This Document can be made available in alternative formats upon request

State of Minnesota

Printed Page No. 522

HOUSE OF REPRESENTATIVES

EIGHTY-SIXTH SESSION

HOUSE FILE NO. 2926

February 12, 2010
Authored by Hosch
The bill was read for the first time and referred to the Committee on Health Care and Human Services Policy and Oversight
March 22, 2010
Committee Recommendation and Adoption of Report:
To Pass as Amended
Read Second Time

1.1 A bill for an act
1.2 relating to human services; amending children's mental health policy provisions;
1.3 making a technical change to community health workers; amending Minnesota
1.4 Statutes 2008, sections 256B.761; 260C.157, subdivision 3; Minnesota Statutes
1.5 2009 Supplement, sections 245.4885, subdivisions 1, 1a; 254B.05, subdivision 1;
1.6 256B.0625, subdivision 49; 256B.0943, subdivision 9.

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

1.8 Section 1. Minnesota Statutes 2009 Supplement, section 245.4885, subdivision 1,
1.9 is amended to read:

1.10 Subdivision 1. **Admission criteria.** (a) Prior to admission, except in the case of
1.11 emergency admission, all children referred for treatment of severe emotional disturbance
1.12 in a treatment foster care setting, residential treatment facility, or informally admitted to a
1.13 regional treatment center shall undergo an assessment to determine the appropriate level
1.14 of care if public funds are used to pay for the services.

1.15 (b) The county board shall determine the appropriate level of care when
1.16 county-controlled funds are used to pay for the services. When the child is enrolled in
1.17 a prepaid health program under section 256B.69, the enrolled child's contracted health
1.18 plan must determine the appropriate level of care. <u>When Indian Health Services funds</u>
1.19 <u>or funds of a tribally owned facility funded under the Indian Self-Determination and</u>
1.20 <u>Education Assistance Act, Public Law 93-638, are to be used, the Indian Health Services</u>
1.21 <u>or 638 tribal health facility must determine the appropriate level of care.</u> When more than
1.22 one entity bears responsibility for coverage, the entities shall coordinate level of care
1.23 determination activities to the extent possible.

1.24 (c) The level of care determination shall determine whether the proposed treatment:

1.25 (1) is necessary;

2.1 (2) is appropriate to the child's individual treatment needs;
2.2 (3) cannot be effectively provided in the child's home; and
2.3 (4) provides a length of stay as short as possible consistent with the individual
2.4 child's need.
2.5 (d) When a level of care determination is conducted, the responsible entity may
2.6 not determine that referral or admission to a treatment foster care setting or residential
2.7 treatment facility is not appropriate solely because services were not first provided to the
2.8 child in a less restrictive setting and the child failed to make progress toward or meet
2.9 treatment goals in the less restrictive setting. The level of care determination must be
2.10 based on a diagnostic assessment that includes a functional assessment which evaluates
2.11 family, school, and community living situations; and an assessment of the child's need
2.12 for care out of the home using a validated tool which assesses a child's functional status
2.13 and assigns an appropriate level of care. The validated tool must be approved by the
2.14 commissioner of human services. If a diagnostic assessment including a functional
2.15 assessment has been completed by a mental health professional within the past 180 days,
2.16 a new diagnostic assessment need not be completed unless in the opinion of the current
2.17 treating mental health professional the child's mental health status has changed markedly
2.18 since the assessment was completed. The child's parent shall be notified if an assessment
2.19 will not be completed and of the reasons. A copy of the notice shall be placed in the
2.20 child's file. Recommendations developed as part of the level of care determination process
2.21 shall include specific community services needed by the child and, if appropriate, the
2.22 child's family, and shall indicate whether or not these services are available and accessible
2.23 to the child and family.
2.24 (e) During the level of care determination process, the child, child's family, or child's
2.25 legal representative, as appropriate, must be informed of the child's eligibility for case
2.26 management services and family community support services and that an individual
2.27 family community support plan is being developed by the case manager, if assigned.
2.28 (f) The level of care determination shall comply with section 260C.212. The parent
2.29 shall be consulted in the process, unless clinically detrimental to the child.
2.30 (g) The level of care determination, and placement decision, and recommendations
2.31 for mental health services must be documented in the child's record.

2.32 Sec. 2. Minnesota Statutes 2009 Supplement, section 245.4885, subdivision 1a,
2.33 is amended to read:
2.34 Subd. 1a. **Emergency admission.** Effective July 1, 2006, if a child is admitted to
2.35 a treatment foster care setting, residential treatment facility, ~~or acute care hospital for~~

~~emergency treatment~~ or held for emergency care by a regional treatment center under section 253B.05, subdivision 1, the level of care determination must occur within five working days of admission.

Sec. 3. Minnesota Statutes 2009 Supplement, section 254B.05, subdivision 1, is amended to read:

Subdivision 1. **Licensure required.** Programs licensed by the commissioner are eligible vendors. Hospitals may apply for and receive licenses to be eligible vendors, notwithstanding the provisions of section 245A.03. American Indian programs ~~located on federally recognized tribal lands~~ that provide chemical dependency primary treatment, extended care, transitional residence, or outpatient treatment services, and are licensed by tribal government are eligible vendors. Detoxification programs are not eligible vendors. Programs that are not licensed as a chemical dependency residential or nonresidential treatment program by the commissioner or by tribal government are not eligible vendors. To be eligible for payment under the Consolidated Chemical Dependency Treatment Fund, a vendor of a chemical dependency service must participate in the Drug and Alcohol Abuse Normative Evaluation System and the treatment accountability plan.

Effective January 1, 2000, vendors of room and board are eligible for chemical dependency fund payment if the vendor:

(1) has rules prohibiting residents bringing chemicals into the facility or using chemicals while residing in the facility and provide consequences for infractions of those rules;

(2) has a current contract with a county or tribal governing body;

(3) is determined to meet applicable health and safety requirements;

(4) is not a jail or prison; and

(5) is not concurrently receiving funds under chapter 256I for the recipient.

Sec. 4. Minnesota Statutes 2009 Supplement, 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

4.1 245.462, subdivision 18, clauses (1) to ~~(5)~~ (6), and section 245.4871, subdivision 27,
4.2 clauses (1) to (5), or dentist, or at least five years of supervised experience by a certified
4.3 public health nurse operating under the direct authority of an enrolled unit of government.

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

4.6 (b) Community health workers must work under the supervision of a medical
4.7 assistance enrolled physician, registered nurse, advanced practice registered nurse, mental
4.8 health professional as defined in section 245.462, subdivision 18, clauses (1) to ~~(5)~~ (6),
4.9 and section 245.4871, subdivision 27, clauses (1) to (5), or dentist, or work under the
4.10 supervision of a certified public health nurse operating under the direct authority of an
4.11 enrolled unit of government.

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

4.14 Sec. 5. Minnesota Statutes 2009 Supplement, section 256B.0943, subdivision 9,
4.15 is amended to read:

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

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

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

4.26 (3) a day treatment program is provided to a group of clients by a multidisciplinary
4.27 team under the clinical supervision of a mental health professional. The day treatment
4.28 program must be provided in and by: (i) an outpatient hospital accredited by the Joint
4.29 Commission on Accreditation of Health Organizations and licensed under sections
4.30 144.50 to 144.55; (ii) a community mental health center under section 245.62; or (iii)
4.31 an entity that is under contract with the county board to operate a program that meets
4.32 the requirements of section 245.4712, subdivision 2, or 245.4884, subdivision 2, and
4.33 Minnesota Rules, parts 9505.0170 to 9505.0475. The day treatment program must
4.34 stabilize the client's mental health status while developing and improving the client's
4.35 independent living and socialization skills. The goal of the day treatment program must

5.1 be to reduce or relieve the effects of mental illness and provide training to enable the
5.2 client to live in the community. The program must be available at least one day a week
5.3 for a two-hour time block. The two-hour time block must include at least one hour of
5.4 individual or group psychotherapy. The remainder of the structured treatment program
5.5 may include individual or group psychotherapy ~~and recreation therapy, socialization~~
5.6 ~~therapy, or independent living skills therapy~~, and individual or group skills training, if
5.7 included in the client's individual treatment plan. Day treatment programs are not part of
5.8 inpatient or residential treatment services. A day treatment program may provide fewer
5.9 than the minimally required hours for a particular child during a billing period in which
5.10 the child is transitioning into, or out of, the program; and

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

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

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

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

5.27 (3) crisis assistance must be time-limited and designed to resolve or stabilize crisis
5.28 through arrangements for direct intervention and support services to the child and the
5.29 child's family. Crisis assistance must utilize resources designed to address abrupt or
5.30 substantial changes in the functioning of the child or the child's family as evidenced by
5.31 a sudden change in behavior with negative consequences for well being, a loss of usual
5.32 coping mechanisms, or the presentation of danger to self or others;

5.33 (4) mental health behavioral aide services must be medically necessary treatment
5.34 services, identified in the child's individual treatment plan and individual behavior plan,
5.35 which are performed minimally by a paraprofessional qualified according to subdivision
5.36 7, paragraph (b), clause (3), and which are designed to improve the functioning of the

6.1 child in the progressive use of developmentally appropriate psychosocial skills. Activities
6.2 involve working directly with the child, child-peer groupings, or child-family groupings
6.3 to practice, repeat, reintroduce, and master the skills defined in subdivision 1, paragraph
6.4 (p), as previously taught by a mental health professional or mental health practitioner
6.5 including:

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

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

6.10 (iii) reinforcing the child's accomplishments;

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

6.12 (v) assigning further practice activities; and

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

6.15 A mental health behavioral aide must document the delivery of services in written
6.16 progress notes. The mental health behavioral aide must implement treatment strategies
6.17 in the individual treatment plan and the individual behavior plan. The mental health
6.18 behavioral aide must document the delivery of services in written progress notes. Progress
6.19 notes must reflect implementation of the treatment strategies, as performed by the mental
6.20 health behavioral aide and the child's responses to the treatment strategies; and

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

6.22 (i) ~~a total of one hour of on-site observation by a mental health professional during~~
6.23 ~~the first 12 hours of service provided to a child~~ a clinical supervision plan approved by
6.24 the responsible mental health professional;

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

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

6.30 Sec. 6. Minnesota Statutes 2008, section 256B.761, is amended to read:

6.31 **256B.761 REIMBURSEMENT FOR MENTAL HEALTH SERVICES.**

6.32 (a) Effective for services rendered on or after July 1, 2001, payment for medication
6.33 management provided to psychiatric patients, outpatient mental health services, day
6.34 treatment services, home-based mental health services, and family community support

7.1 services shall be paid at the lower of (1) submitted charges, or (2) 75.6 percent of the
7.2 50th percentile of 1999 charges.
7.3 (b) Effective July 1, 2001, the medical assistance rates for outpatient mental health
7.4 services provided by an entity that operates: (1) a Medicare-certified comprehensive
7.5 outpatient rehabilitation facility; and (2) a facility that was certified prior to January 1,
7.6 1993, with at least 33 percent of the clients receiving rehabilitation services in the most
7.7 recent calendar year who are medical assistance recipients, will be increased by 38 percent,
7.8 when those services are provided within the comprehensive outpatient rehabilitation
7.9 facility and provided to residents of nursing facilities owned by the entity.
7.10 (c) The commissioner shall establish three levels of payment for mental health
7.11 diagnostic assessment, based on three levels of complexity. The aggregate payment under
7.12 the tiered rates must not exceed the projected aggregate payments for mental health
7.13 diagnostic assessment under the previous single rate. The new rate structure is effective
7.14 January 1, 2011, or upon federal approval, whichever is later.

7.15 Sec. 7. Minnesota Statutes 2008, section 260C.157, subdivision 3, is amended to read:
7.16 Subd. 3. **Juvenile treatment screening team.** (a) The responsible social services
7.17 agency shall establish a juvenile treatment screening team to conduct screenings and
7.18 prepare case plans under this subdivision. The team, which may be the team constituted
7.19 under section 245.4885 or 256B.092 or Minnesota Rules, parts 9530.6600 to 9530.6655,
7.20 shall consist of social workers, juvenile justice professionals, and persons with expertise
7.21 in the treatment of juveniles who are emotionally disabled, chemically dependent, or have
7.22 a developmental disability. The team shall involve parents or guardians in the screening
7.23 process as appropriate. The team may be the same team as defined in section 260B.157,
7.24 subdivision 3.
7.25 (b) The social services agency shall determine whether a child brought to its
7.26 attention for the purposes described in this section is an Indian child, as defined in section
7.27 260C.007, subdivision 21, and shall determine the identity of the Indian child's tribe, as
7.28 defined in section 260.755, subdivision 9. When a child to be evaluated is an Indian child,
7.29 the team provided in paragraph (a) shall include a designated representative of the Indian
7.30 child's tribe, unless the child's tribal authority declines to appoint a representative. The
7.31 Indian child's tribe may delegate its authority to represent the child to any other federally
7.32 recognized Indian tribe, as defined in section 260.755, subdivision 12.
7.33 ~~(b)~~ (c) If the court, prior to, or as part of, a final disposition, proposes to place a child:
7.34 (1) for the primary purpose of treatment for an emotional disturbance, a
7.35 developmental disability, or chemical dependency in a residential treatment facility out

8.1 of state or in one which is within the state and licensed by the commissioner of human
8.2 services under chapter 245A; or
8.3 (2) in any out-of-home setting potentially exceeding 30 days in duration, including a
8.4 postdispositional placement in a facility licensed by the commissioner of corrections or
8.5 human services, the court shall ascertain whether the child is an Indian child and shall
8.6 notify the county welfare agency and, if the child is an Indian child, shall notify the Indian
8.7 child's tribe. The county's juvenile treatment screening team must either: (i) screen and
8.8 evaluate the child and file its recommendations with the court within 14 days of receipt
8.9 of the notice; or (ii) elect not to screen a given case and notify the court of that decision
8.10 within three working days.
8.11 ~~(c)~~ (d) If the screening team has elected to screen and evaluate the child, the child
8.12 may not be placed for the primary purpose of treatment for an emotional disturbance, a
8.13 developmental disability, or chemical dependency, in a residential treatment facility out of
8.14 state nor in a residential treatment facility within the state that is licensed under chapter
8.15 245A, unless one of the following conditions applies:
8.16 (1) a treatment professional certifies that an emergency requires the placement
8.17 of the child in a facility within the state;
8.18 (2) the screening team has evaluated the child and recommended that a residential
8.19 placement is necessary to meet the child's treatment needs and the safety needs of the
8.20 community, that it is a cost-effective means of meeting the treatment needs, and that it
8.21 will be of therapeutic value to the child; or
8.22 (3) the court, having reviewed a screening team recommendation against placement,
8.23 determines to the contrary that a residential placement is necessary. The court shall state
8.24 the reasons for its determination in writing, on the record, and shall respond specifically
8.25 to the findings and recommendation of the screening team in explaining why the
8.26 recommendation was rejected. The attorney representing the child and the prosecuting
8.27 attorney shall be afforded an opportunity to be heard on the matter.
8.28 (e) When the county's juvenile treatment screening team has elected to screen and
8.29 evaluate a child determined to be an Indian child, the team shall provide notice to the
8.30 tribe or tribes that accept jurisdiction for the Indian child or that recognize the child as a
8.31 member of the tribe or as a person eligible for membership in the tribe, and permit the
8.32 tribe's representative to participate in the screening team.
8.33 (f) When the Indian child's tribe or tribal health care services provider or Indian
8.34 Health Services provider proposes to place a child for the primary purpose of treatment
8.35 for an emotional disturbance, a developmental disability, or co-occurring emotional
8.36 disturbance and chemical dependency, the Indian child's tribe or the tribe delegated by

9.1 the child's tribe shall submit necessary documentation to the county juvenile treatment
9.2 screening team, which must invite the Indian child's tribe to designate a representative to
9.3 the screening team.