgets;

(3) shall allocate each county's revenues proportionally across applicable expenditures;

(4) shall adjust each county's base to allow for major changes in state or federal block grants or other revenues that can be used for mental health services, but are not dedicated to mental health; in this case, the commissioner shall calculate the mental health

share of total county expenditures that were eligible to be funded from that revenue source in the base year, and use that mental health share to allocate the change in those revenues to mental health. This clause applies to changes in revenues that are beyond the county's control; and

(5) may adjust a county's base if the county's population is substantially declining and the county's per capita mental health expenditures are substantially higher than the state average, and the commissioner has determined that mental health services in that county would not be negatively impacted.

(c) Paragraph (b), clause (4) expires December 31, 2011.

Sec. 3. Minnesota Statutes 2008, section 245.4835, subdivision 2, is amended to read:

Subd. 2. **Failure to maintain expenditures.** (a) If a county does not comply with subdivision 1, the commissioner shall require the county to develop a corrective action plan according to a format and timeline established by the commissioner. If the commissioner determines that a county has not developed an acceptable corrective action plan within the required timeline, or that the county is not in compliance with an approved corrective action plan, the protections provided to that county under section 245.485 do not apply.

(b) The commissioner shall consider the following factors to determine whether to approve a county's corrective action plan:

(1) the degree to which a county is maximizing revenues for mental health services from noncounty sources;

(2) the degree to which a county is expanding use of alternative services that meet mental health needs, but do not count as mental health services within existing reporting systems. If approved by the commissioner, the alternative services must be included in the county's base as well as subsequent years. The commissioner's approval for alternative services must be based on the following criteria:

(i) the service must be provided to children with emotional disturbance or adults with mental illness;

(ii) the services must be based on an individual treatment plan or individual community support plan as defined in the Comprehensive Mental Health Act; and

(iii) the services must be supervised by a mental health professional and provided by staff who meet the staff qualifications defined in sections 256B.0943, subdivision 7, and 256B.0622, subdivision 5.

(c) Additional county expenditures to make up for the prior year's underspending may be spread out over a two-year period.

Sec. 4. Minnesota Statutes 2008, section 245.4871, subdivision 26, is amended to read:

Subd. 26. **Mental health practitioner.** "Mental health practitioner" means a person providing services to children with emotional disturbances. A mental health practitioner must have training and experience in working with children. A mental health practitioner must be qualified in at least one of the following ways:

(1) holds a bachelor's degree in one of the behavioral sciences or related fields from an accredited college or university and:

(i) has at least 2,000 hours of supervised experience in the delivery of mental health services to children with emotional disturbances; or

(ii) is fluent in the non-English language of the ethnic group to which at least 50 percent of the practitioner's clients belong, completes 40 hours of training in the delivery of services to children with emotional disturbances, and receives clinical supervision from a mental health professional at least once a week until the requirement of 2,000 hours of supervised experience is met;

(2) has at least 6,000 hours of supervised experience in the delivery of mental health services to children with emotional disturbances; hours worked as a mental health behavioral aide I or II under section 256B.0943, subdivision 7, may be included in the 6,000 hours of experience;

(3) is a graduate student in one of the behavioral sciences or related fields and is formally assigned by an accredited college or university to an agency or facility for clinical training; or

(4) holds a master's or other graduate degree in one of the behavioral sciences or related fields from an accredited college or university and has less than 4,000 hours post-master's experience in the treatment of emotional disturbance.

Sec. 5. Minnesota Statutes 2008, section 245.4885, subdivision 1, is amended to read:

Subdivision 1. **Admission criteria.** The county board shall, prior to admission, except in the case of emergency admission, determine the needed level of care for all children referred for treatment of severe emotional disturbance in a treatment foster care setting, residential treatment facility, or informally admitted to a regional treatment center if public funds are used to pay for the services. ~~The county board shall also determine the needed level of care for all children admitted to an acute care hospital for treatment of severe emotional disturbance if public funds other than reimbursement under chapters 256B and 256D are used to pay for the services.~~ The level of care determination shall determine whether the proposed treatment:

(1) is necessary;

(2) is appropriate to the child's individual treatment needs;

(3) cannot be effectively provided in the child's home; and

(4) provides a length of stay as short as possible consistent with the individual child's need.

When a level of care determination is conducted, the county board may not determine that referral or admission to a treatment foster care setting~~;~~ or residential treatment facility~~, or acute care hospital~~ is not appropriate solely because services were not first provided to the child in a less restrictive setting and the child failed to make progress toward or meet treatment goals in the less restrictive setting. The level of care determination must be based on a diagnostic assessment that includes a functional assessment which evaluates family, school, and community living situations; and an assessment of the child's need for care out of the home using a validated tool which assesses a child's functional status and assigns an appropriate level of care. The validated tool must be approved by the commissioner of human services. If a diagnostic assessment including a functional assessment has been completed by a mental health professional within the past 180 days, a new diagnostic assessment need not be completed unless in the opinion of the current treating mental health professional the child's mental health status has changed markedly since the assessment was completed. The child's parent shall be notified if an assessment will not be completed and of the reasons. A copy of the notice shall be placed in the child's file. Recommendations developed as part of the level of care determination process shall include specific community services needed by the child and, if appropriate, the child's family, and shall indicate whether or not these services are available and accessible to the child and family.

During the level of care determination process, the child, child's family, or child's legal representative, as appropriate, must be informed of the child's eligibility for case management services and family community support services and that an individual family community support plan is being developed by the case manager, if assigned.

The level of care determination shall comply with section 260C.212. Wherever possible, the parent shall be consulted in the process, unless clinically inappropriate.

The level of care determination, and placement decision, and recommendations for mental health services must be documented in the child's record.

An alternate review process may be approved by the commissioner if the county board demonstrates that an alternate review process has been established by the county board and the times of review, persons responsible for the review, and review criteria are comparable to the standards in clauses (1) to (4).

Sec. 6. Minnesota Statutes 2008, section 245.50, subdivision 5, is amended to read:

Subd. 5. **Special contracts; bordering states.** (a) An individual who is detained, committed, or placed on an involuntary basis under chapter 253B may be confined or treated in a bordering state pursuant to a contract under this section. An individual who is detained, committed, or placed on an involuntary basis under the civil law of a bordering state may be confined or treated in Minnesota pursuant to a contract under this section. A peace or health officer who is acting under the authority of the sending state may transport an individual to a receiving agency that provides services pursuant to a contract under this section and may transport the individual back to the sending state under the laws of the sending state. Court orders valid under the law of the sending state are granted recognition and reciprocity in the receiving state for individuals covered by a contract under this section to the extent that the court orders relate to confinement for treatment or care of mental illness or chemical dependency. Such treatment or care may address other conditions that may be co-occurring with the mental illness or chemical dependency. These court orders are not subject to legal challenge in the courts of the receiving state. Individuals who are detained, committed, or placed under the law of a sending state and who are transferred to a receiving state under this section continue to be in the legal custody of the authority responsible for them under the law of the sending state. Except in emergencies, those individuals may not be transferred, removed, or furloughed from a receiving agency without the specific approval of the authority responsible for them under the law of the sending state.

(b) While in the receiving state pursuant to a contract under this section, an individual shall be subject to the sending state's laws and rules relating to length of confinement, reexaminations, and extensions of confinement. No individual may be sent to another state pursuant to a contract under this section until the receiving state has enacted a law recognizing the validity and applicability of this section.

(c) If an individual receiving services pursuant to a contract under this section leaves the receiving agency without permission and the individual is subject to involuntary confinement under the law of the sending state, the receiving agency shall use all reasonable means to return the individual to the receiving agency. The receiving agency shall immediately report the absence to the sending agency. The receiving state has the primary responsibility for, and the authority to direct, the return of these individuals within its borders and is liable for the cost of the action to the extent that it would be liable for costs of its own resident.

(d) Responsibility for payment for the cost of care remains with the sending agency.

(e) This subdivision also applies to county contracts under subdivision 2 which include emergency care and treatment provided to a county resident in a bordering state.

(f) If a Minnesota resident is admitted to a facility in a bordering state under this chapter, a physician, licensed psychologist who has a doctoral degree in psychology, or an advance practice registered nurse certified in mental health, who is licensed in the bordering state, may act as an examiner under sections 253B.07, 253B.08, 253B.092, 253B.12, and 253B.17 subject to the same requirements and limitations in section 253B.02, subdivision 7. Such examiner may initiate an emergency hold under section 253B.05 on a Minnesota resident who is in a hospital that is under contract with a Minnesota governmental entity under this section provided the resident, in the opinion of the examiner, meets the criteria in section 253B.05.

Sec. 7. Minnesota Statutes 2008, section 256B.0615, subdivision 1, is amended to read:

Subdivision 1. **Scope.** Medical assistance covers mental health certified peers specialists services, as established in subdivision 2, subject to federal approval, if provided to recipients who are eligible for services under sections 256B.0622 ~~and~~, 256B.0623, and 256B.0624 and are provided by a certified peer specialist who has completed the training under subdivision 5.

Sec. 8. Minnesota Statutes 2008, section 256B.0615, subdivision 3, is amended to read:

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

Sec. 9. Minnesota Statutes 2008, section 256B.0622, subdivision 8, is amended to read:

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

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

(c) The host county shall recommend to the commissioner one rate for each entity that will bill medical assistance for residential services under this section and ~~two rates~~ one rate for each nonresidential provider. ~~The first nonresidential rate is for recipients who are not receiving residential services. The second nonresidential rate is for recipients who are temporarily receiving residential services and need continued contact with the nonresidential team to assure timely discharge from residential services.~~ If a single entity provides both services, one rate is established for the entity's residential services and another rate for the entity's nonresidential services under this section. In developing these rates, the host county shall consider and document:

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

(2) ~~actual~~ that the proposed costs incurred by entities providing the services are allowable, allocable and reasonable, and are consistent with federal reimbursement requirements including Code of Federal Regulations, title 48, chapter 1, part 31, as relating to for-profit entities, and Office of Management and Budget Circular Number A-122, as relating to nonprofit entities;

(3) the intensity and frequency of services to be provided to each recipient, including the proposed overall number of units of service to be delivered;

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

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

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

(d) The rate for intensive rehabilitative mental health services must exclude room and board, as defined in section 256I.03, subdivision 6, and services not covered under this section, such as partial hospitalization, home care, and inpatient services. Physician services that are not separately billed may be included in the rate to the extent that a psychiatrist is a member of the treatment team. The county's recommendation shall specify the period for which the rate will be applicable, not to exceed two years.

(e) When services under this section are provided by an assertive community team, case management functions must be an integral part of the team.

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

(g) The commissioner shall approve or reject the county's rate recommendation, based on the commissioner's own analysis of the criteria in paragraph (c).

(h) Paragraph (c), clause (2), is effective for services provided on or after January 1, 2010, to December 31, 2011, and does not change contracts or agreements relating to services provided before January 1, 2010.

Sec. 10. Minnesota Statutes 2008, section 256B.0622, is amended by adding a subdivision to read:

Subd. 8a. **Adjustments based on actual costs and units.** (a) After each calendar year, the commissioner shall compare actual costs and units of service for each provider to the costs and units of service that were used as the basis for the approved rate.

(b) For purposes of this subdivision, "revenue" means actual units of service multiplied by the approved rate and "allowed cost" means costs that are consistent with the budget that was used as the basis for the approved rate, or other costs subsequently approved by the county and the commissioner based on the criteria in subdivision 8, paragraph (c), clause (2).

(c) The commissioner shall require repayment from the provider if the provider has not incurred the costs included in the approved budget, if costs are determined to be unallowable under the criteria in subdivision 8, paragraph (c), clause (2), or if a provider's revenue is more than 105 percent of actual allowed costs due to utilization beyond the projections in the approved budget. The repayment to the commissioner will be proportional to the percent of total units of service reimbursed by the commissioner.

(d) If a provider's revenue is less than 95 percent of actual allowed costs due to lower utilization than projected, the commissioner may adjust the rate so that the provider can recover 95 percent of actual allowable costs. The resulting additional payment by the commissioner will be proportional to the percent of total units of service reimbursed by the commissioner.

(e) The commissioner has the authority to audit programs using all applicable state and federal laws and regulations, including those referenced in subdivision 8, paragraph (c), clause (2).

(f) This subdivision is effective for services provided on or after January 1, 2010, to December 31, 2011, and does not change contracts or agreements relating to services provided before January 1, 2010.

Sec. 11. Minnesota Statutes 2008, section 256B.0623, subdivision 5, is amended to read:

Subd. 5. **Qualifications of provider staff.** Adult rehabilitative mental health services must be provided by qualified individual provider staff of a certified provider entity. Individual provider staff must be qualified under one of the following criteria:

(1) a mental health professional as defined in section 245.462, subdivision 18, clauses (1) to (5). If the recipient has a current diagnostic assessment by a licensed mental health professional as defined in section 245.462, subdivision 18, clauses (1) to (5), recommending receipt of adult mental health rehabilitative services, the definition of mental health professional for purposes of this section includes a person who is qualified under section 245.462, subdivision 18, clause (6), and who holds a current and valid national certification as a certified rehabilitation counselor or certified psychosocial rehabilitation practitioner;

(2) a mental health practitioner as defined in section 245.462, subdivision 17. The mental health practitioner must work under the clinical supervision of a mental health professional;

(3) a certified peer specialist under section 256B.0615. The certified peer specialist must work under the clinical supervision of a mental health professional; or

(4) a mental health rehabilitation worker. A mental health rehabilitation worker means a staff person working under the direction of a mental health practitioner or mental health professional and under the clinical supervision of a mental health professional in the implementation of rehabilitative mental health services as identified in the recipient's individual treatment plan who:

(i) is at least 21 years of age;

(ii) has a high school diploma or equivalent;

(iii) has successfully completed 30 hours of training during the ~~past~~ two years immediately prior to the date of hire, or before provision of direct services, in all of the following areas: recipient rights, recipient-centered individual treatment planning, behavioral terminology, mental illness, co-occurring mental illness and substance abuse, psychotropic medications and side effects, functional assessment, local community resources, adult vulnerability, recipient confidentiality; and

(iv) meets the qualifications in subitem (A) or (B):

(A) has an associate of arts degree or two years full-time postsecondary education in one of the behavioral sciences or human services~~, or~~, is a registered nurse without a bachelor's degree~~.~~, or who within the previous ten years has:

(1) three years of personal life experience with serious and persistent mental illness;

(2) three years of life experience as a primary caregiver to an adult with a serious mental illness or traumatic brain injury; or

(3) 4,000 hours of supervised paid work experience in the delivery of mental health services to adults with a serious mental illness or traumatic brain injury; or

(B)(1) is fluent in the non-English language or competent in the culture of the ethnic group to which at least 20 percent of the mental health rehabilitation worker's clients belong;

(2) receives during the first 2,000 hours of work, monthly documented individual clinical supervision by a mental health professional;

(3) has 18 hours of documented field supervision by a mental health professional or practitioner during the first 160 hours of contact work with recipients, and at least six hours of field supervision quarterly during the following year;

(4) has review and cosignature of charting of recipient contacts during field supervision by a mental health professional or practitioner; and

(5) has ~~40~~ 15 hours of additional continuing education on mental health topics during the first year of employment and 15 hours during every additional year of employment.

Sec. 12. Minnesota Statutes 2008, section 256B.0624, subdivision 8, is amended to read:

Subd. 8. **Adult crisis stabilization staff qualifications.** (a) Adult mental health crisis stabilization services must be provided by qualified individual staff of a qualified provider entity. Individual provider staff must have the following qualifications:

(1) be a mental health professional as defined in section 245.462, subdivision 18, clauses (1) to (5);

(2) be a mental health practitioner as defined in section 245.462, subdivision 17. The mental health practitioner must work under the clinical supervision of a mental health professional; or

(3) be a certified peer specialist under section 256B.0615. The certified peer specialist must work under the clinical supervision of a mental health professional; or

(4) be a mental health rehabilitation worker who meets the criteria in section 256B.0623, subdivision 5, clause ~~(3)~~ (4); works under the direction of a mental health practitioner as defined in section 245.462, subdivision 17, or under direction of a mental health professional; and works under the clinical supervision of a mental health professional.

(b) Mental health practitioners and mental health rehabilitation workers must have completed at least 30 hours of training in crisis intervention and stabilization during the past two years.

Sec. 13. Minnesota Statutes 2008, section 256B.0625, subdivision 49, is amended to read:

Subd. 49. **Community health worker.** (a) Medical assistance covers the care coordination and patient education services provided by a community health worker if the community health worker has:

(1) received a certificate from the Minnesota State Colleges and Universities System approved community health worker curriculum; or

(2) at least five years of supervised experience with an enrolled physician, registered nurse, advanced practice registered nurse, mental health professional as defined in section 245.462, subdivision 18, clauses (1) to (5), and section 245.4871, subdivision 27, clauses (1) to (5), or dentist, or at least five years of supervised experience by a certified public health nurse operating under the direct authority of an enrolled unit of government.

Community health workers eligible for payment under clause (2) must complete the certification program by January 1, 2010, to continue to be eligible for payment.

(b) Community health workers must work under the supervision of a medical assistance enrolled physician, registered nurse, advanced practice registered nurse, mental health professional as defined in section 245.462, subdivision 18, clauses (1) to (5), and section 245.4871, subdivision 27, clauses (1) to (5), or dentist, or work under the supervision of a certified public health nurse operating under the direct authority of an enrolled unit of government.

(c) Care coordination and patient education services covered under this subdivision include, but are not limited to, services relating to oral health and dental care.

Sec. 14. Minnesota Statutes 2008, section 256B.0943, subdivision 1, is amended to read:

Subdivision 1. **Definitions.** For purposes of this section, the following terms have the meanings given them.

(a) "Children's therapeutic services and supports" means the flexible package of mental health services for children who require varying therapeutic and rehabilitative levels of intervention. The services are time-limited interventions that are delivered using various treatment modalities and combinations of services designed to reach treatment outcomes identified in the individual treatment plan.

(b) "Clinical supervision" means the overall responsibility of the mental health professional for the control and direction of individualized treatment planning, service delivery, and treatment review for each client. A mental health professional who is an enrolled Minnesota health care program provider accepts full professional responsibility

for a supervisee's actions and decisions, instructs the supervisee in the supervisee's work, and oversees or directs the supervisee's work.

(c) "County board" means the county board of commissioners or board established under sections 402.01 to 402.10 or 471.59.

(d) "Crisis assistance" has the meaning given in section 245.4871, subdivision 9a.

(e) "Culturally competent provider" means a provider who understands and can utilize to a client's benefit the client's culture when providing services to the client. A provider may be culturally competent because the provider is of the same cultural or ethnic group as the client or the provider has developed the knowledge and skills through training and experience to provide services to culturally diverse clients.

(f) "Day treatment program" for children means a site-based structured program consisting of group psychotherapy for more than three individuals and other intensive therapeutic services provided by a multidisciplinary team, under the clinical supervision of a mental health professional.

(g) "Diagnostic assessment" has the meaning given in section 245.4871, subdivision 11.

(h) "Direct service time" means the time that a mental health professional, mental health practitioner, or mental health behavioral aide spends face-to-face with a client and the client's family. Direct service time includes time in which the provider obtains a client's history or provides service components of children's therapeutic services and supports. Direct service time does not include time doing work before and after providing direct services, including scheduling, maintaining clinical records, consulting with others about the client's mental health status, preparing reports, receiving clinical supervision ~~directly related to the client's psychotherapy session~~, and revising the client's individual treatment plan.

(i) "Direction of mental health behavioral aide" means the activities of a mental health professional or mental health practitioner in guiding the mental health behavioral aide in providing services to a client. The direction of a mental health behavioral aide must be based on the client's individualized treatment plan and meet the requirements in subdivision 6, paragraph (b), clause (5).

(j) "Emotional disturbance" has the meaning given in section 245.4871, subdivision 15. For persons at least age 18 but under age 21, mental illness has the meaning given in section 245.462, subdivision 20, paragraph (a).

(k) "Individual behavioral plan" means a plan of intervention, treatment, and services for a child written by a mental health professional or mental health practitioner,

under the clinical supervision of a mental health professional, to guide the work of the mental health behavioral aide.

(l) "Individual treatment plan" has the meaning given in section 245.4871, subdivision 21.

(m) "Mental health behavioral aide services" means medically necessary one-on-one activities performed by a trained paraprofessional to assist a child retain or generalize psychosocial skills as taught by a mental health professional or mental health practitioner and as described in the child's individual treatment plan and individual behavior plan. Activities involve working directly with the child or child's family as provided in subdivision 9, paragraph (b), clause (4).

~~(m)~~ (n) "Mental health professional" means an individual as defined in section 245.4871, subdivision 27, clauses (1) to (5), or tribal vendor as defined in section 256B.02, subdivision 7, paragraph (b).

~~(n)~~ (o) "Preschool program" means a day program licensed under Minnesota Rules, parts 9503.0005 to 9503.0175, and enrolled as a children's therapeutic services and supports provider to provide a structured treatment program to a child who is at least 33 months old but who has not yet attended the first day of kindergarten.

~~(o)~~ (p) "Skills training" means individual, family, or group training, delivered by or under the direction of a mental health professional, designed to ~~improve the basic functioning of the child with emotional disturbance and the child's family in the activities of daily living and community living, and to improve the social functioning of the child and the child's family in areas important to the child's maintaining or reestablishing residency in the community. Individual, family, and group skills training must:~~

~~(1) consist of activities designed to promote skill development of the child and the child's family in the use of age-appropriate daily living skills, interpersonal and family relationships, and leisure and recreational services;~~

~~(2) consist of activities that will assist the family's understanding of normal child development and to use parenting skills that will help the child with emotional disturbance achieve the goals outlined in the child's individual treatment plan; and~~

~~(3) promote family preservation and unification, promote the family's integration with the community, and reduce the use of unnecessary out-of-home placement or institutionalization of children with emotional disturbance.~~ facilitate the acquisition of psychosocial skills that are medically necessary to rehabilitate the child to an age-appropriate developmental trajectory heretofore disrupted by a psychiatric illness or to self-monitor, compensate for, cope with, counteract, or replace skills deficits or

maladaptive skills acquired over the course of a psychiatric illness. Skills training is subject to the following requirements:

(1) a mental health professional or a mental health practitioner must provide skills training;

(2) the child must always be present during skills training; however, a brief absence of the child for no more than ten percent of the session unit may be allowed to redirect or instruct family members;

(3) skills training delivered to children or their families must be targeted to the specific deficits or maladaptations of the child's mental health disorder and must be prescribed in the child's individual treatment plan;

(4) skills training delivered to the child's family must teach skills needed by parents to enhance the child's skill development and to help the child use in daily life the skills previously taught by a mental health professional or mental health practitioner and to develop or maintain a home environment that supports the child's progressive use skills;

(5) group skills training may be provided to multiple recipients who, because of the nature of their emotional, behavioral, or social dysfunction, can derive mutual benefit from interaction in a group setting, which must be staffed as follows:

(i) one mental health professional or one mental health practitioner under supervision of a licensed mental health professional must work with a group of four to eight clients; or

(ii) two mental health professionals or two mental health practitioners under supervision of a licensed mental health professional, or one professional plus one practitioner must work with a group of nine to 12 clients.

Sec. 15. Minnesota Statutes 2008, section 256B.0943, subdivision 2, is amended to read:

Subd. 2. **Covered service components of children's therapeutic services and supports.** (a) Subject to federal approval, medical assistance covers medically necessary children's therapeutic services and supports as defined in this section that an eligible provider entity certified under ~~subdivisions~~ subdivision 4 ~~and 5~~ provides to a client eligible under subdivision 3.

(b) The service components of children's therapeutic services and supports are:

(1) individual, family, and group psychotherapy;

(2) individual, family, or group skills training provided by a mental health professional or mental health practitioner;

(3) crisis assistance;

(4) mental health behavioral aide services; and

(5) direction of a mental health behavioral aide.

(c) Service components in paragraph (b) may be combined to constitute therapeutic programs, including day treatment programs and therapeutic preschool programs. ~~Although day treatment and preschool programs have specific client and provider eligibility requirements, medical assistance only pays for the service components listed in paragraph (b).~~

Sec. 16. Minnesota Statutes 2008, section 256B.0943, subdivision 4, is amended to read:

Subd. 4. **Provider entity certification.** (a) Effective July 1, 2003, the commissioner shall establish an initial provider entity application and certification process and recertification process to determine whether a provider entity has an administrative and clinical infrastructure that meets the requirements in subdivisions 5 and 6. The commissioner shall recertify a provider entity at least every three years. The commissioner shall establish a process for decertification of a provider entity that no longer meets the requirements in this section. ~~The county, tribe, and the commissioner shall be mutually responsible and accountable for the county's, tribe's, and state's part of the certification, recertification, and decertification processes.~~

(b) For purposes of this section, a provider entity must be:

(1) an Indian health services facility or a facility owned and operated by a tribe or tribal organization operating as a 638 facility under Public Law 93-638 certified by the state;

(2) a county-operated entity certified by the state; or

(3) a noncounty entity ~~recommended for certification by the provider's host county and~~ certified by the state.

Sec. 17. Minnesota Statutes 2008, section 256B.0943, subdivision 5, is amended to read:

Subd. 5. **Provider entity administrative infrastructure requirements.** (a) To be an eligible provider entity under this section, a provider entity must have an administrative infrastructure that establishes authority and accountability for decision making and oversight of functions, including finance, personnel, system management, clinical practice, and performance measurement. The provider must have written policies and procedures that it reviews and updates every three years and distributes to staff initially and upon each subsequent update.

(b) The administrative infrastructure written policies and procedures must include:

(1) personnel procedures, including a process for: (i) recruiting, hiring, training, and retention of culturally and linguistically competent providers; (ii) conducting a criminal background check on all direct service providers and volunteers; (iii) investigating, reporting, and acting on violations of ethical conduct standards; (iv) investigating, reporting, and acting on violations of data privacy policies that are compliant with federal and state laws; (v) utilizing volunteers, including screening applicants, training and supervising volunteers, and providing liability coverage for volunteers; and (vi) documenting that each mental health professional, mental health practitioner, or mental health behavioral aide meets the applicable provider qualification criteria, training criteria under subdivision 8, and clinical supervision or direction of a mental health behavioral aide requirements under subdivision 6;

(2) fiscal procedures, including internal fiscal control practices and a process for collecting revenue that is compliant with federal and state laws;

~~(3) if a client is receiving services from a case manager or other provider entity, a service coordination process that ensures services are provided in the most appropriate manner to achieve maximum benefit to the client. The provider entity must ensure coordination and nonduplication of services consistent with county board coordination procedures established under section 245.4881, subdivision 5;~~

~~(4)~~ (3) a performance measurement system, including monitoring to determine cultural appropriateness of services identified in the individual treatment plan, as determined by the client's culture, beliefs, values, and language, and family-driven services; and

~~(5)~~ (4) a process to establish and maintain individual client records. The client's records must include:

(i) the client's personal information;

(ii) forms applicable to data privacy;

(iii) the client's diagnostic assessment, updates, results of tests, individual treatment plan, and individual behavior plan, if necessary;

(iv) documentation of service delivery as specified under subdivision 6;

(v) telephone contacts;

(vi) discharge plan; and

(vii) if applicable, insurance information.

(c) A provider entity that uses a restrictive procedure with a client must meet the requirements of section 245.8261.

Sec. 18. Minnesota Statutes 2008, section 256B.0943, subdivision 6, is amended to read:

Subd. 6. **Provider entity clinical infrastructure requirements.** (a) To be an eligible provider entity under this section, a provider entity must have a clinical infrastructure that utilizes diagnostic assessment, ~~an~~ individualized treatment ~~plan~~ plans, service delivery, and individual treatment plan review that are culturally competent, child-centered, and family-driven to achieve maximum benefit for the client. The provider entity must review, and update as necessary the clinical policies and procedures every three years and must distribute the policies and procedures to staff initially and upon each subsequent update.

(b) The clinical infrastructure written policies and procedures must include policies and procedures for:

(1) providing or obtaining a client's diagnostic assessment that identifies acute and chronic clinical disorders, co-occurring medical conditions, sources of psychological and environmental problems, ~~and~~ including a functional assessment. The functional assessment component must clearly summarize the client's individual strengths and needs;

(2) developing an individual treatment plan that ~~is~~:

(i) is based on the information in the client's diagnostic assessment;

(ii) identified goals and objectives of treatment, treatment strategy, schedule for accomplishing treatment goals and objectives, and the individuals responsible for providing treatment services and supports;

~~(ii)~~ (iii) is developed ~~no later than the end of the first psychotherapy session~~ after ~~the~~ completion of the client's diagnostic assessment by ~~the~~ a mental health professional ~~who provides the client's psychotherapy~~ and before the provision of children's therapeutic services and supports;

~~(iii)~~ (iv) is developed through a child-centered, family-driven, culturally appropriate planning process ~~that identifies service needs and individualized, planned, and culturally appropriate interventions that contain specific treatment goals and objectives for the client and the client's family or foster family~~;

~~(iv)~~ (v) is reviewed at least once every 90 days and revised, if necessary; and

~~(v)~~ (vi) is signed by the clinical supervisor and by the client or~~, if appropriate,~~ by the client's parent or other person authorized by statute to consent to mental health services for the client;

(3) developing an individual behavior plan that documents ~~services~~ treatment strategies to be provided by the mental health behavioral aide. The individual behavior plan must include:

(i) detailed instructions on the ~~service~~ treatment strategies to be provided;

(ii) time allocated to each ~~service~~ treatment strategy;

(iii) methods of documenting the child's behavior;

(iv) methods of monitoring the child's progress in reaching objectives; and

(v) goals to increase or decrease targeted behavior as identified in the individual treatment plan;

(4) providing clinical supervision of the mental health practitioner and mental health behavioral aide. A mental health professional must document the clinical supervision the professional provides by cosigning individual treatment plans and making entries in the client's record on supervisory activities. Clinical supervision does not include the authority to make or terminate court-ordered placements of the child. A clinical supervisor must be available for urgent consultation as required by the individual client's needs or the situation. Clinical supervision may occur individually or in a small group to discuss treatment and review progress toward goals. The focus of clinical supervision must be the client's treatment needs and progress and the mental health practitioner's or behavioral aide's ability to provide services;

(4a) ~~CTSS certified provider entities providing~~ meeting day treatment and therapeutic preschool programs ~~must meet the~~ conditions in items (i) to (iii):

(i) the supervisor must be present and available on the premises more than 50 percent of the time in a five-working-day period during which the supervisee is providing a mental health service;

(ii) the diagnosis and the client's individual treatment plan or a change in the diagnosis or individual treatment plan must be made by or reviewed, approved, and signed by the supervisor; and

(iii) every 30 days, the supervisor must review and sign the record ~~of~~ indicating the supervisor has reviewed the client's care for all activities in the preceding 30-day period;

(4b) meeting the clinical supervision standards in items (i) to (iii) for all other services provided under CTSS~~, clinical supervision standards provided in items (i) to (iii) must be used~~:

(i) medical assistance shall reimburse for services provided by a mental health practitioner who maintains a consulting relationship with a mental health professional who accepts full professional responsibility ~~and is present on site for at least one observation during the first 12 hours in which the mental health practitioner provides the individual, family, or group skills training to the child or the child's family~~;

(ii) medical assistance shall reimburse for services provided by a mental health behavioral aide who maintains a consulting relationship with a mental health professional

who accepts full professional responsibility and has an approved plan for clinical supervision of the behavioral aide. Plans will be approved in accordance with supervision standards promulgated by the commissioner of human services;

~~(ii) thereafter,~~ (iii) the mental health professional is required to be present on site for observation as clinically appropriate when the mental health practitioner or mental health behavioral aide is providing ~~individual, family, or group skills training to the child or the child's family~~ CTSS services; and

~~(iii)~~ (iv) when conducted, the ~~observation must be a minimum of one clinical unit. The~~ on-site presence of the mental health professional must be documented in the child's record and signed by the mental health professional who accepts full professional responsibility;

(5) providing direction to a mental health behavioral aide. For entities that employ mental health behavioral aides, the clinical supervisor must be employed by the provider entity or other certified children's therapeutic supports and services provider entity to ensure necessary and appropriate oversight for the client's treatment and continuity of care. The mental health professional or mental health practitioner giving direction must begin with the goals on the individualized treatment plan, and instruct the mental health behavioral aide on how to construct therapeutic activities and interventions that will lead to goal attainment. The professional or practitioner giving direction must also instruct the mental health behavioral aide about the client's diagnosis, functional status, and other characteristics that are likely to affect service delivery. Direction must also include determining that the mental health behavioral aide has the skills to interact with the client and the client's family in ways that convey personal and cultural respect and that the aide actively solicits information relevant to treatment from the family. The aide must be able to clearly explain the activities the aide is doing with the client and the activities' relationship to treatment goals. Direction is more didactic than is supervision and requires the professional or practitioner providing it to continuously evaluate the mental health behavioral aide's ability to carry out the activities of the individualized treatment plan and the individualized behavior plan. When providing direction, the professional or practitioner must:

(i) review progress notes prepared by the mental health behavioral aide for accuracy and consistency with diagnostic assessment, treatment plan, and behavior goals and the professional or practitioner must approve and sign the progress notes;

(ii) identify changes in treatment strategies, revise the individual behavior plan, and communicate treatment instructions and methodologies as appropriate to ensure that treatment is implemented correctly;

(iii) demonstrate family-friendly behaviors that support healthy collaboration among the child, the child's family, and providers as treatment is planned and implemented;

(iv) ensure that the mental health behavioral aide is able to effectively communicate with the child, the child's family, and the provider; and

(v) record the results of any evaluation and corrective actions taken to modify the work of the mental health behavioral aide;

(6) providing service delivery that implements the individual treatment plan and meets the requirements under subdivision 9; and

(7) individual treatment plan review. The review must determine the extent to which the services have met the goals and objectives in the previous treatment plan. The review must assess the client's progress and ensure that services and treatment goals continue to be necessary and appropriate to the client and the client's family or foster family. Revision of the individual treatment plan does not require a new diagnostic assessment unless the client's mental health status has changed markedly. The updated treatment plan must be signed by the clinical supervisor and by the client, if appropriate, and by the client's parent or other person authorized by statute to give consent to the mental health services for the child.

Sec. 19. Minnesota Statutes 2008, section 256B.0943, subdivision 7, is amended to read:

Subd. 7. **Qualifications of individual and team providers.** (a) An individual or team provider working within the scope of the provider's practice or qualifications may provide service components of children's therapeutic services and supports that are identified as medically necessary in a client's individual treatment plan.

(b) An individual provider must be qualified as:

(1) a mental health professional as defined in subdivision 1, paragraph (m); or

(2) a mental health practitioner as defined in section 245.4871, subdivision 26. The mental health practitioner must work under the clinical supervision of a mental health professional; or

(3) a mental health behavioral aide working under the ~~direction~~ clinical supervision of a mental health professional to implement the rehabilitative mental health services identified in the client's individual treatment plan and individual behavior plan.

(A) A level I mental health behavioral aide must:

(i) be at least 18 years old;

(ii) have a high school diploma or general equivalency diploma (GED) or two years of experience as a primary caregiver to a child with severe emotional disturbance within the previous ten years; and

(iii) meet preservice and continuing education requirements under subdivision 8.

(B) A level II mental health behavioral aide must:

(i) be at least 18 years old;

(ii) have an associate or bachelor's degree or 4,000 hours of experience in delivering clinical services in the treatment of mental illness concerning children or adolescents; and

(iii) meet preservice and continuing education requirements in subdivision 8.

(c) A preschool program multidisciplinary team must include at least one mental health professional and one or more of the following individuals under the clinical supervision of a mental health professional:

(i) a mental health practitioner; or

(ii) a program person, including a teacher, assistant teacher, or aide, who meets the qualifications and training standards of a level I mental health behavioral aide.

(d) A day treatment multidisciplinary team must include at least one mental health professional and one mental health practitioner.

Sec. 20. Minnesota Statutes 2008, section 256B.0943, subdivision 9, is amended to read:

Subd. 9. **Service delivery criteria.** (a) In delivering services under this section, a certified provider entity must ensure that:

(1) each individual provider's caseload size permits the provider to deliver services to both clients with severe, complex needs and clients with less intensive needs. The provider's caseload size should reasonably enable the provider to play an active role in service planning, monitoring, and delivering services to meet the client's and client's family's needs, as specified in each client's individual treatment plan;

(2) site-based programs, including day treatment and preschool programs, provide staffing and facilities to ensure the client's health, safety, and protection of rights, and that the programs are able to implement each client's individual treatment plan;

(3) a day treatment program is provided to a group of clients by a multidisciplinary team under the clinical supervision of a mental health professional. The day treatment program must be provided in and by: (i) an outpatient hospital accredited by the Joint Commission on Accreditation of Health Organizations and licensed under sections 144.50 to 144.55; (ii) a community mental health center under section 245.62; ~~and~~ or (iii) an entity that is under contract with the county board to operate a program that meets the

requirements of sections 245.4712, subdivision 2, ~~and~~ or 245.4884, subdivision 2, and Minnesota Rules, parts 9505.0170 to 9505.0475. The day treatment program must stabilize the client's mental health status while developing and improving the client's independent living and socialization skills. The goal of the day treatment program must be to reduce or relieve the effects of mental illness and provide training to enable the client to live in the community. The program must be available at least one day a week for a two-hour ~~three-hour~~ time block. The ~~three-hour~~ two-hour time block must include at least one hour~~, but no more than two hours,~~ of individual or group psychotherapy. ~~The remainder of the three-hourtime block may include recreation therapy, socialization therapy, or independent living skills therapy, but only if the therapies are included in the client's individual treatment plan~~ The remainder of the structured treatment program may include individual or group psychotherapy and individual or group skills training, if included in the client's individual treatment plan. Day treatment programs are not part of inpatient or residential treatment services. A day treatment program may provide fewer than the minimally required hours for a particular child during a billing period in which the child is transitioning into, or out of, the program; and

(4) a therapeutic preschool program is a structured treatment program offered to a child who is at least 33 months old, but who has not yet reached the first day of kindergarten, by a preschool multidisciplinary team in a day program licensed under Minnesota Rules, parts 9503.0005 to 9503.0175. The program must be available ~~at least one day a week for a minimum two-hour time block~~ two hours per day, five days per week, and 12 months of each calendar year. The structured treatment program may include individual or group psychotherapy and ~~recreation therapy, socialization therapy, or independent living skills therapy~~ individual or group skills training, if included in the client's individual treatment plan. A therapeutic preschool program may provide fewer than the minimally required hours for a particular child during a billing period in which the child is transitioning into, or out of, the program.

(b) A provider entity must deliver the service components of children's therapeutic services and supports in compliance with the following requirements:

(1) individual, family, and group psychotherapy must be delivered as specified in Minnesota Rules, part 9505.0323;

(2) individual, family, or group skills training must be provided by a mental health professional or a mental health practitioner who has a consulting relationship with a mental health professional who accepts full professional responsibility for the training;

(3) crisis assistance must be time-limited and designed to resolve or stabilize crisis through arrangements for direct intervention and support services to the child and the

child's family. Crisis assistance must utilize resources designed to address abrupt or substantial changes in the functioning of the child or the child's family as evidenced by a sudden change in behavior with negative consequences for well being, a loss of usual coping mechanisms, or the presentation of danger to self or others;

(4) mental health behavioral aide services must be medically necessary ~~services that are provided by a mental health behavioral aide must be~~ treatment services, identified in the child's individual treatment plan and individual behavior plan, which are performed minimally by a paraprofessional qualified according to subdivision 7, paragraph (b), clause (3), and which are designed to improve the functioning of the child ~~and support the family in activities of daily and community living.~~ in the progressive use of developmentally appropriate psychosocial skills. Activities involve working directly with the child, child-peer groupings, or child-family groupings to practice, repeat, reintroduce, and master the skills defined in subdivision 1, paragraph (p), as previously taught by a mental health professional or mental health practitioner including:

(i) providing cues or prompts in skill-building peer-to-peer or parent-child interactions so that the child progressively recognizes and responds to the cues independently;

(ii) performing as a practice partner or role-play partner;

(iii) reinforcing the child's accomplishments;

(iv) generalizing skill-building activities in the child's multiple natural settings;

(v) assigning further practice activities; and

(vi) intervening as necessary to redirect the child's target behavior and to de-escalate behavior that puts the child or other person at risk of injury.

A mental health behavioral aide must document the delivery of services in written progress notes. The mental health behavioral aide must implement ~~goals in the treatment plan for the child's emotional disturbance that allow the child to acquire developmentally and therapeutically appropriate daily living skills, social skills, and leisure and recreational skills through targeted activities. These activities may include:~~

~~(i) assisting a child as needed with skills development in dressing, eating, and toileting;~~

~~(ii) assisting, monitoring, and guiding the child to complete tasks, including facilitating the child's participation in medical appointments;~~

~~(iii) observing the child and intervening to redirect the child's inappropriate behavior;~~

~~(iv) assisting the child in using age-appropriate self-management skills as related to the child's emotional disorder or mental illness, including problem solving, decision~~

~~making, communication, conflict resolution, anger management, social skills, and recreational skills;~~

~~(v) implementing deescalation techniques as recommended by the mental health professional;~~

~~(vi) implementing any other mental health service that the mental health professional has approved as being within the scope of the behavioral aide's duties; or~~

~~(vii) assisting the parents to develop and use parenting skills that help the child achieve the goals outlined in the child's individual treatment plan or individual behavioral plan. Parenting skills must be directed exclusively to the child's treatment~~ treatment strategies in the individual treatment plan and the individual behavior plan. The mental health behavioral aide must document the delivery of services in written progress notes. Progress notes must reflect implementation of the treatment strategies, as performed by the mental health behavioral aide and the child's responses to the treatment strategies; and

(5) direction of a mental health behavioral aide must include the following:

(i) a total of one hour of on-site observation by a mental health professional during the first 12 hours of service provided to a child;

(ii) ongoing on-site observation by a mental health professional or mental health practitioner for at least a total of one hour during every 40 hours of service provided to a child; and

(iii) immediate accessibility of the mental health professional or mental health practitioner to the mental health behavioral aide during service provision.

Sec. 21. Minnesota Statutes 2008, section 256B.0944, subdivision 5, is amended to read:

Subd. 5. **Mobile crisis intervention staff qualifications.** (a) To provide children's mental health mobile crisis intervention services, a mobile crisis intervention team must include:

(1) at least two mental health professionals as defined in section 256B.0943, subdivision 1, paragraph ~~(m)~~ (n); or

(2) a combination of at least one mental health professional and one mental health practitioner as defined in section 245.4871, subdivision 26, with the required mental health crisis training and under the clinical supervision of a mental health professional on the team.

(b) The team must have at least two people with at least one member providing on-site crisis intervention services when needed. Team members must be experienced in mental health assessment, crisis intervention techniques, and clinical decision making

under emergency conditions and have knowledge of local services and resources. The team must recommend and coordinate the team's services with appropriate local resources, including the county social services agency, mental health service providers, and local law enforcement, if necessary.