# MINNESOTA

*This summary of state regulations and policy represents only a snapshot at a point in time, is not comprehensive, and should not be taken to constitute legal advice or guidance. State Medicaid requirements are included at the end of this summary.*

## Types of Facilities

*Mental Health (MH)*: Minnesota regulates several types of residential mental health programs that provide different levels of service for adults:

- Residential mental health programs provide services to people with mental illness in a residential setting as either a Category I or Category II program.
  - *Category I programs*: residential settings that emphasize services provided at the program while encouraging the use of community resources.
  - *Category II*: transitional semi-independent or supervised group supportive living settings that offer a combination of services provided at the program and services provided in the community and emphasize securing community resources for most daily programming and employment. Because services in Category II may be offered on-site, we include these facilities in the summary.

- *Intensive residential treatment services (IRTS)*: provide comprehensive, short-term intensive residential treatment for adults who are experiencing significant difficulty with daily life activities because of a serious mental illness. According to the state website, these programs must follow the requirements of a variance. These requirements also apply to subsidiary categories of programs that provide crisis intervention and specialized treatment for persons with eating disorders. IRTS programs may serve up to 16 recipients per program and must be licensed.

*Substance Use Disorder (SUD)*: There are two categories of regulated adult residential SUD treatment programs:

- *Detoxification Program*: a licensed program that provides short-term care on a 24-hour a day basis for the purpose of detoxifying clients and facilitating access to chemical dependency treatment as indicated by an assessment of needs.

- *Chemical Dependency Programs (CDPs)*: Researchers did not locate a definition for CDPs, but they do serve individuals with a substance use disorder and those with specified characteristics that a license holder proposes to serve. The regulations apply specifically to those programs serving Minnesota residents that requires expenditure of public funds.

*Unregulated Facilities*: Other than forensic residential treatment, researchers did not locate reference to regulated adult residential MH treatment facilities or to regulated adult residential SUD treatment facilities other than those identified above in 1a. We exclude from this summary the forensic program known as the Minnesota Security Hospital, which includes residential mental health treatment in a secure or supervised setting to adults who have been committed to the care of the Department of Human Services as mentally ill and dangerous. This program is operated by the Minnesota Department of Human Services. According to the state website, the forensic program must follow the requirements of a variance as well as other state laws. The forensic program also must be licensed.

## Approach

*Mental Health (MH) and Substance Use Disorder (SUD)*: Licensure by the Department of Human Services is required for all mental health Category I and II residential treatment facilities (5 beds or more only) and substance use disorder treatment facilities.

## Processes of Licensure or Certification and Accreditation

*Mental Health (MH) and Substance Use Disorder (SUD)*:

- Licensure by the Department of Human Services is required for facilities. Licensure duration is two years, by which time a renewal application must be submitted. An inspection is required for licensure and renewal.
    - The Department of Human Services also offers voluntary certification of Category I or II facilities that serve people with a primary diagnosis of mental illness where the home is not the primary residence of the license holder and certain additional requirements are met.
    - Accreditation is recognized but not required. Where appropriate the commissioner shall identify and implement alternative methods of regulation and enforcement to the extent authorized in this subdivision. These methods shall include: (1) when the standards of another state or federal governmental agency or an independent accreditation body have been shown to require the same standards, methods, or alternative methods to achieve substantially the same intended outcomes as the licensing standards, the commissioner shall consider compliance with the governmental or accreditation standards to be equivalent to partial compliance with the licensing standards; and (2) use of an abbreviated inspection that employs key standards that have been shown to predict full compliance with the rules.

- For CDPs, the state will assess need prior to issuing a license.

- For IRTSs, the Department of Human Services requires licensure and has additional certification requirements for Crisis Stabilization Services (CSS) and specialized mental health treatment services for persons with eating disorders (EDTP).

## Cause-Based Monitoring

*Mental Health (MH) and Substance Use Disorder (SUD)*: Unless otherwise specified in statute, the commissioner may conduct routine inspections biennially. In addition, the commissioner may access the licensed facility without prior notice and as often as the commissioner considers necessary if the commissioner is investigating alleged maltreatment, conducting a licensing inspection, or investigating an alleged violation of applicable laws or rules. At the time of application for licensure or renewal, the applicant or license holder must acknowledge that, if the applicant or license holder elects to receive any public funding reimbursement from the commissioner for services provided under the license, that the applicant's or license holder's compliance with the provider enrollment agreement or registration requirements for receipt of public funding may be monitored; and noncompliance with the provider enrollment agreement or registration requirements for receipt of public funding that is identified through a licensing investigation or licensing inspection, or noncompliance with a licensing requirement that is a basis of enrollment for reimbursement for a service, may result in administrative, civil, or criminal penalties as provided by law.

The commissioner may suspend or revoke the license, impose a fine, or secure an injunction against the continuing operation of the program of a license holder who does not comply with applicable law or rule. The commissioner shall act immediately to temporarily suspend a license if the license holder's actions or failure to comply with applicable law or rule pose an imminent risk of harm to the health, safety, or rights of persons served by the program; or while the program continues to operate pending an appeal of an order of revocation, the commissioner identifies one or more subsequent violations of law or rule which may adversely affect the health or safety of persons served by the program.

## Access Requirements

*Mental Health (MH)*: Researchers did not locate wait time standards for Category I or II facilities.

An IRTS must be able to receive referral information from any source at the IRTS location all days of the year and at any time; respond within eight hours of receiving a referral to the referral source and, within that time frame, provide the referral source what information is required for the license holder to make a determination concerning admission; consider the program's staffing patterns and competencies of staff when making a determination concerning whether the program is able to meet the needs of a person seeking admission; and

make a determination concerning the admission within 72 hours of having received all information is received. When recipients meet their program goals or are otherwise found to no longer be eligible for services or the recipient's needs cannot be met by the license holder, the license holder must make arrangements for the recipient's discharge.

*Substance Use Disorder (SUD)*: For CDPs, to receive public assistance, a chemical use assessment must be conducted by qualified staff for each client seeking treatment within 20 calendar days from the date an appointment was requested for the client. Within ten calendar days after the initial assessment interview, the placing authority must complete the assessment, make determinations, and authorize services. For a CDP, if the client is likely to be a danger to self or others, has severe medical problems, or has severe emotional or behavioral symptoms that prevent placement in a CDP, the placement authority must immediately help the client obtain appropriate services.

## Staffing

*Mental Health (MH)*: The regulations establish requirements for Category I and II programs regarding personnel policies and procedures, including but not limited to ones related to staff orientation and staff development requiring at least 15 hours of training per year (including but not limited to crisis intervention, community resources, rights, cultural awareness, medications, and staff stress). There also are specific requirements regarding personnel files.

For Category I programs, there are requirements regarding the program administrator, program director, mental health therapists, mental health counselors, and mental health workers, with credentialing requirements for all but the first. There are requirements for "sufficient staff" as well as the following ratio requirements: The number of work hours performed by the program director shall be prorated based on resident capacity with a ratio of 40 hours per week to 40 residents. With this ratio, applicants shall be allowed to use one program director to direct more than one program and shall be allowed to use one full-time program director for programs with less than a 40-bed resident capacity. With this ratio, applicants shall not be required to have more than one full-time program director for programs with more than a 40-bed resident capacity. However, applicants or programs with more than a 40-bed capacity shall describe whatever additional assistance they intend to provide for the program director function. The number of work hours performed by the mental health therapist and mental health counselor and mental health worker may be combined in different ways, depending on program needs, to achieve a ratio of one full-time equivalent position for each five residents (1:5 FTE, averaged weekly). When the work hours are combined, the facility shall have written documentation that supervision is provided.

For Category II programs, there are requirements regarding the program administrator, program director, mental health therapists, mental health counselors, and mental health workers, with credentialing requirements for all but the first. There are requirements for "sufficient staff" as well as the following ratio requirements: The number of work hours

performed by the program director shall be prorated based on resident capacity with the ratio of 40 hours per week to 40 residents. With this ratio, applicants shall be allowed to use one program director to direct more than one program and shall be allowed to use one full-time program director for programs with less than a 40-bed resident capacity. With this ratio, applicants shall not be required to have more than one full-time program director for programs with more than a 40-bed resident capacity. However, applicants or programs with more than a 40-bed capacity shall describe whatever additional assistance they intend to provide for the program director function. The number of work hours performed by the mental health therapist, mental health counselor, and mental health worker may be combined to achieve a ratio of one full-time equivalent staff position for each ten residents (1:10 FTE, averaged weekly). When the work hours are combined, the facility shall have written documentation that supervision is provided.

For IRTS facilities, the variance contains detailed requirements for orientation and ongoing training including but not limited to best practice service delivery that includes (among others) trauma informed care and integrated dual diagnosis treatment. Among the requirements for direct care, nonlicensed staff is training in motivational interviewing. Specific hours of training are indicated. IRTS facilities must have sufficient staff to provide the services offered by the program and have sufficient staff available to provide 24-hour-per-day coverage and to: meet the needs identified in the recipients' ITPs; implement program requirements; and, safely supervise and direct the activities of recipients taking into account the recipients' level of behavioral and psychiatric stability, cultural needs, and vulnerabilities. Additional requirements are in the variance, including staffing ratios for direct and mental health staff. Qualifications are in place for the Clinical Supervisor, RN, and Treatment Director. Standards of supervision and observation are in place for direct care rehabilitation workers.

If one or more recipients are receiving CSS, the staff must include a mental health professional and at least one individual who is a mental health practitioner or rehabilitation worker who has had 30 hours of training in crisis services in the last two years. During the first 48 hours that a recipient who is receiving CSS is in the program, the license holder must have at least two staff working 24 hours a day. Staffing levels may be reduced following the 48 hours provided the staffing levels continue to meet the recipients' needs as specified in their individualized crisis stabilization treatment plans.

For EDTPs, the license holder must ensure and maintain documentation that all staff have knowledge or competency in the following areas: The characteristics, and treatment of recipients with special needs such as substance abuse, obsessive compulsive disorder, and eating disorders; and first aid and cardiopulmonary resuscitation (CPR) training.

*Substance Use Disorder (SUD)*: For detoxification facilities, there are requirements for the program director, a responsible staff person at all times, a technician (awake at all times, one per 15 clients), an assessor, registered nurse responsibilities, and medical director responsibilities. Staff qualifications are established for those who have direct client contact, including a requirement that they be free of "chemical use problems" for at least two years,

although, for technicians, the time is six months. Remaining chemical use problem-free is a term of employment. Credentials are not stated for the medical director. The facility must maintain personnel policies and procedures, including but not limited to ones regarding orientation and training. Those working with clients must have 30 hours of continuing education every two years. Among other things, training must include approved therapeutic holds and use of protective procedures. Regulations also govern personnel files.

For CDPs, staff must receive state-mandated HIV training. Regulations include requirements and qualifications for a treatment director, alcohol and drug counselor supervisor, a responsible staff member (present at all times), and staff trained in first aid and CPR (present at all times). There also are requirements related to paraprofessional staff, care coordination providers, recovery peers, volunteers, student interns, and individuals with a temporary permit. The personnel requirements include a treatment group not to exceed 16 clients. There are requirements that staff be free of "problematic substance use."

## Placement

*Mental Health (MH)*: Each Category I or II program shall develop admission criteria delineating the types and characteristics of persons who can and cannot be served by the program. Intake policies and procedures shall be developed including the role of community resources.

An IRTS must have admission and discharge criteria that meet set criteria, unless the IRTS only provides crisis stabilization services. The license holder must not limit or restrict services to recipients based solely on: (1) The recipient's substance use; (2) The county in which the recipient resides; or, (3) Whether the recipient elects to receive other services for which they may be eligible, including but not limited to case management services. A mental health professional or mental health practitioner with clinical supervision must complete a functional assessment of the recipient within ten calendar days of admission. The assessment must be updated at least every 30 days and within five calendar days prior to discharge. Within five days of the recipient's admission, a diagnostic assessment must be completed or updated by a mental health professional. A level of care assessment of the recipient using the LOCUS must be completed by a mental health professional or a mental health practitioner with clinical supervision, within ten days of the recipient's admission. If the recipient is assessed through LOCUS as needing "medically monitored level of service" (level 5), this supports the recipient's need for IRTS. If the recipient is assessed to have needs that are not at this level, the clinical supervisor must evaluate and document how the recipient's admission to and continued services in IRTS is medically necessary. Within ten days of admission, all recipients must be screened for the possibility of a co-occurring substance use disorder, unless they have a current substance use diagnosis. There must be a health screening of each recipient within 72 hours of admission.

For certification as a CSS, the license holder must develop and maintain specific admission criteria.

An EDTP recipient must be diagnosed with an eating disorder of Anorexia Nervosa (AN), Bulimia Nervosa (BN), or Eating Disorder Not Otherwise Specified (EDNOS) as defined in the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM).

*Substance Use Disorder (SUD)*: For detoxification programs, a license holder must have a written admission policy containing specific admission criteria. The admission policy must be approved and signed by the medical director of the facility and designate which staff members are authorized to admit and discharge clients. A detoxification program may only admit persons who meet the admission criteria and who, at the time of admission: (A) appear intoxicated; (B) experience physical, mental, or emotional problems due to withdrawal from alcohol or other drugs; (C) are being held under apprehend and hold orders; (D) have been committed and need temporary placement; (E) are held under emergency holds or peace and health officer holds; or (F) need to stay temporarily in a protective environment because of a crisis related to substance use disorder. Persons meeting this criterion may be admitted only at the request of the county of fiscal responsibility. Persons admitted according to this provision must not be restricted to the facility.

A license holder must screen each client admitted to determine whether the client suffers from substance use disorder. A license holder must provide or arrange for the provision of a chemical use assessment for each client who suffers from substance use disorder at the time the client is identified. If a client is readmitted within one year of the most recent assessment, an update to the assessment must be completed. If a client is readmitted and it has been more than one year since the last assessment, a new assessment must be completed. License holders must have written procedures for assessing and monitoring client health. If the client was intoxicated at the time services were initiated, the procedure must include a follow-up screening conducted between four and 12 hours after service initiation that collects information relating to health complaints and behavioral risk factors that the client may not have been able to communicate clearly at service initiation.

For CDPs, to receive public assistance, a chemical use assessment must be conducted for each client seeking treatment before the client is placed in a treatment program. The assessment must be conducted by qualified staff within 20 calendar days from the date an appointment was requested for the client. Within ten calendar days after the initial assessment interview, the placing authority must complete the assessment, make determinations, and authorize services. A comprehensive assessment of the client's substance use disorder must be administered face-to-face by an alcohol and drug counselor within three calendar days after service initiation for a residential program.

There also are access standards for CDPs. The placement authority must determine appropriate services for clients by determining the client's acute intoxication/withdrawal potential, their biomedical conditions and complications, their emotional/behavioral/cognitive condition, their readiness for change, their relapse/continued use/continued problem potential, and their recovery environment. If the client is likely to be a danger to self or others, has severe medical

problems, or has severe emotional or behavioral symptoms, the assessor will immediately help the client obtain appropriate services.

## Treatment and Discharge Planning and Aftercare Services

*Mental Health (MH)*: All residential Category I or II MH treatment programs require a treatment plan, discharge planning, and aftercare/follow up requirements. Within 10 days after admission, the mental health residential program staff will write short-term goals with each resident in order to address the resident's immediate needs. Within 30 days, the program staff will write an individual program plan developed by an interdisciplinary team. A quarterly review of the resident's response to the individual treatment plan and his or her involvement in the facility's overall program shall be written. A discharge or transfer summary shall be written for each person transferred or discharged. The summary shall include, among other things, an aftercare plan which identifies the persons, including at least the resident, a program staff member, and a representative of the referring agency, who participated in the development of the aftercare plan; goals and objectives for the first three months after discharge or transfer; and individuals or agencies who will be working with the resident after discharge or transfer; and a forwarding address and telephone number for follow-up contacts.

IRTS facilities must develop an individualized treatment plan. An initial treatment plan must be completed within 24 hours of the recipient's admission and must be completed by a mental health professional or a mental health practitioner under clinical supervision. The license holder must develop and maintain an individual abuse prevention plan. Within ten days of admission, the initial treatment plan must be refined and further developed and must be updated at least every 30 days. The plan must include at least one discharge goal. When a recipient's needs cannot be met by the license holder or the recipient has needs for services after discharge, the license holder must make arrangements to transfer the recipient to services that are appropriate given the recipient's needs and that are expected to meet the recipient's needs.

For certification as a CSS, the license holder must develop an individualized crisis stabilization treatment plan within 24 hours of admission.

An EDTP recipient must be discharged when at least one of the following criteria is met: (a) The recipient has achieved maximum benefit from treatment or successfully met the goals of the individualized treatment plan (ITP); (b) The recipient's symptoms and needs may be managed at a lesser level of service and adequate supports and services are available; (c) The recipient exhibits a severe exacerbation of symptoms, decreased functioning or disruptive or dangerous behaviors and requires a more intensive level of service; (d) The recipient has medical or physical health needs that the license holder is not able adequately address; (e)The recipient does not participate in the program despite multiple attempts to engage him or her and to address nonparticipation issues; (f) The recipient does not make progress toward treatment goals and there is no reasonable expectation that progress will be made; or, (g) The recipient

leaves against medical advice for an extended period (determined by written procedures of provider agency).

*Substance Use Disorder (SUD)*: For detoxification programs, the license holder must have a written plan for addressing the needs of individuals whose potential for medical problems may require acute medical care. This includes clients whose pregnancy, in combination with their presenting problem, requires services not provided by the program, and clients who pose a substantial likelihood of harm to themselves or others if their behavior is beyond the behavior management capabilities of the program and staff. A license holder must have a written policy, approved and signed by the medical director, that specifies conditions under which clients may be discharged or transferred. The policy must include guidelines for determining when a client is detoxified and whether a client is ready for discharge or transfer, and any procedures staff must follow.

CDPs must have both a service initiation and service termination policy. CDPs require an initial service plan on the day of service initiation, which will include, among other things, as determination if a person is a "vulnerable adult" (an adult client of a residential program is a vulnerable adult). There must also be a treatment plan within 7 days of initiation. A treatment plan review must be entered in a client's file weekly or after each treatment service, whichever is less frequent, by the staff member providing the service. At a CDP, if a client is discharged at staff request, the service discharge summary must include crisis and other appropriate referrals for the client's needs and offer assistance to the client to access the services. If a client successfully completes treatment, the service discharge summary must also include continuing care recommendations, including transitions between more or less intense services, or more frequent to less frequent services, and referrals made with specific attention to continuity of care for mental health, as needed.

## Treatment Services

*Mental Health (MH)*: For Category I or II programs, the following resources need to be offered by either the program or through a working agreement with other community resources: case management services, crisis services, independent living skills training, mental health therapy, motivation and remotivation services, recreation and leisure time services, socialization services, support group services, social services, vocational services, and other services if need is indicated by the resident assessment.

IRTS facilities must provide on a daily basis medically necessary rehabilitation services for each IRTS recipient using individualized treatment interventions based on the recipients' assessed needs. The license holder must also provide individualized treatment that promotes recipient choice, and active involvement in the service planning and recovery processes. License holders must integrate Illness Management and Recovery (IMR) practices in the design of their programs and delivery of services. License holders must address the needs of recipients who have co-occurring substance use disorders using Integrated Dual Diagnosis Treatment (IDDT).

As further elaborated in the variance, licensees also must provide: (1) Independent living skills training; (2) Family involvement support services; (3) Crisis prevention planning; and (4) Peer specialist support services. If the license holder offers additional mental health treatment services, the treatment must meet the definition of a best practice and be delivered by staff who have received adequate training in the provision of the treatment and who are supervised by a mental health professional who is competent in the delivery of the treatment.

For certification as a CSS, the license holder must provide assessment of immediate needs and factors that lead to the crisis, individualized crisis stabilization treatment planning, supportive counseling, skills training, and referrals to other needed services.

An EDTP must have the capacity to effectively manage the recipient's co-morbid or other medical conditions. The following service must be provided to be certified as an EDTP: (a) Specific nutrition care services provided by a nutrition care service provider; (b) Oversight of medical services must be provided by or under the direction of a licensed independent practitioner (LIP) and specific medical services must be provided; (c) The following services must be available as needed to address the medical and health care needs of recipients: Physical and occupational therapy; dental care; physician services; and laboratory services; (d) A licensed independent practitioner (LIP) and nutrition care provider must be members of the treatment team. These staff shall not provide mental health rehabilitation services unless they are also qualified as a mental health professional, a mental health practitioner, or a mental health rehabilitation worker.

*Substance Use Disorder (SUD)*: For detoxification programs, a license holder must provide referrals to appropriate chemical dependency services as indicated by the chemical use assessment. Referrals may also be made for mental health, economic assistance, social services, and prenatal care and other health services as the client may require. A license holder must provide information for obtaining assistance regarding: substance use disorder, including the effects of alcohol and other drugs and specific information about the effects of chemical use on unborn children; tuberculosis and reporting known cases of tuberculosis disease to health care authorities; and HIV. License holders must have a standardized data collection tool for collecting health related information about each client. The procedures must specify the physical signs and symptoms that require consultation with a registered nurse or a physician and that require transfer to an acute care medical facility. The procedures must specify the actions to be taken to address specific complicating conditions including pregnancy or the presence of physical signs or symptoms of any other medical condition.

For CDPs, license holders must offer individual and group counseling, client education strategies to avoid inappropriate substance use and health problems related to substance use, a service to help client integrate gains made during treatment into daily living, a service to address issues related to co-occurring disorders, peer recovery support services provided 1-to-1 by an individual in recovery, and care coordination. A treatment service provided to a client must be provided according to the individual treatment plan and must consider cultural differences and special needs of a client. Additional services may include: relationship counseling, therapeutic

recreation, stress management and physical well-being, living skills development, employment or educational services, socialization skills, and room, board, and supervision at the treatment site to provide the client with a safe and appropriate environment to gain and practice new skills. CDPs that serve parents with their children must provide parent education regarding child safety.

## Patient Rights and Safety Standards

*Mental Health (MH) and Substance Use Disorder (SUD)*: Individuals in residential settings are included in a category of vulnerable adults with specific additional rights. Among other things, reporting of suspected maltreatment is mandated, as is investigation of the reports.

*Mental Health (MH)*: The regulations require all Category I or II residential MH treatment facilities to develop a written statement of residents' rights. There must be a complaint/grievance process accessible to patients. The state reserves the right to conduct inspections in response to complaint/grievance reports. Restraint, seclusion, and use of medications for crisis management are allowed but restricted.

IRTS facilities must report critical incidents to the department's licensing division in writing and within ten days of the occurrence. Among other rights, recipients are entitled to a written statement of rights, communication, freedom from discrimination, courtesy and respect, freedom from maltreatment, and confidentiality.

*Substance Use Disorder (SUD)*: For detoxification facilities, "protective procedures" (restraint and seclusion) are allowed but restricted. The licensee must conduct a quarterly review of all protective procedure use. The facilities must have a grievance process accessible to patients.

CDPs must have a grievance process accessible to patients. CDPs are also subject to the patient bill of rights applicable to drug and alcohol counselors which provides rights including but not limited to understanding their rights, not to be stereotyped, and freedom from maltreatment and exploitation. Those civilly committed to CDPs also have rights under the civil commitment statute, which, among other things, allows but restricts restraint, and includes rights to communication and consent, among others. Critical incidents must be reported.

## Quality Assurance or Improvement

*Mental Health (MH) and Substance Use Disorder (SUD)*: The commissioner shall evaluate the effects of the rules listed in Human Services Regulations at least once every five years. One aspect of that evaluation will be a discussion of the rules' effect on the availability and quality of licensed programs.

*Mental Health (MH)*: Each program Category I or II program shall institute an evaluation process to be conducted on an ongoing basis. The evaluation process shall be outcome-based and consistent with the emphasis on individual treatment planning. In a format developed by the commissioner, the data and documentation shall be submitted to the commissioner on an annual, aggregate basis for statewide summaries and for planning the use of state resources.

IRTS facilities must develop a written quality assurance and improvement plan that must also include processes to review the data or information in the plan.

*Substance Use Disorder (SUD)*: The license holder must participate in the drug and alcohol abuse normative evaluation system by submitting, in a format provided by the commissioner, information concerning each client admitted to the program.

## Governance

*Mental Health (MH) and Substance Use Disorder (SUD)*: As part of licensure application, the applicant must provide information on program leadership and must have policies that relate to regulatory compliance.

*Mental Health (MH)*: Category I or II treatment facilities must have an advisory committee that meets regularly, and a comprehensive annual report to be provided to the governing body, the advisory committee, the host county, and the Department.

An IRTS must have policies and procedures that are reviewed at least annually by the Treatment Director and updated as needed.

*Substance Use Disorder (SUD)*: Detoxification facilities must have written policies and procedures; and, at application, must include information on insurance and bonding. CDPs must have written policies and procedures.

## Special Populations

*Mental Health (MH)*: Requirements regarding residential services were not explicitly described in the state regulations.

*Substance Use Disorder (SUD)*: For CDPs, additional requirements relate to CDPs that service parents with their children and those that serve persons with co-occurring disorders; and regarding HIV training in CDPs.

## Location of Regulatory and Licensing Requirements

Department of Human Services Mental Health Regulations[1], Department of Human Services Substance Use Treatment Regulations[2], Department of Human Services Licensure Statute[3], Chemical Dependency Statute[4], Reporting of Maltreatment of Vulnerable Adults[5], Vulnerable Adult[6], Required Documentation and Reports[7], Client Welfare statute[8], Rights of Patients Civilly Committed[9], Department of Human Services Residential Mental Health Programs for Adults website[10], IRTS variance to Minnesota rules[11], Forensic variance to Minnesota rules[12]. Regulatory data collected May 24, 2019.

## Other Information Sources

D. Hulzebos, P. Thomas (DHS BHD); National Conference of State Legislatures CON Program Overview, http://www.ncsl.org/research/health/con-certificate-of-need-state-laws.aspx

[1] See https://www.revisor.mn.gov/rules/9520/.

[2] See https://www.revisor.mn.gov/rules/9530/.

[3] See https://www.revisor.mn.gov/statutes/cite/245A.03.

[4] See https://www.revisor.mn.gov/statutes/cite/245G.

[5] See https://www.revisor.mn.gov/statutes/cite/626.557.

[6] See https://www.revisor.mn.gov/statutes/cite/626.5572.

[7] See https://www.revisor.mn.gov/rules/9520.0570/.

[8] See https://www.revisor.mn.gov/statutes/cite/148F.165.

[9] See https://www.revisor.mn.gov/statutes/cite/253B.

[10] See https://mn.gov/dhs/partners-and-providers/licensing/adult-behavioral-health-residential-facilities/.

[11] See https://www.dhs.state.mn.us/main/idcplg?IdcService=GET_FILE&RevisionSelectionMethod=LatestReleased&Rendition=Primary&allowInterrupt=1&noSaveAs=1&dDocName=DHS16_150079.

[12] See https://mn.gov/dhs/assets/Forensic_tcm1053-383485.pdf.

# MINNESOTA MEDICAID

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## Approach

*Mental Health (MH) and Substance Use Disorder (SUD)*: The Minnesota Department of Human Services (DHS) oversees the state Medicaid program. Minnesota relies on the in lieu of provision and on Disproportionate Share Hospital (DSH) payments for reimbursement of some services in Institutions for Mental Diseases (IMDs).

*Substance Use Disorder (SUD)*: In addition to Medicaid coverage of services in non-IMDs in the state plan, Minnesota has a Section 1115 waiver that permits expenditures for otherwise covered services furnished to otherwise eligible individuals who are primarily receiving treatment and withdrawal management services for substance use disorder who are short-term (statewide average length of stay of 30 days) residents in facilities that meet the definition of an IMD.

## Types of Facilities

*Substance Use Disorder (SUD)*: The residential settings identified in the waiver include the following:

- Residential treatment in an IMD.
- Medically monitored withdrawal management in an IMD.
- Clinically managed withdrawal management in an IMD.

Medication-assisted treatment also is to be available to those in IMDs.

## Processes of Medicaid Enrollment

*Mental Health (MH) and Substance Use Disorder (SUD)*:

- A vendor that wants to participate in the medical assistance program shall apply to the department on forms provided by the department. The forms must contain an application

and a statement of the terms for participation. Upon approval of the application by the department, the signed statement of the terms for participation and the application constitute the provider agreement. Providers must meet profession, certification and licensure requirements according to applicable state and federal laws and regulations specific to the service(s) they provide.

## Staffing

*Substance Use Disorder (SUD)*: Pursuant to the Section 1115 waiver, the state must establish residential treatment provider qualifications in licensure, policy or provider manuals, managed care contracts or credentialing, or other requirements or guidance that meet program standards in the ASAM Criteria or other nationally recognized, SUD-specific program standards regarding credentials of staff for residential treatment settings. The state must assess the availability of providers in the key levels of care throughout the state, or in the regions of the state participating under this demonstration, including those that offer MAT.

## Placement

*Substance Use Disorder (SUD)*: In accordance with the state 1115 waiver, the state must establish a requirement that providers assess treatment needs based on SUD-specific, multidimensional assessment tools, such as the ASAM Criteria or other comparable assessment and placement tools that reflect evidence-based clinical treatment guidelines, as well as a utilization management approach such that beneficiaries have access to SUD services at the appropriate level of care and that the interventions are appropriate for the diagnosis and level of care, including an independent process for reviewing placement in residential treatment settings.

## Treatment and Discharge Planning and Aftercare Services

*Mental Health (MH) and Substance Use Disorder (SUD)*: Requirements regarding residential services were not explicitly described in the state Medicaid regulations.

## Treatment Services

*Substance Use Disorder (SUD)*: Under the Section 1115 waiver, beneficiaries will have access to high quality, evidence-based OUD and other SUD treatment services ranging from medically supervised withdrawal management to on-going chronic care for these conditions in cost-effective settings while also improving care coordination and care for comorbid physical and mental health conditions. Pursuant to the Section 1115 waiver, the state must establish

residential treatment program standards regarding in particular the types of services and hours of clinical care for residential treatment settings. The state must establish a requirement that residential treatment providers offer MAT on-site or facilitate access to MAT off-site.

## Care Coordination

*Substance Use Disorder (SUD)*: Under the Section 1115 waiver, beneficiaries will have improved care coordination and care for comorbid physical and mental health conditions. The state must ensure establishment and implementation of policies to ensure residential facilities link beneficiaries with community-based services and supports following stays in these facilities.

## Quality Assurance or Improvement

*Substance Use Disorder (SUD)*: Pursuant to the Section 1115 waiver, the state must establish a provider review process to ensure that residential treatment providers deliver care consistent with the specifications in the ASAM Criteria or other nationally recognized SUD program standards based on evidence-based clinical treatment guidelines for types of services, hours of clinical care, and credentials of staff for residential treatment settings.

## Special Populations

*Mental Health (MH) and Substance Use Disorder (SUD)*: Requirements regarding residential services were not explicitly described in the state Medicaid regulations.

## Location of Medicaid Requirements

Minnesota Administrative Rules Chapter 9506, MinnesotaCare[13]; Minnesota Department of Human Services Health Care Programs and Services Overview Legal References[14]; Website on Enrollment with Minnesota Health Care Programs[15];
Minnesota Substance Use Disorder System Reform[16]. Regulatory data collected January 8, 2020.

[13] See https://www.revisor.mn.gov/rules/9506/.

[14] See https://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=id_008922.

[15] See https://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=ENROLL-HOME.

[16] See https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/?entry=47450.

## Other Information Sources

Kaiser Family Foundation. State Options for Medicaid Coverage of Inpatient Behavioral Health Services. KFF: San Francisco. November 2019. http://files.kff.org/attachment/Report-Brief-State-Options-for-Medicaid-Coverage-of-Inpatient-Behavioral-Health-Services

This state summary is part of the report **"State Residential Treatment for Behavioral Health Conditions: Regulation and Policy"**. The full report and other state summaries are available at https://aspe.hhs.gov/state-bh-residential-treatment.