

**SENATE
STATE OF MINNESOTA
NINETY-THIRD SESSION**

S.F. No. 3701

(SENATE AUTHORS: MORRISON)

DATE
02/15/2024

D-PG

Introduction and first reading
Referred to Health and Human Services

OFFICIAL STATUS

1.1 A bill for an act

1.2 relating to behavioral health; modifying community support services program

1.3 standards; modifying the first episode of psychosis grant program; adding

1.4 occupational therapists to adult rehabilitative mental health services provider staff;

1.5 modifying medical assistance reimbursement rates for nonemergency transportation

1.6 services; adding option for contact via secure electronic message for mental health

1.7 case management payment; establishing protected transport start-up grants;

1.8 establishing engagement services pilot grants; establishing an early episode of

1.9 bipolar disorder grant program; requiring the commissioner of human services to

1.10 make recommendations for a formula-based allocation for mental health grant

1.11 services; requiring reports; appropriating money; amending Minnesota Statutes

1.12 2022, sections 245.462, subdivision 6; 245.4905; 256B.0623, subdivision 5;

1.13 256B.0625, subdivision 20; Minnesota Statutes 2023 Supplement, section

1.14 256B.0625, subdivision 17; Laws 2023, chapter 70, article 20, section 2, subdivision

1.15 29; proposing coding for new law in Minnesota Statutes, chapters 245; 253B.

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

1.17 Section 1. Minnesota Statutes 2022, section 245.462, subdivision 6, is amended to read:

1.18 Subd. 6. **Community support services program.** "Community support services program"

1.19 means services, other than inpatient or residential treatment services, provided or coordinated

1.20 by an identified program and staff under the treatment supervision of a mental health

1.21 professional designed to help adults with serious and persistent mental illness to function

1.22 and remain in the community. A community support services program includes:

- 1.23 (1) client outreach,
- 1.24 (2) medication monitoring,
- 1.25 (3) assistance in independent living skills,
- 1.26 (4) development of employability and work-related opportunities,

- 2.1 (5) crisis assistance,
- 2.2 (6) psychosocial rehabilitation,
- 2.3 (7) help in applying for government benefits, and
- 2.4 (8) housing support services.

2.5 The community support services program must be coordinated with the case management
 2.6 services specified in section 245.4711. A program that meets the accreditation standards
 2.7 for Clubhouse International model programs meets the requirements of this subdivision.

2.8 Sec. 2. Minnesota Statutes 2022, section 245.4905, is amended to read:

2.9 **245.4905 FIRST EPISODE OF PSYCHOSIS GRANT PROGRAM.**

2.10 Subdivision 1. **Creation.** The first episode of psychosis grant program is established in
 2.11 the Department of Human Services to fund evidence-based interventions for youth and
 2.12 young adults at risk of developing or experiencing a an early or first episode of psychosis
 2.13 ~~and a public awareness campaign on the signs and symptoms of psychosis.~~ First episode of
 2.14 psychosis services are eligible for children's mental health grants as specified in section
 2.15 245.4889, subdivision 1, paragraph (b), clause (15). The Department of Human Services
 2.16 must seek to fund eligible providers of first episode of psychosis services and assist with
 2.17 program establishment throughout the state.

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

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

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

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

2.30 (4) use all available funding streams.

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

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

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

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

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

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

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

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

3.21 Sec. 3. **[245.4908] EARLY EPISODE OF BIPOLAR DISORDER GRANT**
 3.22 **PROGRAM.**

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

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

3.30 (1) provide intensive treatment and support for adolescents and young adults experiencing
 3.31 or at risk of experiencing early episode of bipolar disorder. Intensive treatment and support
 3.32 includes medication management, psychoeducation for an individual and an individual's

4.1 family, case management, employment support, education support, cognitive behavioral
4.2 approaches, social skills training, peer and family peer support, crisis planning, and stress
4.3 management;

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

4.7 (3) use all available funding streams.

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

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

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

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

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

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

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

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

4.28 Sec. 4. **[253B.042] ENGAGEMENT SERVICES PILOT GRANTS.**

4.29 Subdivision 1. **Creation.** The engagement services pilot grant program is established
4.30 in the Department of Human Services, to provide grants to counties or certified community
4.31 behavioral health centers to provide engagement services under section 253B.041.

5.1 Engagement services provide early interventions to prevent an individual from meeting the
5.2 criteria for civil commitment and promote positive outcomes.

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

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

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

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

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

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

5.15 (3) conduct outreach to families and providers; and

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

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

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

6.1 Sec. 5. Minnesota Statutes 2022, section 256B.0623, subdivision 5, is amended to read:

6.2 Subd. 5. **Qualifications of provider staff.** Adult rehabilitative mental health services
6.3 must be provided by qualified individual provider staff of a certified provider entity.

6.4 Individual provider staff must be qualified as:

6.5 (1) a mental health professional who is qualified according to section 245I.04, subdivision
6.6 2;

6.7 (2) a certified rehabilitation specialist who is qualified according to section 245I.04,
6.8 subdivision 8;

6.9 (3) a clinical trainee who is qualified according to section 245I.04, subdivision 6;

6.10 (4) a mental health practitioner qualified according to section 245I.04, subdivision 4;

6.11 (5) a mental health certified peer specialist who is qualified according to section 245I.04,
6.12 subdivision 10; ~~or~~

6.13 (6) a mental health rehabilitation worker who is qualified according to section 245I.04,
6.14 subdivision 14; or

6.15 (7) a licensed occupational therapist, as defined in section 148.6402, subdivision 14.

6.16 Sec. 6. Minnesota Statutes 2023 Supplement, section 256B.0625, subdivision 17, is
6.17 amended to read:

6.18 Subd. 17. **Transportation costs.** (a) "Nonemergency medical transportation service"
6.19 means motor vehicle transportation provided by a public or private person that serves
6.20 Minnesota health care program beneficiaries who do not require emergency ambulance
6.21 service, as defined in section 144E.001, subdivision 3, to obtain covered medical services.

6.22 (b) For purposes of this subdivision, "rural urban commuting area" or "RUCA" means
6.23 a census-tract based classification system under which a geographical area is determined
6.24 to be urban, rural, or super rural.

6.25 (c) Medical assistance covers medical transportation costs incurred solely for obtaining
6.26 emergency medical care or transportation costs incurred by eligible persons in obtaining
6.27 emergency or nonemergency medical care when paid directly to an ambulance company,
6.28 nonemergency medical transportation company, or other recognized providers of
6.29 transportation services. Medical transportation must be provided by:

6.30 (1) nonemergency medical transportation providers who meet the requirements of this
6.31 subdivision;

7.1 (2) ambulances, as defined in section 144E.001, subdivision 2;

7.2 (3) taxicabs that meet the requirements of this subdivision;

7.3 (4) public transit, as defined in section 174.22, subdivision 7; or

7.4 (5) not-for-hire vehicles, including volunteer drivers, as defined in section 65B.472,
7.5 subdivision 1, paragraph (h).

7.6 (d) Medical assistance covers nonemergency medical transportation provided by
7.7 nonemergency medical transportation providers enrolled in the Minnesota health care
7.8 programs. All nonemergency medical transportation providers must comply with the
7.9 operating standards for special transportation service as defined in sections 174.29 to 174.30
7.10 and Minnesota Rules, chapter 8840, and all drivers must be individually enrolled with the
7.11 commissioner and reported on the claim as the individual who provided the service. All
7.12 nonemergency medical transportation providers shall bill for nonemergency medical
7.13 transportation services in accordance with Minnesota health care programs criteria. Publicly
7.14 operated transit systems, volunteers, and not-for-hire vehicles are exempt from the
7.15 requirements outlined in this paragraph.

7.16 (e) An organization may be terminated, denied, or suspended from enrollment if:

7.17 (1) the provider has not initiated background studies on the individuals specified in
7.18 section 174.30, subdivision 10, paragraph (a), clauses (1) to (3); or

7.19 (2) the provider has initiated background studies on the individuals specified in section
7.20 174.30, subdivision 10, paragraph (a), clauses (1) to (3), and:

7.21 (i) the commissioner has sent the provider a notice that the individual has been
7.22 disqualified under section 245C.14; and

7.23 (ii) the individual has not received a disqualification set-aside specific to the special
7.24 transportation services provider under sections 245C.22 and 245C.23.

7.25 (f) The administrative agency of nonemergency medical transportation must:

7.26 (1) adhere to the policies defined by the commissioner;

7.27 (2) pay nonemergency medical transportation providers for services provided to
7.28 Minnesota health care programs beneficiaries to obtain covered medical services;

7.29 (3) provide data monthly to the commissioner on appeals, complaints, no-shows, canceled
7.30 trips, and number of trips by mode; and

8.1 (4) by July 1, 2016, in accordance with subdivision 18e, utilize a web-based single
8.2 administrative structure assessment tool that meets the technical requirements established
8.3 by the commissioner, reconciles trip information with claims being submitted by providers,
8.4 and ensures prompt payment for nonemergency medical transportation services.

8.5 (g) Until the commissioner implements the single administrative structure and delivery
8.6 system under subdivision 18e, clients shall obtain their level-of-service certificate from the
8.7 commissioner or an entity approved by the commissioner that does not dispatch rides for
8.8 clients using modes of transportation under paragraph (1), clauses (4), (5), (6), and (7).

8.9 (h) The commissioner may use an order by the recipient's attending physician, advanced
8.10 practice registered nurse, physician assistant, or a medical or mental health professional to
8.11 certify that the recipient requires nonemergency medical transportation services.

8.12 Nonemergency medical transportation providers shall perform driver-assisted services for
8.13 eligible individuals, when appropriate. Driver-assisted service includes passenger pickup
8.14 at and return to the individual's residence or place of business, assistance with admittance
8.15 of the individual to the medical facility, and assistance in passenger securement or in securing
8.16 of wheelchairs, child seats, or stretchers in the vehicle.

8.17 (i) Nonemergency medical transportation providers must take clients to the health care
8.18 provider using the most direct route, and must not exceed 30 miles for a trip to a primary
8.19 care provider or 60 miles for a trip to a specialty care provider, unless the client receives
8.20 authorization from the local agency.

8.21 (j) Nonemergency medical transportation providers may not bill for separate base rates
8.22 for the continuation of a trip beyond the original destination. Nonemergency medical
8.23 transportation providers must maintain trip logs, which include pickup and drop-off times,
8.24 signed by the medical provider or client, whichever is deemed most appropriate, attesting
8.25 to mileage traveled to obtain covered medical services. Clients requesting client mileage
8.26 reimbursement must sign the trip log attesting mileage traveled to obtain covered medical
8.27 services.

8.28 (k) The administrative agency shall use the level of service process established by the
8.29 commissioner to determine the client's most appropriate mode of transportation. If public
8.30 transit or a certified transportation provider is not available to provide the appropriate service
8.31 mode for the client, the client may receive a onetime service upgrade.

8.32 (l) The covered modes of transportation are:

9.1 (1) client reimbursement, which includes client mileage reimbursement provided to
9.2 clients who have their own transportation, or to family or an acquaintance who provides
9.3 transportation to the client;

9.4 (2) volunteer transport, which includes transportation by volunteers using their own
9.5 vehicle;

9.6 (3) unassisted transport, which includes transportation provided to a client by a taxicab
9.7 or public transit. If a taxicab or public transit is not available, the client can receive
9.8 transportation from another nonemergency medical transportation provider;

9.9 (4) assisted transport, which includes transport provided to clients who require assistance
9.10 by a nonemergency medical transportation provider;

9.11 (5) lift-equipped/ramp transport, which includes transport provided to a client who is
9.12 dependent on a device and requires a nonemergency medical transportation provider with
9.13 a vehicle containing a lift or ramp;

9.14 (6) protected transport, which includes transport provided to a client who has received
9.15 a prescreening that has deemed other forms of transportation inappropriate and who requires
9.16 a provider: (i) with a protected vehicle that is not an ambulance or police car and has safety
9.17 locks, a video recorder, and a transparent thermoplastic partition between the passenger and
9.18 the vehicle driver; and (ii) who is certified as a protected transport provider; and

9.19 (7) stretcher transport, which includes transport for a client in a prone or supine position
9.20 and requires a nonemergency medical transportation provider with a vehicle that can transport
9.21 a client in a prone or supine position.

9.22 (m) The local agency shall be the single administrative agency and shall administer and
9.23 reimburse for modes defined in paragraph (l) according to paragraphs (p) and (q) when the
9.24 commissioner has developed, made available, and funded the web-based single administrative
9.25 structure, assessment tool, and level of need assessment under subdivision 18e. The local
9.26 agency's financial obligation is limited to funds provided by the state or federal government.

9.27 (n) The commissioner shall:

9.28 (1) verify that the mode and use of nonemergency medical transportation is appropriate;

9.29 (2) verify that the client is going to an approved medical appointment; and

9.30 (3) investigate all complaints and appeals.

9.31 (o) The administrative agency shall pay for the services provided in this subdivision and
9.32 seek reimbursement from the commissioner, if appropriate. As vendors of medical care,

10.1 local agencies are subject to the provisions in section 256B.041, the sanctions and monetary
10.2 recovery actions in section 256B.064, and Minnesota Rules, parts 9505.2160 to 9505.2245.

10.3 (p) Payments for nonemergency medical transportation must be paid based on the client's
10.4 assessed mode under paragraph (k), not the type of vehicle used to provide the service. The
10.5 medical assistance reimbursement rates for nonemergency medical transportation services
10.6 that are payable by or on behalf of the commissioner for nonemergency medical
10.7 transportation services are:

10.8 (1) \$0.22 per mile for client reimbursement;

10.9 (2) up to 100 percent of the Internal Revenue Service business deduction rate for volunteer
10.10 transport;

10.11 (3) equivalent to the standard fare for unassisted transport when provided by public
10.12 transit, and \$12.10 for the base rate and \$1.43 per mile when provided by a nonemergency
10.13 medical transportation provider;

10.14 (4) \$14.30 for the base rate and \$1.43 per mile for assisted transport;

10.15 (5) \$19.80 for the base rate and \$1.70 per mile for lift-equipped/ramp transport;

10.16 (6) \$75 for the base rate for the first 100 miles, with an additional \$75 for any trip over
10.17 100 miles, and \$2.40 per mile for protected transport; and

10.18 (7) \$60 for the base rate and \$2.40 per mile for stretcher transport, and \$9 per trip for
10.19 an additional attendant if deemed medically necessary.

10.20 (q) The base rate for nonemergency medical transportation services in areas defined
10.21 under RUCA to be super rural is equal to 111.3 percent of the respective base rate in
10.22 paragraph (p), clauses (1) to (7). The mileage rate for nonemergency medical transportation
10.23 services in areas defined under RUCA to be rural or super rural areas is:

10.24 (1) for a trip equal to 17 miles or less, equal to 125 percent of the respective mileage
10.25 rate in paragraph (p), clauses (1) to (7); and

10.26 (2) for a trip between 18 and 50 miles, equal to 112.5 percent of the respective mileage
10.27 rate in paragraph (p), clauses (1) to (7).

10.28 (r) For purposes of reimbursement rates for nonemergency medical transportation services
10.29 under paragraphs (p) and (q), the zip code of the recipient's place of residence shall determine
10.30 whether the urban, rural, or super rural reimbursement rate applies.

11.1 (s) The commissioner, when determining reimbursement rates for nonemergency medical
11.2 transportation under paragraphs (p) and (q), shall exempt all modes of transportation listed
11.3 under paragraph (l) from Minnesota Rules, part 9505.0445, item R, subitem (2).

11.4 (t) Effective for the first day of each calendar quarter in which the price of gasoline as
11.5 posted publicly by the United States Energy Information Administration exceeds \$3.00 per
11.6 gallon, the commissioner shall adjust the rate paid per mile in paragraph (p) by one percent
11.7 up or down for every increase or decrease of ten cents for the price of gasoline. The increase
11.8 or decrease must be calculated using a base gasoline price of \$3.00. The percentage increase
11.9 or decrease must be calculated using the average of the most recently available price of all
11.10 grades of gasoline for Minnesota as posted publicly by the United States Energy Information
11.11 Administration.

11.12 Sec. 7. Minnesota Statutes 2022, section 256B.0625, subdivision 20, is amended to read:

11.13 Subd. 20. **Mental health case management.** (a) To the extent authorized by rule of the
11.14 state agency, medical assistance covers case management services to persons with serious
11.15 and persistent mental illness and children with severe emotional disturbance. Services
11.16 provided under this section must meet the relevant standards in sections 245.461 to 245.4887,
11.17 the Comprehensive Adult and Children's Mental Health Acts, Minnesota Rules, parts
11.18 9520.0900 to 9520.0926, and 9505.0322, excluding subpart 10.

11.19 (b) Entities meeting program standards set out in rules governing family community
11.20 support services as defined in section 245.4871, subdivision 17, are eligible for medical
11.21 assistance reimbursement for case management services for children with severe emotional
11.22 disturbance when these services meet the program standards in Minnesota Rules, parts
11.23 9520.0900 to 9520.0926 and 9505.0322, excluding subparts 6 and 10.

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

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

11.32 (2) at least a telephone contact or contact via secure electronic message, if preferred by
11.33 the adult client, with the adult or the adult's legal representative and document a face-to-face

12.1 contact either in person or by interactive video that meets the requirements of subdivision
12.2 20b with the adult or the adult's legal representative within the preceding two months.

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

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

12.10 (f) Payment for mental health case management provided by vendors who contract with
12.11 a county must be calculated in accordance with section 256B.076, subdivision 2. Payment
12.12 for mental health case management provided by vendors who contract with a Tribe must
12.13 be based on a monthly rate negotiated by the Tribe. The rate must not exceed the rate charged
12.14 by the vendor for the same service to other payers. If the service is provided by a team of
12.15 contracted vendors, the team shall determine how to distribute the rate among its members.
12.16 No reimbursement received by contracted vendors shall be returned to the county or tribe,
12.17 except to reimburse the county or tribe for advance funding provided by the county or tribe
12.18 to the vendor.

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

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

12.33 (i) Notwithstanding any administrative rule to the contrary, prepaid medical assistance
12.34 and MinnesotaCare include mental health case management. When the service is provided

13.1 through prepaid capitation, the nonfederal share is paid by the state and the county pays no
13.2 share.

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

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

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

13.12 (2) programming the information systems.

13.13 (l) Payments to counties and tribal agencies for case management expenditures under
13.14 this section shall only be made from federal earnings from services provided under this
13.15 section. When this service is paid by the state without a federal share through fee-for-service,
13.16 50 percent of the cost shall be provided by the state. Payments to county-contracted vendors
13.17 shall include the federal earnings, the state share, and the county share.

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

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

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

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

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

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

14.1 Sec. 8. Laws 2023, chapter 70, article 20, section 2, subdivision 29, is amended to read:

14.2 **Subd. 29. Grant Programs; Adult Mental Health**
14.3 **Grants**

132,327,000 121,270,000

14.4 **(a) Mobile crisis grants to Tribal Nations.**

14.5 \$1,000,000 in fiscal year 2024 and \$1,000,000
14.6 in fiscal year 2025 are for mobile crisis grants
14.7 under Minnesota Statutes section 245.4661,
14.8 subdivision 9, paragraph (b), clause (15), to
14.9 Tribal Nations.

14.10 **(b) Mental health provider supervision**

14.11 **grant program.** \$1,500,000 in fiscal year
14.12 2024 and \$1,500,000 in fiscal year 2025 are
14.13 for the mental health provider supervision
14.14 grant program under Minnesota Statutes,
14.15 section 245.4663.

14.16 **(c) Minnesota State University, Mankato**
14.17 **community behavioral health center.**

14.18 \$750,000 in fiscal year 2024 and \$750,000 in
14.19 fiscal year 2025 are for a grant to the Center
14.20 for Rural Behavioral Health at Minnesota State
14.21 University, Mankato to establish a community
14.22 behavioral health center and training clinic.

14.23 The community behavioral health center must
14.24 provide comprehensive, culturally specific,
14.25 trauma-informed, practice- and
14.26 evidence-based, person- and family-centered
14.27 mental health and substance use disorder
14.28 treatment services in Blue Earth County and
14.29 the surrounding region to individuals of all
14.30 ages, regardless of an individual's ability to
14.31 pay or place of residence. The community
14.32 behavioral health center and training clinic
14.33 must also provide training and workforce
14.34 development opportunities to students enrolled
14.35 in the university's training programs in the

15.1 fields of social work, counseling and student
 15.2 personnel, alcohol and drug studies,
 15.3 psychology, and nursing. Upon request, the
 15.4 commissioner must make information
 15.5 regarding the use of this grant funding
 15.6 available to the chairs and ranking minority
 15.7 members of the legislative committees with
 15.8 jurisdiction over behavioral health. This is a
 15.9 onetime appropriation and is available until
 15.10 June 30, 2027.

15.11 **(d) White Earth Nation; adult mental health**
 15.12 **initiative.** \$300,000 in fiscal year 2024 and
 15.13 \$300,000 in fiscal year 2025 are for adult
 15.14 mental health initiative grants to the White
 15.15 Earth Nation. This is a onetime appropriation.

15.16 **(e) Mobile crisis grants.** \$8,472,000 in fiscal
 15.17 year 2024 and ~~\$8,380,000~~ \$8,472,000 in fiscal
 15.18 year 2025 are for the mobile crisis grants
 15.19 under Minnesota Statutes, section 245.4661,
 15.20 subdivision 9, paragraph (b), clause (15). This
 15.21 ~~is a onetime appropriation and~~ is available
 15.22 until June 30, 2027. This funding is added to
 15.23 the base.

15.24 **(f) Base level adjustment.** The general fund
 15.25 base is \$121,980,000 in fiscal year 2026 and
 15.26 \$121,980,000 in fiscal year 2027.

15.27 Sec. 9. **MENTAL HEALTH SERVICES FORMULA-BASED ALLOCATION.**

15.28 The commissioner of human services shall consult with the commissioner of management
 15.29 and budget, counties, Tribes, mental health providers, and advocacy organizations to develop
 15.30 recommendations for moving from the children's and adult mental health grant funding
 15.31 structure to a formula-based allocation structure for mental health service. The
 15.32 recommendations must consider formula-based allocations for grants for respite care,
 15.33 school-linked behavioral health, mobile crisis teams, and first episode of psychosis programs.

16.1 **Sec. 10. APPROPRIATION; ENGAGEMENT SERVICES PILOT GRANTS.**

16.2 \$2,000,000 in fiscal year 2025 is appropriated from the general fund to the commissioner
16.3 of human services for engagement services pilot grants under Minnesota Statutes, section
16.4 253B.042. This funding is added to the base.

16.5 **Sec. 11. APPROPRIATION; EARLY EPISODE OF BIPOLAR GRANT PROGRAM.**

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

16.9 **Sec. 12. APPROPRIATION; FIRST EPISODE OF PSYCHOSIS GRANT**
16.10 **PROGRAM.**

16.11 \$2,000,000 in fiscal year 2025 is appropriated from the general fund to the commissioner
16.12 of human services for the first episode of psychosis grant program under Minnesota Statutes,
16.13 section 245.4905. This funding is added to the base. The commissioner may distribute this
16.14 funding to fully fund current grantee programs, increase a current grantee program's capacity,
16.15 and to expand grants for programs to outside the seven-county metropolitan area. The
16.16 commissioner must continue to fund current grantee programs to ensure stability and
16.17 continuity of care, if the current grantee programs have met requirements for usage of grant
16.18 funds previously received.

16.19 **Sec. 13. APPROPRIATION; HOUSING WITH SUPPORTS FOR ADULTS WITH**
16.20 **SERIOUS MENTAL ILLNESS.**

16.21 \$2,000,000 in fiscal year 2025 is appropriated from the general fund to the commissioner
16.22 of human services for adult mental health grants under Minnesota Statutes, section 245.4661,
16.23 subdivision 9, paragraph (a), clause (2), to support increased availability of housing options
16.24 with supports for adults with serious mental illness. This funding is added to the base.

16.25 **Sec. 14. APPROPRIATION; PROTECTED TRANSPORT START-UP GRANTS.**

16.26 \$500,000 in fiscal year 2025 is appropriated from the general fund to the commissioner
16.27 of human services to provide start-up grants to nonemergency medical transportation
16.28 providers to configure vehicles to meet protected transport requirements. This funding is
16.29 added to the base.