ARTICLE 4

BEHAVIORAL HEALTH

Section 1. Minnesota Statutes 2024, section 3.757, subdivision 1, is amended to read:

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

(b) "Municipality" has the meaning provided in section 466.01, subdivision 1.

(c) "Opioid litigation" means any civil litigation, demand, or settlement in lieu of litigation alleging unlawful conduct related to the marketing, sale, or distribution of opioids in this state or other alleged illegal actions that contributed to the excessive use of opioids.

(d) "Released claim" means any cause of action or other claim that has been released in a statewide opioid settlement agreement, including matters identified as a released claim as that term or a comparable term is defined in a statewide opioid settlement agreement.

(e) "Settling defendant" means an entity that engages in, has engaged in, or has provided consultation services regarding the manufacture, marketing, promotion, sale, distribution, or dispensing of opioids, and that has been the subject of a statewide opioid settlement agreement or bankruptcy plan, including but not limited to Johnson & Johnson, AmerisourceBergen Corporation, Cardinal Health, Inc., McKesson Corporation, Teva Pharmaceuticals, Allergan plc, CVS Health Corporation, Walgreens Boots Alliance, Inc., ~~and~~ Walmart, Inc., and Purdue Pharma L.P., as well as related subsidiaries, affiliates, officers, directors, and other related entities specifically named as a released entity in a statewide opioid settlement agreement.

(f) "Statewide opioid settlement agreement" means an agreement~~, including consent judgments, assurances of discontinuance, and related agreements or documents,~~ between the attorney general, on behalf of the state, and a settling defendant, to provide or allocate remuneration for conduct related to the manufacture, marketing, promotion, sale, dispensing, or distribution of opioids in this state or other alleged illegal actions that contributed to the excessive use of opioids. A statewide opioid settlement agreement includes consent judgments, assurances of discontinuance, and related agreements or documents, that contain structural or payment provisions requiring or anticipating the participation of municipalities and allowing for the allocation of settlement funds between the state and municipalities to be set through a state-specific agreement.

ARTICLE 9

BEHAVIORAL HEALTH POLICY

UEH2115-1

ARTICLE 4

SUBSTANCE USE DISORDER TREATMENT SERVICES POLICY

House Language H2115-2

Sec. 2. Minnesota Statutes 2024, section 144.651, subdivision 2, is amended to read:

Subd. 2. **Definitions.** For the purposes of this section, "patient" means a person who is admitted to an acute care inpatient facility for a continuous period longer than 24 hours, for the purpose of diagnosis or treatment bearing on the physical or mental health of that person. For purposes of subdivisions 4 to 9, 12, 13, 15, 16, and 18 to 20, "patient" also means a person who receives health care services at an outpatient surgical center or at a birth center licensed under section 144.615. "Patient" also means a minor who is admitted to a residential program as defined in section 253C.01. For purposes of subdivisions 1, 3 to 16, 18, 20 and 30, "patient" also means any person who is receiving mental health treatment on an outpatient basis or in a community support program or other community-based program. "Resident" means a person who is admitted to a nonacute care facility including extended care facilities, nursing homes, and boarding care homes for care required because of prolonged mental or physical illness or disability, recovery from injury or disease, or advancing age. For purposes of all subdivisions except subdivisions 28 and 29, "resident" also means a person who is admitted to a facility licensed as a board and lodging facility under Minnesota Rules, parts 4625.0100 to 4625.2355, a boarding care home under sections 144.50 to 144.56, or a supervised living facility under Minnesota Rules, parts 4665.0100 to 4665.9900, and which operates a rehabilitation program licensed under chapter 245G or 245I, or Minnesota Rules, parts 9530.6510 to 9530.6590. For purposes of all subdivisions except subdivisions 20, 28, 29, 32, and 33, "resident" also means a person who is admitted to a facility licensed to provide intensive residential treatment services or residential crisis stabilization under section 245I.23.

S2669-3

Section 1. Minnesota Statutes 2024, section 144.651, subdivision 2, is amended to read:

Subd. 2. **Definitions.** For the purposes of this section, "patient" means a person who is admitted to an acute care inpatient facility for a continuous period longer than 24 hours, for the purpose of diagnosis or treatment bearing on the physical or mental health of that person. For purposes of subdivisions 4 to 9, 12, 13, 15, 16, and 18 to 20, "patient" also means a person who receives health care services at an outpatient surgical center or at a birth center licensed under section 144.615. "Patient" also means a minor who is admitted to a residential program as defined in section 253C.01. For purposes of subdivisions 1, 3 to 16, 18, 20 and 30, "patient" also means any person who is receiving mental health treatment on an outpatient basis or in a community support program or other community-based program. "Resident" means a person who is admitted to a nonacute care facility including extended care facilities, nursing homes, and boarding care homes for care required because of prolonged mental or physical illness or disability, recovery from injury or disease, or advancing age. For purposes of all subdivisions except subdivisions 28 and 29, "resident" also means a person who is admitted to a facility licensed as a board and lodging facility under Minnesota Rules, parts 4625.0100 to 4625.2355, a boarding care home under sections 144.50 to 144.56, or a supervised living facility under Minnesota Rules, parts 4665.0100 to 4665.9900, and which operates a rehabilitation program licensed under chapter 245G or 245I, or Minnesota Rules, parts 9530.6510 to 9530.6590. For purposes of all subdivisions except subdivisions 20, 28, 29, 32, and 33, resident also means a person who is admitted to a facility licensed to provide intensive residential treatment services or residential crisis stabilization under section 245I.23.

UEH2115-1

Section 1. Minnesota Statutes 2024, section 4.046, subdivision 2, is amended to read:

Subd. 2. **Subcabinet membership.** The subcabinet consists of the following members:

(1) the commissioner of human services;

(2) the commissioner of health;

(3) the commissioner of education;

(4) the commissioner of public safety;

(5) the commissioner of corrections;

(6) the commissioner of management and budget;

(7) the commissioner of higher education;

(8) the commissioner of children, youth, and families;

(9) the chief executive officer of direct care and treatment;

(10) the commissioner of commerce;

(11) the director of the Office of Cannabis Management;

~~(8)~~ (12) the chair of the Interagency Council on Homelessness; and

~~(9)~~ (13) the governor's director of addiction and recovery, who shall serve as chair of the subcabinet.

Sec. 2. Minnesota Statutes 2024, section 4.046, subdivision 3, is amended to read:

Subd. 3. **Policy and strategy development.** The subcabinet must engage in the following duties related to the development of opioid use, substance use, and addiction policy and strategy:

(1) identify challenges and opportunities that exist relating to accessing treatment and support services and develop recommendations to overcome these barriers for all Minnesotans;

(2) with input from affected communities, develop policies and strategies that will reduce barriers and gaps in service for all Minnesotans seeking treatment for opioid or substance use disorder, particularly for those Minnesotans who are members of communities disproportionately impacted by substance use and addiction;

(3) develop policies and strategies that the state may adopt to expand Minnesota's recovery infrastructure, including detoxification or withdrawal management facilities, treatment facilities, and sober housing;

(4) identify innovative services and strategies for effective treatment and support;

(5) develop policies and strategies to expand services and support for people in Minnesota suffering from opioid or substance use disorder through partnership with the Opioid Epidemic Response Advisory Council and other relevant partnerships;

(6) develop policies and strategies for agencies to manage addiction and the relationship it has with co-occurring conditions;

(7) identify policies and strategies to address opioid or substance use disorder among Minnesotans experiencing homelessness; ~~and~~

(8) submit recommendations to the legislature addressing opioid use, substance use, and addiction in Minnesota~~.~~; and

(9) develop and publish a comprehensive substance use and addiction plan for the state. The plan must establish goals and priorities for a comprehensive continuum of care for substance misuse and substance use disorder for Minnesota. All state agencies' operating programs related to substance use prevention, harm reduction, treatment, or recovery or that are administering state or federal funds for those programs shall set program goals and

Sec. 3. Minnesota Statutes 2024, section 169A.284, is amended to read:

169A.284 ~~CHEMICAL DEPENDENCY~~ COMPREHENSIVE ASSESSMENT CHARGE; SURCHARGE.

Subdivision 1. **When required.** (a) When a court sentences a person convicted of an offense enumerated in section 169A.70, subdivision 2 (~~chemical use~~ comprehensive assessment; requirement; form), except as provided in paragraph (c), it shall order the person to pay the cost of the comprehensive assessment directly to the entity conducting the assessment or providing the assessment services in an amount determined by the entity conducting or providing the service and shall impose a ~~chemical dependency~~ comprehensive assessment charge of $25. The court may waive the $25 comprehensive assessment charge, but may not waive the cost for the assessment paid directly to the entity conducting the assessment or providing assessment services. A person shall pay an additional surcharge of $5 if the person is convicted of a violation of section 169A.20 (driving while impaired) within five years of a prior impaired driving conviction or a prior conviction for an offense arising out of an arrest for a violation of section 169A.20 or Minnesota Statutes 1998, section 169.121 (driver under influence of alcohol or controlled substance) or 169.129 (aggravated DWI-related violations; penalty). This section applies when the sentence is executed, stayed, or suspended. The court may not waive payment of or authorize payment in installments of the comprehensive assessment charge and surcharge ~~in installments~~ unless it makes written findings on the record that the convicted person is indigent or that the comprehensive assessment charge and surcharge would create undue hardship for the convicted person or that person's immediate family.

(b) The ~~chemical dependency~~ comprehensive assessment charge and surcharge required under this section are in addition to the surcharge required by section 357.021, subdivision 6 (surcharges on criminal and traffic offenders).

(c) The court must not order the person convicted of an offense enumerated in section 169A.70, subdivision 2 (comprehensive assessment; requirement; form), to pay the cost of the comprehensive assessment if the individual is eligible for payment of the comprehensive assessment under chapter 254B or 256B.

Subd. 2. **Distribution of money.** The court administrator shall collect and forward the ~~chemical dependency~~ comprehensive assessment charge and the $5 surcharge, if any, to the commissioner of management and budget to be deposited in the state treasury and credited to the general fund.

priorities in accordance with the state plan. Each state agency shall submit its relevant plans and budgets to the subcabinet for review upon request.

S2669-3

Sec. 4. Minnesota Statutes 2024, section 245.462, subdivision 4, is amended to read:

Subd. 4. **Case management service provider.** (a) "Case management service provider" means a case manager or case manager associate employed by the county or other entity authorized by the county board to provide case management services specified in section 245.4711.

(b) A case manager must:

(1) be skilled in the process of identifying and assessing a wide range of client needs;

(2) be knowledgeable about local community resources and how to use those resources for the benefit of the client;

(3) be a mental health practitioner as defined in section 245I.04, subdivision 4, or have a bachelor's degree in one of the behavioral sciences or related fields including, but not limited to, social work, psychology, or nursing from an accredited college or university. A case manager who is not a mental health practitioner ~~and~~ or who does not have a bachelor's degree in one of the behavioral sciences or related fields must meet the requirements of paragraph (c); and

(4) meet the supervision and continuing education requirements described in paragraphs (d), (e), and (f), as applicable.

(c) Case managers without a bachelor's degree or with a bachelor's degree that is not in one of the behavioral sciences or related fields must meet one of the requirements in clauses (1) to ~~(3)~~ (5):

(1) have ~~three or~~ four years of experience as a case manager associate as defined in this section;

(2) be a registered nurse without a bachelor's degree and have a combination of specialized training in psychiatry and work experience consisting of community interaction and involvement or community discharge planning in a mental health setting totaling three years; ~~or~~

(3) be a person who qualified as a case manager under the 1998 Department of Human Service waiver provision and meet the continuing education and mentoring requirements in this section~~.~~;

(4) prior to direct service delivery, complete at least 80 hours of specific training on the characteristics and needs of adults with serious and persistent mental illness that is consistent with national practices standards; or

Sec. 2. Minnesota Statutes 2024, section 245.462, subdivision 4, is amended to read:

Subd. 4. **Case management service provider.** (a) "Case management service provider" means a case manager or case manager associate employed by the county or other entity authorized by the county board to provide case management services specified in section 245.4711.

(b) A case manager must:

(1) be skilled in the process of identifying and assessing a wide range of client needs;

(2) be knowledgeable about local community resources and how to use those resources for the benefit of the client;

(3) be a mental health practitioner as defined in section 245I.04, subdivision 4, or have a bachelor's degree in one of the behavioral sciences or related fields including, but not limited to, social work, psychology, or nursing from an accredited college or university. A case manager who is not a mental health practitioner ~~and~~ or who does not have a bachelor's degree in one of the behavioral sciences or related fields must meet the requirements of paragraph (c); and

(4) meet the supervision and continuing education requirements described in paragraphs (d), (e), and (f), as applicable.

(c) Case managers without a bachelor's degree or with a bachelor's degree that is not in one of the behavioral sciences or related fields must meet one of the requirements in clauses (1) to ~~(3)~~ (5):

(1) have three or four years of experience as a case manager associate as defined in this section;

(2) be a registered nurse without a bachelor's degree and have a combination of specialized training in psychiatry and work experience consisting of community interaction and involvement or community discharge planning in a mental health setting totaling three years; ~~or~~

(3) be a person who qualified as a case manager under the 1998 Department of Human Service waiver provision and meet the continuing education and mentoring requirements in this section~~.~~;

(4) prior to direct service delivery, complete at least 80 hours of specific training on the characteristics and needs of adults with serious and persistent mental illness that is consistent with national practice standards; or

(5) prior to direct service delivery, demonstrate competency in practice and knowledge of the characteristics and needs of adults with serious and persistent mental illness, consistent with national practices standards.

(d) A case manager with at least 2,000 hours of supervised experience in the delivery of services to adults with mental illness must receive regular ongoing supervision and clinical supervision totaling 38 hours per year of which at least one hour per month must be clinical supervision regarding individual service delivery with a case management supervisor. The remaining 26 hours of supervision may be provided by a case manager with two years of experience. Group supervision may not constitute more than one-half of the required supervision hours. Clinical supervision must be documented in the client record.

(e) A case manager without 2,000 hours of supervised experience in the delivery of services to adults with mental illness must:

(1) receive clinical supervision regarding individual service delivery from a mental health professional at least one hour per week until the requirement of 2,000 hours of experience is met; and

(2) complete 40 hours of training approved by the commissioner in case management skills and the characteristics and needs of adults with serious and persistent mental illness.

(f) A case manager who is not licensed, registered, or certified by a health-related licensing board must receive 30 hours of continuing education and training in mental illness and mental health services every two years.

(g) A case manager associate (CMA) must:

(1) work under the direction of a case manager or case management supervisor;

(2) be at least 21 years of age;

(3) have at least a high school diploma or its equivalent; and

(4) meet one of the following criteria:

(i) have an associate of arts degree in one of the behavioral sciences or human services;

(ii) be a certified peer specialist under section 256B.0615;

(iii) be a registered nurse without a bachelor's degree;

(iv) within the previous ten years, have three years of life experience with serious and persistent mental illness as defined in subdivision 20; or as a child had severe emotional disturbance as defined in section 245.4871, subdivision 6; or have three years life experience as a primary caregiver to an adult with serious and persistent mental illness within the previous ten years;

(v) have 6,000 hours work experience as a nondegreed state hospital technician; or

(5) prior to direct service delivery, demonstrate competency in practice and knowledge of the characteristics and needs of adults with serious and persistent mental illness, consistent with national practice standards.

(d) A case manager with at least 2,000 hours of supervised experience in the delivery of services to adults with mental illness must receive regular ongoing supervision and clinical supervision totaling 38 hours per year of which at least one hour per month must be clinical supervision regarding individual service delivery with a case management supervisor. The remaining 26 hours of supervision may be provided by a case manager with two years of experience. Group supervision may not constitute more than one-half of the required supervision hours. Clinical supervision must be documented in the client record.

(e) A case manager without 2,000 hours of supervised experience in the delivery of services to adults with mental illness must:

(1) receive clinical supervision regarding individual service delivery from a mental health professional at least one hour per week until the requirement of 2,000 hours of experience is met; and

(2) complete 40 hours of training approved by the commissioner in case management skills and the characteristics and needs of adults with serious and persistent mental illness.

(f) A case manager who is not licensed, registered, or certified by a health-related licensing board must receive 30 hours of continuing education and training in mental illness and mental health services every two years.

(g) A case manager associate (CMA) must:

(1) work under the direction of a case manager or case management supervisor;

(2) be at least 21 years of age;

(3) have at least a high school diploma or its equivalent; and

(4) meet one of the following criteria:

(i) have an associate of arts degree in one of the behavioral sciences or human services;

(ii) be a certified peer specialist under section 256B.0615;

(iii) be a registered nurse without a bachelor's degree;

(iv) within the previous ten years, have three years of life experience with serious and persistent mental illness as defined in subdivision 20; or as a child had severe emotional disturbance as defined in section 245.4871, subdivision 6; or have three years life experience as a primary caregiver to an adult with serious and persistent mental illness within the previous ten years;

(v) have 6,000 hours work experience as a nondegreed state hospital technician; or

(vi) have at least 6,000 hours of supervised experience in the delivery of services to persons with mental illness.

Individuals meeting one of the criteria in items (i) to (v) may qualify as a case manager after four years of supervised work experience as a case manager associate. Individuals meeting the criteria in item (vi) may qualify as a case manager after three years of supervised experience as a case manager associate.

(h) A case management associate must meet the following supervision, mentoring, and continuing education requirements:

(1) have 40 hours of preservice training described under paragraph (e), clause (2);

(2) receive ~~at least 40~~ annual hours of continuing education in mental illness and mental health services ~~annually; and~~ according to the following schedule, based on years of service as a case management associate:

(i) at least 40 hours in the first year;

(ii) at least 30 hours in the second year;

(iii) at least 20 hours in the third year; and

(iv) at least 20 hours in the fourth year; and

(3) receive at least ~~five~~ four hours of ~~mentoring~~ supervision per ~~week~~ month from a case management ~~mentor~~ supervisor.

~~A "case management mentor" means a qualified, practicing case manager or case management supervisor who teaches or advises and provides intensive training and clinical supervision to one or more case manager associates. Mentoring may occur while providing direct services to consumers in the office or in the field and may be provided to individuals or groups of case manager associates. At least two mentoring hours per week must be individual and face-to-face.~~

(i) A case management supervisor must meet the criteria for mental health professionals, as specified in subdivision 18.

(j) An immigrant who does not have the qualifications specified in this subdivision may provide case management services to adult immigrants with serious and persistent mental illness who are members of the same ethnic group as the case manager if the person:

(1) is currently enrolled in and is actively pursuing credits toward the completion of a bachelor's degree in one of the behavioral sciences or a related field including, but not limited to, social work, psychology, or nursing from an accredited college or university;

(2) completes 40 hours of training as specified in this subdivision; and

(3) receives clinical supervision at least once a week until the requirements of this subdivision are met.

(vi) have at least 6,000 hours of supervised experience in the delivery of services to persons with mental illness.

Individuals meeting one of the criteria in items (i) to (v) may qualify as a case manager after four years of supervised work experience as a case manager associate. Individuals meeting the criteria in item (vi) may qualify as a case manager after three years of supervised experience as a case manager associate.

(h) A case management associate must meet the following supervision, mentoring, and continuing education requirements:

(1) have 40 hours of preservice training described under paragraph (e), clause (2);

(2) receive ~~at least 40~~ hours of annual continuing education in mental illness and mental health services ~~annually; and~~ according to the following schedule, based on years of service as a case management associate:

(i) at least 40 hours in the first year;

(ii) at least 30 hours in the second year;

(iii) at least 20 hours in the third year; and

(iv) at least 20 hours in the fourth year; and

(3) receive at least ~~five~~ four hours of ~~mentoring~~ supervision per ~~week~~ month from a case management ~~mentor~~ supervisor.

~~A "case management mentor" means a qualified, practicing case manager or case management supervisor who teaches or advises and provides intensive training and clinical supervision to one or more case manager associates. Mentoring may occur while providing direct services to consumers in the office or in the field and may be provided to individuals or groups of case manager associates. At least two mentoring hours per week must be individual and face-to-face.~~

(i) A case management supervisor must meet the criteria for mental health professionals, as specified in subdivision 18.

(j) An immigrant who does not have the qualifications specified in this subdivision may provide case management services to adult immigrants with serious and persistent mental illness who are members of the same ethnic group as the case manager if the person:

(1) is currently enrolled in and is actively pursuing credits toward the completion of a bachelor's degree in one of the behavioral sciences or a related field including, but not limited to, social work, psychology, or nursing from an accredited college or university;

(2) completes 40 hours of training as specified in this subdivision; and

(3) receives clinical supervision at least once a week until the requirements of this subdivision are met.

Sec. 3. Minnesota Statutes 2024, section 245.4661, subdivision 9, is amended to read:

Subd. 9. **Services and programs.** (a) The following three distinct grant programs are funded under this section:

(1) mental health crisis services;

(2) housing with supports for adults with serious mental illness; and

(3) projects for assistance in transitioning from homelessness (PATH program).

(b) In addition, the following are eligible for grant funds:

(1) community education and prevention;

(2) client outreach;

(3) early identification and intervention;

(4) adult outpatient diagnostic assessment and psychological testing;

(5) peer support services;

(6) community support program services (CSP);

(7) adult residential crisis stabilization;

(8) supported employment;

(9) assertive community treatment (ACT);

(10) housing subsidies;

(11) basic living, social skills, and community intervention;

(12) emergency response services;

(13) adult outpatient psychotherapy;

(14) adult outpatient medication management;

(15) adult mobile crisis services, including the purchase and renovation of vehicles by mobile crisis teams in order to provide protected transport under section 256B.0625, subdivision 17, paragraph (l), clause (6);

(16) adult day treatment;

(17) partial hospitalization;

(18) adult residential treatment;

(19) adult mental health targeted case management; and

(20) transportation.

Sec. 5. Minnesota Statutes 2024, section 245.469, is amended to read:

245.469 EMERGENCY SERVICES.

Subdivision 1. **Availability of emergency services.** (a) County boards must provide or contract for enough emergency services within the county to meet the needs of adults, children, and families in the county who are experiencing an emotional crisis or mental illness. Clients must not be charged for services provided. Emergency service providers must ~~not delay the timely provision of emergency services to a client because of the unwillingness or inability of the client to pay for services~~ meet the qualifications under section 256B.0624, subdivision 4. Emergency services must include assessment, crisis intervention, and appropriate case disposition. Emergency services must:

(1) promote the safety and emotional stability of each client;

(2) minimize further deterioration of each client;

(3) help each client to obtain ongoing care and treatment;

(4) prevent placement in settings that are more intensive, costly, or restrictive than necessary and appropriate to meet client needs; and

(5) provide support, psychoeducation, and referrals to each client's family members, service providers, and other third parties on behalf of the client in need of emergency services.

(b) If a county provides engagement services under section 253B.041, the county's emergency service providers must refer clients to engagement services when the client meets the criteria for engagement services.

Subd. 2. **Specific requirements.** (a) The county board shall require that all service providers of emergency services to adults or children with mental illness provide immediate direct access to a mental health professional during regular business hours. For evenings, weekends, and holidays, the service may be by direct toll-free telephone access to a mental health professional, clinical trainee, or mental health practitioner.

(b) The commissioner may waive the requirement in paragraph (a) that the evening, weekend, and holiday service be provided by a mental health professional, clinical trainee, or mental health practitioner if the county documents that:

(1) mental health professionals, clinical trainees, or mental health practitioners are unavailable to provide this service;

(2) services are provided by a designated person with training in human services who receives treatment supervision from a mental health professional; and

(3) the service provider is not also the provider of fire and public safety emergency services.

Sec. 4. Minnesota Statutes 2024, section 245.469, is amended to read:

245.469 EMERGENCY SERVICES.

Subdivision 1. **Availability of emergency services.** (a) County boards must provide or contract for enough emergency services within the county to meet the needs of adults, children, and families in the county who are experiencing an emotional crisis or mental illness. Clients must not be charged for services provided. Emergency service providers must ~~not delay the timely provision of emergency services to a client because of the unwillingness or inability of the client to pay for services~~ meet the qualifications under section 256B.0624, subdivision 4. Emergency services must include assessment, crisis intervention, and appropriate case disposition. Emergency services must:

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(b) The commissioner may waive the requirement in paragraph (a) that the evening, weekend, and holiday service be provided by a mental health professional, clinical trainee, or mental health practitioner if the county documents that:

(1) mental health professionals, clinical trainees, or mental health practitioners are unavailable to provide this service;

(2) services are provided by a designated person with training in human services who receives treatment supervision from a mental health professional; and

(3) the service provider is not also the provider of fire and public safety emergency services.

(c) The commissioner may waive the requirement in paragraph (b), clause (3), that the evening, weekend, and holiday service not be provided by the provider of fire and public safety emergency services if:

(1) every person who will be providing the first telephone contact has received at least eight hours of training on emergency mental health services approved by the commissioner;

(2) every person who will be providing the first telephone contact will annually receive at least four hours of continued training on emergency mental health services approved by the commissioner;

(3) the local social service agency has provided public education about available emergency mental health services and can assure potential users of emergency services that their calls will be handled appropriately;

(4) the local social service agency agrees to provide the commissioner with accurate data on the number of emergency mental health service calls received;

(5) the local social service agency agrees to monitor the frequency and quality of emergency services; and

(6) the local social service agency describes how it will comply with paragraph (d).

(d) Whenever emergency service during nonbusiness hours is provided by anyone other than a mental health professional, a mental health professional must be available on call for an emergency assessment and crisis intervention services, and must be available for at least telephone consultation within 30 minutes.

Subd. 3. **Mental health crisis services.** The commissioner of human services shall increase access to mental health crisis services for children and adults. In order to increase access, the commissioner must:

(1) ~~develop a central phone number where calls can be routed to the appropriate crisis services~~ promote the 988 Lifeline;

(2) provide telephone consultation 24 hours a day to mobile crisis teams who are serving people with traumatic brain injury or intellectual disabilities who are experiencing a mental health crisis;

(3) expand crisis services across the state, including rural areas of the state and examining access per population;

(4) establish and implement state standards and requirements for crisis services as outlined in section 256B.0624; and

(5) provide grants to adult mental health initiatives, counties, tribes, or community mental health providers to establish new mental health crisis residential service capacity.

(c) The commissioner may waive the requirement in paragraph (b), clause (3), that the evening, weekend, and holiday service not be provided by the provider of fire and public safety emergency services if:

(1) every person who will be providing the first telephone contact has received at least eight hours of training on emergency mental health services approved by the commissioner;

(2) every person who will be providing the first telephone contact will annually receive at least four hours of continued training on emergency mental health services approved by the commissioner;

(3) the local social service agency has provided public education about available emergency mental health services and can assure potential users of emergency services that their calls will be handled appropriately;

(4) the local social service agency agrees to provide the commissioner with accurate data on the number of emergency mental health service calls received;

(5) the local social service agency agrees to monitor the frequency and quality of emergency services; and

(6) the local social service agency describes how it will comply with paragraph (d).

(d) Whenever emergency service during nonbusiness hours is provided by anyone other than a mental health professional, a mental health professional must be available on call for an emergency assessment and crisis intervention services, and must be available for at least telephone consultation within 30 minutes.

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(3) expand crisis services across the state, including rural areas of the state and examining access per population;

(4) establish and implement state standards and requirements for crisis services as outlined in section 256B.0624; and

(5) provide grants to adult mental health initiatives, counties, tribes, or community mental health providers to establish new mental health crisis residential service capacity.

Priority will be given to regions that do not have a mental health crisis residential services program, do not have an inpatient psychiatric unit within the region, do not have an inpatient psychiatric unit within 90 miles, or have a demonstrated need based on the number of crisis residential or intensive residential treatment beds available to meet the needs of the residents in the region. At least 50 percent of the funds must be distributed to programs in rural Minnesota. Grant funds may be used for start-up costs, including but not limited to renovations, furnishings, and staff training. Grant applications shall provide details on how the intended service will address identified needs and shall demonstrate collaboration with crisis teams, other mental health providers, hospitals, and police.

Sec. 6. Minnesota Statutes 2024, section 245.481, is amended to read:

245.481 FEES FOR MENTAL HEALTH SERVICES.

A client or, in the case of a child, the child or the child's parent may be required to pay a fee for mental health services provided under sections 245.461 to 245.4682, 245.470 to 245.486, and 245.487 to 245.4889. The fee must be based on the person's ability to pay according to the fee schedule adopted by the county board. In adopting the fee schedule for mental health services, the county board may adopt the fee schedule provided by the commissioner or adopt a fee schedule recommended by the county board and approved by the commissioner. Agencies or individuals under contract with a county board to provide mental health services under sections 245.461 to 245.486 and 245.487 to 245.4889 must not charge clients whose mental health services are paid wholly or in part from public funds fees which exceed the county board's adopted fee schedule. This section does not apply to regional treatment center fees, which are governed by sections 246.50 to 246.55.

Sec. 7. Minnesota Statutes 2024, section 245.4871, subdivision 4, is amended to read:

Subd. 4. **Case management service provider.** (a) "Case management service provider" means a case manager or case manager associate employed by the county or other entity authorized by the county board to provide case management services specified in subdivision 3 for the child with severe emotional disturbance and the child's family.

(b) A case manager must:

(1) have experience and training in working with children;

(2) be a mental health practitioner under section 245I.04, subdivision 4, or have at least a bachelor's degree in one of the behavioral sciences or a related field including, but not limited to, social work, psychology, or nursing from an accredited college or university or meet the requirements of paragraph (d);

(3) have experience and training in identifying and assessing a wide range of children's needs;

(4) be knowledgeable about local community resources and how to use those resources for the benefit of children and their families; and

Priority will be given to regions that do not have a mental health crisis residential services program, do not have an inpatient psychiatric unit within the region, do not have an inpatient psychiatric unit within 90 miles, or have a demonstrated need based on the number of crisis residential or intensive residential treatment beds available to meet the needs of the residents in the region. At least 50 percent of the funds must be distributed to programs in rural Minnesota. Grant funds may be used for start-up costs, including but not limited to renovations, furnishings, and staff training. Grant applications shall provide details on how the intended service will address identified needs and shall demonstrate collaboration with crisis teams, other mental health providers, hospitals, and police.

Sec. 5. Minnesota Statutes 2024, section 245.4871, subdivision 4, is amended to read:

Subd. 4. **Case management service provider.** (a) "Case management service provider" means a case manager or case manager associate employed by the county or other entity authorized by the county board to provide case management services specified in subdivision 3 for the child with severe emotional disturbance and the child's family.

(b) A case manager must:

(1) have experience and training in working with children;

(2) be a mental health practitioner under section 245I.04, subdivision 4, or have at least a bachelor's degree in one of the behavioral sciences or a related field including, but not limited to, social work, psychology, or nursing from an accredited college or university or meet the requirements of paragraph (d);

(3) have experience and training in identifying and assessing a wide range of children's needs;

(4) be knowledgeable about local community resources and how to use those resources for the benefit of children and their families; and

(5) meet the supervision and continuing education requirements of paragraphs (e), (f), and (g), as applicable.

(c) A case manager may be a member of any professional discipline that is part of the local system of care for children established by the county board.

(d) A case manager ~~without~~ who is not a mental health practitioner and does not have a bachelor's degree or who has a bachelor's degree that is not in one of the behavioral sciences or related fields must meet one of the requirements in clauses (1) to ~~(3)~~ (5):

(1) have three or four years of experience as a case manager associate;

(2) be a registered nurse without a bachelor's degree who has a combination of specialized training in psychiatry and work experience consisting of community interaction and involvement or community discharge planning in a mental health setting totaling three years; ~~or~~

(3) be a person who qualified as a case manager under the 1998 Department of Human Services waiver provision and meets the continuing education, supervision, and mentoring requirements in this section~~.~~;

(4) prior to direct service delivery, complete at least 80 hours of specific training on the characteristics and needs of children with serious mental illness that is consistent with national practices standards; or

(5) prior to direct service delivery, demonstrate competency in practice and knowledge of the characteristics and needs of children with serious mental illness, consistent with national practices standards.

(e) A case manager with at least 2,000 hours of supervised experience in the delivery of mental health services to children must receive regular ongoing supervision and clinical supervision totaling 38 hours per year, of which at least one hour per month must be clinical supervision regarding individual service delivery with a case management supervisor. The other 26 hours of supervision may be provided by a case manager with two years of experience. Group supervision may not constitute more than one-half of the required supervision hours.

(f) A case manager without 2,000 hours of supervised experience in the delivery of mental health services to children with emotional disturbance must:

(1) begin 40 hours of training approved by the commissioner of human services in case management skills and in the characteristics and needs of children with severe emotional disturbance before beginning to provide case management services; and

(2) receive clinical supervision regarding individual service delivery from a mental health professional at least one hour each week until the requirement of 2,000 hours of experience is met.

(5) meet the supervision and continuing education requirements of paragraphs (e), (f), and (g), as applicable.

(c) A case manager may be a member of any professional discipline that is part of the local system of care for children established by the county board.

(d) A case manager ~~without a bachelor's degree~~ who is not a mental health practitioner and does not have a bachelor's degree or who has a bachelor's degree that is not in one of the behavioral sciences or related fields must meet one of the requirements in clauses (1) to ~~(3)~~ (5):

(1) have three or four years of experience as a case manager associate;

(2) be a registered nurse without a bachelor's degree who has a combination of specialized training in psychiatry and work experience consisting of community interaction and involvement or community discharge planning in a mental health setting totaling three years; ~~or~~

(3) be a person who qualified as a case manager under the 1998 Department of Human Services waiver provision and meets the continuing education, supervision, and mentoring requirements in this section~~.~~;

(4) prior to direct service delivery, complete at least 80 hours of specific training on the characteristics and needs of children with severe emotional disturbance, consistent with national practices standards; or

(5) prior to direct service delivery, demonstrate competency in practice and knowledge of the characteristics and needs of children with severe emotional disturbance, consistent with national practices standards.

(e) A case manager with at least 2,000 hours of supervised experience in the delivery of mental health services to children must receive regular ongoing supervision and clinical supervision totaling 38 hours per year, of which at least one hour per month must be clinical supervision regarding individual service delivery with a case management supervisor. The other 26 hours of supervision may be provided by a case manager with two years of experience. Group supervision may not constitute more than one-half of the required supervision hours.

(f) A case manager without 2,000 hours of supervised experience in the delivery of mental health services to children with emotional disturbance must:

(1) begin 40 hours of training approved by the commissioner of human services in case management skills and in the characteristics and needs of children with severe emotional disturbance before beginning to provide case management services; and

(2) receive clinical supervision regarding individual service delivery from a mental health professional at least one hour each week until the requirement of 2,000 hours of experience is met.

(g) A case manager who is not licensed, registered, or certified by a health-related licensing board must receive 30 hours of continuing education and training in severe emotional disturbance and mental health services every two years.

(h) Clinical supervision must be documented in the child's record. When the case manager is not a mental health professional, the county board must provide or contract for needed clinical supervision.

(i) The county board must ensure that the case manager has the freedom to access and coordinate the services within the local system of care that are needed by the child.

(j) A case manager associate (CMA) must:

(1) work under the direction of a case manager or case management supervisor;

(2) be at least 21 years of age;

(3) have at least a high school diploma or its equivalent; and

(4) meet one of the following criteria:

(i) have an associate of arts degree in one of the behavioral sciences or human services;

(ii) be a registered nurse without a bachelor's degree;

(iii) have three years of life experience as a primary caregiver to a child with serious emotional disturbance as defined in subdivision 6 within the previous ten years;

(iv) have 6,000 hours work experience as a nondegreed state hospital technician; or

(v) have 6,000 hours of supervised work experience in the delivery of mental health services to children with emotional disturbances; hours worked as a mental health behavioral aide I or II under section 256B.0943, subdivision 7, may count toward the 6,000 hours of supervised work experience.

Individuals meeting one of the criteria in items (i) to (iv) may qualify as a case manager after four years of supervised work experience as a case manager associate. Individuals meeting the criteria in item (v) may qualify as a case manager after three years of supervised experience as a case manager associate.

(k) Case manager associates must meet the following supervision, mentoring, and continuing education requirements;

(1) have 40 hours of preservice training described under paragraph (f), clause (1);

(2) receive at least 40 hours of continuing education in severe emotional disturbance and mental health service annually; and

(3) receive at least five hours of mentoring per week from a case management mentor. A "case management mentor" means a qualified, practicing case manager or case management supervisor who teaches or advises and provides intensive training and clinical supervision

(g) A case manager who is not licensed, registered, or certified by a health-related licensing board must receive 30 hours of continuing education and training in severe emotional disturbance and mental health services every two years.

(h) Clinical supervision must be documented in the child's record. When the case manager is not a mental health professional, the county board must provide or contract for needed clinical supervision.

(i) The county board must ensure that the case manager has the freedom to access and coordinate the services within the local system of care that are needed by the child.

(j) A case manager associate (CMA) must:

(1) work under the direction of a case manager or case management supervisor;

(2) be at least 21 years of age;

(3) have at least a high school diploma or its equivalent; and

(4) meet one of the following criteria:

(i) have an associate of arts degree in one of the behavioral sciences or human services;

(ii) be a registered nurse without a bachelor's degree;

(iii) have three years of life experience as a primary caregiver to a child with serious emotional disturbance as defined in subdivision 6 within the previous ten years;

(iv) have 6,000 hours work experience as a nondegreed state hospital technician; or

(v) have 6,000 hours of supervised work experience in the delivery of mental health services to children with emotional disturbances; hours worked as a mental health behavioral aide I or II under section 256B.0943, subdivision 7, may count toward the 6,000 hours of supervised work experience.

Individuals meeting one of the criteria in items (i) to (iv) may qualify as a case manager after four years of supervised work experience as a case manager associate. Individuals meeting the criteria in item (v) may qualify as a case manager after three years of supervised experience as a case manager associate.

(k) Case manager associates must meet the following supervision, mentoring, and continuing education requirements;

(1) have 40 hours of preservice training described under paragraph (f), clause (1);

(2) receive at least 40 hours of continuing education in severe emotional disturbance and mental health service annually; and

(3) receive at least five hours of mentoring per week from a case management mentor. A "case management mentor" means a qualified, practicing case manager or case management supervisor who teaches or advises and provides intensive training and clinical supervision

to one or more case manager associates. Mentoring may occur while providing direct services to consumers in the office or in the field and may be provided to individuals or groups of case manager associates. At least two mentoring hours per week must be individual and face-to-face.

(l) A case management supervisor must meet the criteria for a mental health professional as specified in subdivision 27.

(m) An immigrant who does not have the qualifications specified in this subdivision may provide case management services to child immigrants with severe emotional disturbance of the same ethnic group as the immigrant if the person:

(1) is currently enrolled in and is actively pursuing credits toward the completion of a bachelor's degree in one of the behavioral sciences or related fields at an accredited college or university;

(2) completes 40 hours of training as specified in this subdivision; and

(3) receives clinical supervision at least once a week until the requirements of obtaining a bachelor's degree and 2,000 hours of supervised experience are met.

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

Sec. 8. Minnesota Statutes 2024, section 245.4871, is amended by adding a subdivision to read:

Subd. 7a. **Clinical supervision.** "Clinical supervision" means the oversight responsibility for individual treatment plans and individual mental health service delivery, including oversight provided by the case manager. Clinical supervision must be provided by a mental health professional. The supervising mental health professional must cosign an individual treatment plan and the mental health professional's name must be documented in the client's record.

Sec. 9. Minnesota Statutes 2024, section 245.4871, subdivision 31, is amended to read:

Subd. 31. **Professional home-based family treatment.** (a) "Professional home-based family treatment" means intensive mental health services provided to children because of ~~an emotional disturbance~~ a mental illness: (1) who are at risk of ~~out-of-home placement~~ residential treatment or therapeutic foster care; (2) who are in ~~out-of-home placement~~ residential treatment or therapeutic foster care; or (3) who are returning from ~~out-of-home placement~~ residential treatment or therapeutic foster care.

(b) Services are provided to the child and the child's family primarily in the child's home environment. Services may also be provided in the child's school, child care setting, or other community setting appropriate to the child. Services must be provided on an individual family basis, must be child-oriented and family-oriented, and must be designed using

to one or more case manager associates. Mentoring may occur while providing direct services to consumers in the office or in the field and may be provided to individuals or groups of case manager associates. At least two mentoring hours per week must be individual and face-to-face.

(l) A case management supervisor must meet the criteria for a mental health professional as specified in subdivision 27.

(m) An immigrant who does not have the qualifications specified in this subdivision may provide case management services to child immigrants with severe emotional disturbance of the same ethnic group as the immigrant if the person:

(1) is currently enrolled in and is actively pursuing credits toward the completion of a bachelor's degree in one of the behavioral sciences or related fields at an accredited college or university;

(2) completes 40 hours of training as specified in this subdivision; and

(3) receives clinical supervision at least once a week until the requirements of obtaining a bachelor's degree and 2,000 hours of supervised experience are met.

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

Sec. 6. Minnesota Statutes 2024, section 245.4871, is amended by adding a subdivision to read:

Subd. 7a. **Clinical supervision.** "Clinical supervision" means the oversight responsibility for individual treatment plans and individual mental health service delivery, including oversight provided by the case manager. Clinical supervision must be provided by a mental health professional. The supervising mental health professional must cosign an individual treatment plan, and their name must be documented in the client's record.

THE FOLLOWING TWO SECTIONS ARE FROM S2669-3, ARTICLE 10.

Sec. 25. Minnesota Statutes 2024, section 245.4871, subdivision 31, is amended to read:

Subd. 31. **Professional home-based family treatment.** (a) "Professional home-based family treatment" means intensive mental health services provided to children because of ~~an emotional disturbance~~ mental illness: (1) who are at risk of ~~out-of-home placement~~ residential treatment or therapeutic foster care; (2) who are in ~~out-of-home placement~~ residential treatment or therapeutic foster care; or (3) who are returning from ~~out-of-home placement~~ residential treatment or therapeutic foster care.

(b) Services are provided to the child and the child's family primarily in the child's home environment. Services may also be provided in the child's school, child care setting, or other community setting appropriate to the child. Services must be provided on an individual family basis, must be child-oriented and family-oriented, and must be designed using

information from diagnostic and functional assessments to meet the specific mental health needs of the child and the child's family. Services must be coordinated with other services provided to the child and family.

(c) Examples of services are: (1) individual therapy; (2) family therapy; (3) client outreach; (4) assistance in developing individual living skills; (5) assistance in developing parenting skills necessary to address the needs of the child; (6) assistance with leisure and recreational services; (7) crisis planning, including crisis respite care and arranging for crisis placement; and (8) assistance in locating respite and child care. Services must be coordinated with other services provided to the child and family.

Sec. 10. Minnesota Statutes 2024, section 245.4874, subdivision 1, is amended to read:

Subdivision 1. **Duties of county board.** (a) The county board must:

(1) develop a system of affordable and locally available children's mental health services according to sections 245.487 to 245.4889;

(2) consider the assessment of unmet needs in the county as reported by the local children's mental health advisory council under section 245.4875, subdivision 5, paragraph (b), clause (3). The county shall provide, upon request of the local children's mental health advisory council, readily available data to assist in the determination of unmet needs;

(3) assure that parents and providers in the county receive information about how to gain access to services provided according to sections 245.487 to 245.4889;

(4) coordinate the delivery of children's mental health services with services provided by social services, education, corrections, health, and vocational agencies to improve the availability of mental health services to children and the cost-effectiveness of their delivery;

(5) assure that mental health services delivered according to sections 245.487 to 245.4889 are delivered expeditiously and are appropriate to the child's diagnostic assessment and individual treatment plan;

(6) provide for case management services to each child with ~~severe emotional disturbance~~ serious mental illness according to sections 245.486; 245.4871, subdivisions 3 and 4; and 245.4881, subdivisions 1, 3, and 5;

(7) provide for screening of each child under section 245.4885 upon admission to a residential treatment facility~~, acute care hospital inpatient treatment, or informal admission to a regional treatment center~~;

(8) prudently administer grants and purchase-of-service contracts that the county board determines are necessary to fulfill its responsibilities under sections 245.487 to 245.4889;

(9) assure that mental health professionals, mental health practitioners, and case managers employed by or under contract to the county to provide mental health services are qualified under section 245.4871;

information from diagnostic and functional assessments to meet the specific mental health needs of the child and the child's family. Services must be coordinated with other services provided to the child and the child's family.

(c) Examples of services are: (1) individual therapy; (2) family therapy; (3) client outreach; (4) assistance in developing individual living skills; (5) assistance in developing parenting skills necessary to address the needs of the child; (6) assistance with leisure and recreational services; (7) crisis planning, including crisis respite care and arranging for crisis placement; and (8) assistance in locating respite and child care. Services must be coordinated with other services provided to the child and family.

Sec. 29. Minnesota Statutes 2024, section 245.4874, subdivision 1, is amended to read:

Subdivision 1. **Duties of county board.** (a) The county board must:

(1) develop a system of affordable and locally available children's mental health services according to sections 245.487 to 245.4889;

(2) consider the assessment of unmet needs in the county as reported by the local children's mental health advisory council under section 245.4875, subdivision 5, paragraph (b), clause (3). The county shall provide, upon request of the local children's mental health advisory council, readily available data to assist in the determination of unmet needs;

(3) assure that parents and providers in the county receive information about how to gain access to services provided according to sections 245.487 to 245.4889;

(4) coordinate the delivery of children's mental health services with services provided by social services, education, corrections, health, and vocational agencies to improve the availability of mental health services to children and the cost-effectiveness of their delivery;

(5) assure that mental health services delivered according to sections 245.487 to 245.4889 are delivered expeditiously and are appropriate to the child's diagnostic assessment and individual treatment plan;

(6) provide for case management services to each child with ~~severe emotional disturbance~~ serious mental illness according to sections 245.486; 245.4871, subdivisions 3 and 4; and 245.4881, subdivisions 1, 3, and 5;

(7) provide for screening of each child under section 245.4885 upon admission to a residential treatment facility~~, acute care hospital inpatient treatment, or informal admission to a regional treatment center~~;

(8) prudently administer grants and purchase-of-service contracts that the county board determines are necessary to fulfill its responsibilities under sections 245.487 to 245.4889;

(9) assure that mental health professionals, mental health practitioners, and case managers employed by or under contract to the county to provide mental health services are qualified under section 245.4871;

(10) assure that children's mental health services are coordinated with adult mental health services specified in sections 245.461 to 245.486 so that a continuum of mental health services is available to serve persons with mental illness, regardless of the person's age;

(11) assure that culturally competent mental health consultants are used as necessary to assist the county board in assessing and providing appropriate treatment for children of cultural or racial minority heritage; and

(12) consistent with section 245.486, arrange for or provide a children's mental health screening for:

(i) a child receiving child protective services;

(ii) a child in ~~out-of-home placement~~ residential treatment or therapeutic foster care;

(iii) a child for whom parental rights have been terminated;

(iv) a child found to be delinquent; or

(v) a child found to have committed a juvenile petty offense for the third or subsequent time.

A children's mental health screening is not required when a screening or diagnostic assessment has been performed within the previous 180 days, or the child is currently under the care of a mental health professional.

(b) When a child is receiving protective services or is in ~~out-of-home placement~~ residential treatment or foster care, the court or county agency must notify a parent or guardian whose parental rights have not been terminated of the potential mental health screening and the option to prevent the screening by notifying the court or county agency in writing.

(c) When a child is found to be delinquent or a child is found to have committed a juvenile petty offense for the third or subsequent time, the court or county agency must obtain written informed consent from the parent or legal guardian before a screening is conducted unless the court, notwithstanding the parent's failure to consent, determines that the screening is in the child's best interest.

(d) The screening shall be conducted with a screening instrument approved by the commissioner of human services according to criteria that are updated and issued annually to ensure that approved screening instruments are valid and useful for child welfare and juvenile justice populations. Screenings shall be conducted by a mental health practitioner as defined in section 245.4871, subdivision 26, or a probation officer or local social services agency staff person who is trained in the use of the screening instrument. Training in the use of the instrument shall include:

(1) training in the administration of the instrument;

(2) the interpretation of its validity given the child's current circumstances;

(10) assure that children's mental health services are coordinated with adult mental health services specified in sections 245.461 to 245.486 so that a continuum of mental health services is available to serve persons with mental illness, regardless of the person's age;

(11) assure that culturally competent mental health consultants are used as necessary to assist the county board in assessing and providing appropriate treatment for children of cultural or racial minority heritage; and

(12) consistent with section 245.486, arrange for or provide a children's mental health screening for:

(i) a child receiving child protective services;

(ii) a child in ~~out-of-home placement~~ residential treatment or therapeutic foster care;

(iii) a child for whom parental rights have been terminated;

(iv) a child found to be delinquent; or

(v) a child found to have committed a juvenile petty offense for the third or subsequent time.

A children's mental health screening is not required when a screening or diagnostic assessment has been performed within the previous 180 days, or the child is currently under the care of a mental health professional.

(b) When a child is receiving protective services or is in ~~out-of-home placement~~ residential treatment or foster care, the court or county agency must notify a parent or guardian whose parental rights have not been terminated of the potential mental health screening and the option to prevent the screening by notifying the court or county agency in writing.

(c) When a child is found to be delinquent or a child is found to have committed a juvenile petty offense for the third or subsequent time, the court or county agency must obtain written informed consent from the parent or legal guardian before a screening is conducted unless the court, notwithstanding the parent's failure to consent, determines that the screening is in the child's best interest.

(d) The screening shall be conducted with a screening instrument approved by the commissioner of human services according to criteria that are updated and issued annually to ensure that approved screening instruments are valid and useful for child welfare and juvenile justice populations. Screenings shall be conducted by a mental health practitioner as defined in section 245.4871, subdivision 26, or a probation officer or local social services agency staff person who is trained in the use of the screening instrument. Training in the use of the instrument shall include:

(1) training in the administration of the instrument;

(2) the interpretation of its validity given the child's current circumstances;

(3) the state and federal data practices laws and confidentiality standards;

(4) the parental consent requirement; and

(5) providing respect for families and cultural values.

If the screen indicates a need for assessment, the child's family, or if the family lacks mental health insurance, the local social services agency, in consultation with the child's family, shall have conducted a diagnostic assessment, including a functional assessment. The administration of the screening shall safeguard the privacy of children receiving the screening and their families and shall comply with the Minnesota Government Data Practices Act, chapter 13, and the federal Health Insurance Portability and Accountability Act of 1996, Public Law 104-191. Screening results are classified as private data on individuals, as defined by section 13.02, subdivision 12. The county board or Tribal nation may provide the commissioner with access to the screening results for the purposes of program evaluation and improvement.

(e) When the county board refers clients to providers of children's therapeutic services and supports under section 256B.0943, the county board must clearly identify the desired services components not covered under section 256B.0943 and identify the reimbursement source for those requested services, the method of payment, and the payment rate to the provider.

Sec. 11. Minnesota Statutes 2024, section 245.4881, subdivision 3, is amended to read:

Subd. 3. **Duties of case manager.** (a) Upon a determination of eligibility for case management services, the case manager shall develop an individual family community support plan for a child as specified in subdivision 4, review the child's progress, ~~and~~ monitor the provision of services, and, if the child and the child's parent or legal guardian consent, complete a written functional assessment as defined in section 245.4871, subdivision 18a. If services are to be provided in a host county that is not the county of financial responsibility, the case manager shall consult with the host county and obtain a letter demonstrating the concurrence of the host county regarding the provision of services.

(b) The case manager shall note in the child's record the services needed by the child and the child's family, the services requested by the family, services that are not available, and the unmet needs of the child and child's family. The case manager shall note this provision in the child's record.

Sec. 12. Minnesota Statutes 2024, section 245.4901, subdivision 3, is amended to read:

Subd. 3. **Allowable grant activities and related expenses.** (a) Allowable grant activities and related expenses may include but are not limited to:

(1) identifying and diagnosing mental health conditions and substance use disorders of students;

(3) the state and federal data practices laws and confidentiality standards;

(4) the parental consent requirement; and

(5) providing respect for families and cultural values.

If the screen indicates a need for assessment, the child's family, or if the family lacks mental health insurance, the local social services agency, in consultation with the child's family, shall have conducted a diagnostic assessment, including a functional assessment. The administration of the screening shall safeguard the privacy of children receiving the screening and their families and shall comply with the Minnesota Government Data Practices Act, chapter 13, and the federal Health Insurance Portability and Accountability Act of 1996, Public Law 104-191. Screening results are classified as private data on individuals, as defined by section 13.02, subdivision 12. The county board or Tribal nation may provide the commissioner with access to the screening results for the purposes of program evaluation and improvement.

(e) When the county board refers clients to providers of children's therapeutic services and supports under section 256B.0943, the county board must clearly identify the desired services components not covered under section 256B.0943 and identify the reimbursement source for those requested services, the method of payment, and the payment rate to the provider.

Sec. 7. Minnesota Statutes 2024, section 245.4881, subdivision 3, is amended to read:

Subd. 3. **Duties of case manager.** (a) Upon a determination of eligibility for case management services, the case manager shall develop an individual family community support plan for a child as specified in subdivision 4, review the child's progress, ~~and~~ monitor the provision of services, and if the child and parent or legal guardian consent, complete a written functional assessment as defined by section 245.4871, subdivision 18a. If services are to be provided in a host county that is not the county of financial responsibility, the case manager shall consult with the host county and obtain a letter demonstrating the concurrence of the host county regarding the provision of services.

(b) The case manager shall note in the child's record the services needed by the child and the child's family, the services requested by the family, services that are not available, and the unmet needs of the child and child's family. The case manager shall note this provision in the child's record.

Sec. 8. Minnesota Statutes 2024, section 245.4901, subdivision 3, is amended to read:

Subd. 3. **Allowable grant activities and related expenses.** (a) Allowable grant activities and related expenses may include but are not limited to:

(1) identifying and diagnosing mental health conditions and substance use disorders of students;

(2) delivering mental health and substance use disorder treatment and services to students and their families, including via telehealth consistent with section 256B.0625, subdivision 3b;

(3) supporting families in meeting their child's needs, including accessing needed mental health services to support the child's parent in caregiving and navigating health care, social service, and juvenile justice systems;

(4) providing transportation for students receiving school-linked behavioral health services when school is not in session;

(5) building the capacity of schools to meet the needs of students with mental health and substance use disorder concerns, including school staff development activities for licensed and nonlicensed staff; and

(6) purchasing equipment, connection charges, on-site coordination, set-up fees, and site fees in order to deliver school-linked behavioral health services via telehealth.

(b) Grantees shall obtain all available third-party reimbursement sources as a condition of receiving a grant. For purposes of this grant program, a third-party reimbursement source excludes a public school as defined in section 120A.20, subdivision 1. Grantees shall serve students regardless of health coverage status or ability to pay.

Sec. 13. **[245.4904] INTERMEDIATE SCHOOL DISTRICT BEHAVIORAL HEALTH GRANT PROGRAM.**

Subdivision 1. **Establishment.** The commissioner of human services must establish a grant program to improve behavioral health outcomes for youth attending a qualifying school unit and to build the capacity of schools to support student and teacher needs in the classroom. For the purposes of this section, "qualifying school unit" means an intermediate school district organized under section 136D.01.

Subd. 2. **Eligible applicants.** An eligible applicant is an intermediate school district organized under section 136D.01 and a partner entity or provider that has demonstrated capacity to serve the youth identified in subdivision 1 that is:

(1) a mental health clinic certified under section 245I.20;

(2) a community mental health center under section 256B.0625, subdivision 5;

(3) an Indian health service facility or a facility owned and operated by a Tribe or Tribal organization operating under United States Code, title 25, section 5321;

(4) a provider of children's therapeutic services and supports as defined in section 256B.0943;

(5) enrolled in medical assistance as a mental health or substance use disorder provider agency and employs at least two full-time equivalent mental health professionals qualified according to section 245I.04, subdivision 2, or two alcohol and drug counselors licensed or

(2) delivering mental health and substance use disorder treatment and services to students and their families, including via telehealth consistent with section 256B.0625, subdivision 3b;

(3) supporting families in meeting their child's needs, including accessing needed mental health services to support the parent in caregiving and navigating health care, social service, and juvenile justice systems;

(4) providing transportation for students receiving school-linked behavioral health services when school is not in session;

(5) building the capacity of schools to meet the needs of students with mental health and substance use disorder concerns, including school staff development activities for licensed and nonlicensed staff; and

(6) purchasing equipment, connection charges, on-site coordination, set-up fees, and site fees in order to deliver school-linked behavioral health services via telehealth.

(b) Grantees shall obtain all available third-party reimbursement sources as a condition of receiving a grant. For purposes of this grant program, a third-party reimbursement source excludes a public school as defined in section 120A.20, subdivision 1. Grantees shall serve students regardless of health coverage status or ability to pay.

Sec. 9. **[245.4904] INTERMEDIATE SCHOOL DISTRICT BEHAVIORAL HEALTH GRANT PROGRAM.**

Subdivision 1. **Establishment.** The commissioner of human services must establish a grant program to improve behavioral health outcomes for youth attending a qualifying school unit and to build the capacity of schools to support student and teacher needs in the classroom. For purposes of this section, "qualifying school unit" means an intermediate school district organized under section 136D.01.

Subd. 2. **Eligible applicants.** An eligible applicant is an intermediate school district organized under section 136D.01, and a partner entity or provider that has demonstrated capacity to serve the youth identified in subdivision 1 that is:

(1) a mental health clinic certified under section 245I.20;

(2) a community mental health center under section 256B.0625, subdivision 5;

(3) an Indian health service facility or a facility owned and operated by a Tribe or Tribal organization operating under United States Code, title 25, section 5321;

(4) a provider of children's therapeutic services and supports as defined in section 256B.0943;

(5) enrolled in medical assistance as a mental health or substance use disorder provider agency and employs at least two full-time equivalent mental health professionals qualified according to section 245I.04, subdivision 2, or two alcohol and drug counselors licensed or

exempt from licensure under chapter 148F who are qualified to provide clinical services to children and families;

(6) licensed under chapter 245G and in compliance with the applicable requirements in chapters 245A, 245C, and 260E; section 626.557; and Minnesota Rules, chapter 9544; or

(7) a licensed professional in private practice as defined in section 245G.01, subdivision 17, who meets the requirements of section 254B.05, subdivision 1, paragraph (b).

Subd. 3. **Allowable grant activities and related expenses.** (a) Allowable grant activities and related expenses include but are not limited to:

(1) identifying mental health conditions and substance use disorders of students;

(2) delivering mental health and substance use disorder treatment and supportive services to students and their families within the classroom, including via telehealth consistent with section 256B.0625, subdivision 3b;

(3) delivering therapeutic interventions and customizing an array of supplementary learning experiences for students;

(4) supporting families in meeting their child's needs, including navigating health care, social service, and juvenile justice systems;

(5) providing transportation for students receiving behavioral health services when school is not in session;

(6) building the capacity of schools to meet the needs of students with mental health and substance use disorder concerns, including school staff development activities for licensed and nonlicensed staff; and

(7) purchasing equipment, connection charges, on-site coordination, set-up fees, and site fees in order to deliver school-linked behavioral health services via telehealth.

(b) Grantees must obtain all available third-party reimbursement sources as a condition of receiving grant money. For purposes of this grant program, a third-party reimbursement source does not include a public school as defined in section 120A.20, subdivision 1. Grantees shall serve students regardless of health coverage status or ability to pay.

Subd. 4. **Calculating the share of the appropriation.** (a) Grants must be awarded to qualifying school units proportionately.

(b) The commissioner must calculate the share of the appropriation to be used in each qualifying school unit by multiplying the total appropriation going to the grantees by the qualifying school unit's average daily membership in a setting of federal instructional level 4 or higher and then dividing the product by the total average daily membership in a setting of federal instructional level 4 or higher for the same year for all qualifying school units.

exempt from licensure under chapter 148F who are qualified to provide clinical services to children and families;

(6) licensed under chapter 245G and in compliance with the applicable requirements in chapters 245A, 245C, and 260E; section 626.557; and Minnesota Rules, chapter 9544; or

(7) a licensed professional in private practice as defined in section 245G.01, subdivision 17, who meets the requirements of section 254B.05, subdivision 1, paragraph (b).

Subd. 3. **Allowable grant activities and related expenses.** (a) Allowable grant activities and related expenses include but are not limited to:

(1) identifying mental health conditions and substance use disorders of students;

(2) delivering mental health and substance use disorder treatment and supportive services to students and their families within the classroom, including via telehealth consistent with section 256B.0625, subdivision 3b;

(3) delivering therapeutic interventions and customizing an array of supplementary learning experiences for students;

(4) supporting families in meeting their child's needs, including navigating health care, social service, and juvenile justice systems;

(5) providing transportation for students receiving behavioral health services when school is not in session;

(6) building the capacity of schools to meet the needs of students with mental health and substance use disorder concerns, including school staff development activities for licensed and nonlicensed staff; and

(7) purchasing equipment, connection charges, on-site coordination, set-up fees, and site fees in order to deliver school-linked behavioral health services via telehealth.

(b) Grantees must obtain all available third-party reimbursement sources as a condition of receiving grant funds. For purposes of this grant program, a third-party reimbursement source does not include a public school as defined in section 120A.20, subdivision 1. Grantees shall serve students regardless of health coverage status or ability to pay.

Subd. 4. **Calculating the share of the appropriation.** (a) Grants must be awarded to qualifying school units proportionately.

(b) The commissioner must calculate the share of the appropriation to be used in each qualifying school unit by multiplying the total appropriation going to the grantees by the qualifying school unit's average daily membership in a setting of federal instructional level 4 or higher and then dividing by the total average daily membership in a setting of federal instructional level 4 or higher for the same year for all qualifying school units.

Subd. 5. **Data collection and outcome measurement.** Grantees must provide data to the commissioner for the purpose of evaluating the intermediate school district behavioral health innovation grant program. The commissioner must consult with grantees to develop outcome measures for program capacity and performance.

Sec. 14. Minnesota Statutes 2024, section 245.4907, subdivision 3, is amended to read:

Subd. 3. **Allowable grant activities.** Grantees must use grant funding to provide training for mental health ~~certified~~ family peer ~~specialists~~ specialist candidates and continuing education to certified family peer specialists as specified in section 256B.0616, subdivision 5.

Sec. 15. Minnesota Statutes 2024, section 245.735, subdivision 3b, is amended to read:

Subd. 3b. **Exemptions to host county approval.** Notwithstanding any other law that requires a county contract or other form of county approval for a service listed in subdivision 3, paragraph (d), clause (8), a CCBHC that meets the requirements of this section may enroll as a provider of mental health crisis response services under section 256B.0624 and receive the prospective payment under section 256B.0625, subdivision 5m, for that service without a county contract or county approval.

Subd. 5. **Data collection and outcome measurement.** Grantees must provide data to the commissioner for the purpose of evaluating the Intermediate School District Behavioral Health Innovation grant program. The commissioner must consult with grantees to develop outcome measures for program capacity and performance.

Sec. 10. Minnesota Statutes 2024, section 245.4907, subdivision 3, is amended to read:

Subd. 3. **Allowable grant activities.** Grantees must use grant funding to provide training for mental health ~~certified~~ family peer ~~specialists~~ specialist candidates and continuing education to certified family peer specialists as specified in section 256B.0616, subdivision 5.

Sec. 11. Minnesota Statutes 2024, section 245.50, subdivision 3, is amended to read:

Subd. 3. **Exceptions.** A contract may not be entered into under this section for services to persons who:

(1) are serving a sentence after conviction of a criminal offense;

~~(2) are on probation or parole;~~

~~(3)~~ (2) are the subject of a presentence investigation; or

~~(4)~~ (3) have been committed involuntarily in Minnesota under chapter 253B for treatment of mental illness or chemical dependency, except as provided under subdivision 5.

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

Sec. 12. Minnesota Statutes 2024, section 245.50, is amended by adding a subdivision to read:

Subd. 6. **Contract notice.** A Minnesota mental health, chemical health, or detoxification agency or facility entering into a contract with a bordering state under this section must, within 30 days of the contract's effective date, provide the commissioner of human services with a copy of the contract. If the contract is amended, the agency or facility must provide the commissioner with a copy of each amendment within 30 days of the amendment's effective date.

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

EFFECTIVE DATE. This section is effective upon federal approval. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

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Sec. 16. Minnesota Statutes 2024, section 245F.06, subdivision 2, is amended to read:

Subd. 2. **Comprehensive assessment.** (a) Prior to a medically stable discharge, but not later than 72 hours following admission, a license holder must provide a comprehensive assessment according to sections 245.4863, paragraph (a), and 245G.05, for each patient who has a positive screening for a substance use disorder. If a patient's medical condition prevents a comprehensive assessment from being completed within 72 hours, the license holder must document why the assessment was not completed. The comprehensive assessment must include documentation of the appropriateness of an involuntary referral through the civil commitment process.

(b) If available to the program, a patient's previous comprehensive assessment may be used in the patient record. If a previously completed comprehensive assessment is used, its contents must be reviewed to ensure the assessment is accurate and current and complies with the requirements of this chapter. The review must be completed by a staff person qualified according to section ~~245G.11, subdivision 5~~ 245G.05, subdivision 1. The license holder must document that the review was completed and that the previously completed assessment is accurate and current, or the license holder must complete an updated or new assessment.

Sec. 17. Minnesota Statutes 2024, section 245G.05, subdivision 1, is amended to read:

Subdivision 1. **Comprehensive assessment.** (a) A comprehensive assessment of the client's substance use disorder must be administered face-to-face ~~by an alcohol and drug counselor~~ within five calendar days from the day of service initiation for a residential program or by the end of the fifth day on which a treatment service is provided in a nonresidential program. The number of days to complete the comprehensive assessment excludes the day of service initiation.

(b) A comprehensive assessment must be administered by:

(1) an alcohol and drug counselor;

(2) a mental health professional who meets the qualifications under section 245I.04, subdivision 2, practices within the scope of their professional licensure, and has at least 12 hours of training in substance use disorder and treatment;

(3) a clinical trainee who meets the qualifications under section 245I.04, subdivision 6, practicing under the supervision of a mental health professional who meets the requirements of clause (2); or

Sec. 3. Minnesota Statutes 2024, section 245F.06, subdivision 2, is amended to read:

Subd. 2. **Comprehensive assessment.** (a) Prior to a medically stable discharge, but not later than 72 hours following admission, a license holder must provide a comprehensive assessment according to sections 245.4863, paragraph (a), and 245G.05, for each patient who has a positive screening for a substance use disorder. If a patient's medical condition prevents a comprehensive assessment from being completed within 72 hours, the license holder must document why the assessment was not completed. The comprehensive assessment must include documentation of the appropriateness of an involuntary referral through the civil commitment process.

(b) If available to the program, a patient's previous comprehensive assessment may be used in the patient record. If a previously completed comprehensive assessment is used, its contents must be reviewed to ensure the assessment is accurate and current and complies with the requirements of this chapter. The review must be completed by a staff person qualified according to section ~~245G.11, subdivision 5~~ 245G.05. The license holder must document that the review was completed and that the previously completed assessment is accurate and current, or the license holder must complete an updated or new assessment.

Sec. 4. Minnesota Statutes 2024, section 245G.05, subdivision 1, is amended to read:

Subdivision 1. **Comprehensive assessment.** (a) A comprehensive assessment of the client's substance use disorder must be administered face-to-face ~~by an alcohol and drug counselor~~ within five calendar days from the day of service initiation for a residential program or by the end of the fifth day on which a treatment service is provided in a nonresidential program. The number of days to complete the comprehensive assessment excludes the day of service initiation.

(b) A comprehensive assessment must be administered by:

(1) an alcohol and drug counselor;

(2) a mental health professional who meets the qualifications under section 245I.04, subdivision 2; practices within the scope of their professional licensure; and has at least 12 hours of training in substance use disorder and treatment;

(3) a clinical trainee who meets the qualifications under section 245I.04, subdivision 6, practicing under the supervision of a mental health professional who meets the requirements of clause (2); or

(4) an advanced practice registered nurse as defined in section 148.171, subdivision 3, who practices within the scope of their professional licensure and has at least 12 hours of training in substance use disorder and treatment.

(c) If the comprehensive assessment is not completed within the required time frame, the person-centered reason for the delay and the planned completion date must be documented in the client's file. The comprehensive assessment is complete upon a qualified staff member's dated signature. If the client received a comprehensive assessment that authorized the treatment service, ~~an alcohol and drug counselor~~ a staff member qualified under paragraph (b) may use the comprehensive assessment for requirements of this subdivision but must document a review of the comprehensive assessment and update the comprehensive assessment as clinically necessary to ensure compliance with this subdivision within applicable timelines. ~~An alcohol and drug counselor~~ A staff member qualified under paragraph (b) must sign and date the comprehensive assessment review and update.

Sec. 18. Minnesota Statutes 2024, section 245G.11, subdivision 7, is amended to read:

Subd. 7. **Treatment coordination provider qualifications.** (a) Treatment coordination must be provided by qualified staff. An individual is qualified to provide treatment coordination if the individual meets the qualifications of an alcohol and drug counselor under subdivision 5 or if the individual:

(1) is skilled in the process of identifying and assessing a wide range of client needs;

(2) is knowledgeable about local community resources and how to use those resources for the benefit of the client;

(3) has ~~successfully~~ completed ~~30 hours of classroom instruction on treatment coordination for an individual with substance use disorder~~ 15 hours of education or training on substance use disorder and co-occurring disorders that is consistent with national evidence-based practices;

(4) ~~has either~~ meets one of the following criteria:

(i) has a bachelor's degree in one of the behavioral sciences or related fields; ~~or~~

(ii) ~~current certification as an alcohol and drug counselor, level I, by the Upper Midwest Indian Council on Addictive Disorders; and~~ has a high school diploma or equivalent; or

(iii) is a mental health practitioner who meets the qualifications under section 245I.04, subdivision 4; and

(5) either has at least 1,000 hours of supervised experience working with individuals with substance use disorder or co-occurring conditions, or receives treatment supervision at least once per week until obtaining 1,000 hours of supervised experience working with individuals with substance use disorder or co-occurring conditions.

(4) an advanced practice registered nurse as defined in section 148.171, subdivision 3, who practices within the scope of their professional licensure and has at least 12 hours of training in substance use disorder and treatment.

(c) If the comprehensive assessment is not completed within the required time frame, the person-centered reason for the delay and the planned completion date must be documented in the client's file. The comprehensive assessment is complete upon a qualified staff member's dated signature. If the client received a comprehensive assessment that authorized the treatment service, ~~an alcohol and drug counselor~~ a staff member qualified under paragraph (b) may use the comprehensive assessment for requirements of this subdivision but must document a review of the comprehensive assessment and update the comprehensive assessment as clinically necessary to ensure compliance with this subdivision within applicable timelines. ~~An alcohol and drug counselor~~ A staff member qualified under paragraph (b) must sign and date the comprehensive assessment review and update.

Sec. 5. Minnesota Statutes 2024, section 245G.11, subdivision 7, is amended to read:

Subd. 7. **Treatment coordination provider qualifications.** (a) Treatment coordination must be provided by qualified staff. An individual is qualified to provide treatment coordination if the individual meets the qualifications of an alcohol and drug counselor under subdivision 5 or if the individual:

(1) is skilled in the process of identifying and assessing a wide range of client needs;

(2) is knowledgeable about local community resources and how to use those resources for the benefit of the client;

(3) has ~~successfully~~ completed ~~30~~ 15 hours of ~~classroom instruction on treatment~~ education or training on substance use disorder, co-occurring conditions, and care coordination for ~~an individual~~ individuals with substance use disorder or co-occurring conditions that is consistent with national evidence-based standards;

(4) ~~has either~~ meets one of the following criteria:

(i) has a high school diploma or equivalent;

(ii) has a bachelor's degree in one of the behavioral sciences or related fields; or

~~(ii) current certification as an alcohol and drug counselor, level I, by the Upper Midwest Indian Council on Addictive Disorders~~ (iii) is a mental health practitioner that meets the qualifications under section 245I.04, subdivision 4; and

(5) either has at least ~~2,000~~ 1,000 hours of supervised experience working with individuals with substance use disorder or co-occurring conditions or receives treatment supervision at least once per week until obtaining 1,000 hours of supervised experience working with individuals with substance use disorder or co-occurring conditions.

~~(5) has at least 2,000 hours of supervised experience working with individuals with substance use disorder.~~

(b) ~~A treatment coordinator must receive at least one hour of supervision regarding individual service delivery from an alcohol and drug counselor, or a mental health professional who has substance use treatment and assessments within the scope of their practice, on a monthly basis.~~ A treatment coordinator must receive the following levels of supervision from an alcohol and drug counselor or a mental health professional whose scope of practice includes substance use disorder treatment and assessments:

(1) for a treatment coordinator that has not obtained 1,000 hours of supervised experience under paragraph (a), clause (5), at least one hour of supervision per week; or

(2) for a treatment coordinator that has obtained at least 1,000 hours of supervised experience under paragraph (a), clause (5), at least one hour of supervision per month.

Sec. 19. Minnesota Statutes 2024, section 245I.05, subdivision 3, is amended to read:

Subd. 3. **Initial training.** (a) A staff person must receive training about:

(1) vulnerable adult maltreatment under section 245A.65, subdivision 3; and

(2) the maltreatment of minor reporting requirements and definitions in chapter 260E within 72 hours of first providing direct contact services to a client.

(b) Before providing direct contact services to a client, a staff person must receive training about:

(1) client rights and protections under section 245I.12;

(2) the Minnesota Health Records Act, including client confidentiality, family engagement under section 144.294, and client privacy;

(3) emergency procedures that the staff person must follow when responding to a fire, inclement weather, a report of a missing person, and a behavioral or medical emergency;

(4) specific activities and job functions for which the staff person is responsible, including the license holder's program policies and procedures applicable to the staff person's position;

(5) professional boundaries that the staff person must maintain; and

(6) specific needs of each client to whom the staff person will be providing direct contact services, including each client's developmental status, cognitive functioning, and physical and mental abilities.

(b) ~~A treatment coordinator must receive at least one hour of supervision regarding individual service delivery from an alcohol and drug counselor, or a mental health professional who has substance use treatment and assessments within the scope of their practice, on a monthly basis.~~ An alcohol and drug counselor or a mental health professional who has substance use treatment and assessments within the scope of their practice, must provide the following levels of supervision:

(1) treatment coordinators that have not yet obtained 1,000 hours of supervised experience as required in paragraph (a), clause (5), must receive at least one hour of weekly supervision; or

(2) treatment coordinators that have obtained at least 1,000 hours of supervised experience as required in paragraph (a), clause (5), must receive at least one hour per month of supervision.

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Sec. 13. Minnesota Statutes 2024, section 245I.05, subdivision 3, is amended to read:

Subd. 3. **Initial training.** (a) A staff person must receive training about:

(1) vulnerable adult maltreatment under section 245A.65, subdivision 3; and

(2) the maltreatment of minor reporting requirements and definitions in chapter 260E within 72 hours of first providing direct contact services to a client.

(b) Before providing direct contact services to a client, a staff person must receive training about:

(1) client rights and protections under section 245I.12;

(2) the Minnesota Health Records Act, including client confidentiality, family engagement under section 144.294, and client privacy;

(3) emergency procedures that the staff person must follow when responding to a fire, inclement weather, a report of a missing person, and a behavioral or medical emergency;

(4) specific activities and job functions for which the staff person is responsible, including the license holder's program policies and procedures applicable to the staff person's position;

(5) professional boundaries that the staff person must maintain; and

(6) specific needs of each client to whom the staff person will be providing direct contact services, including each client's developmental status, cognitive functioning, and physical and mental abilities.

(c) Before providing direct contact services to a client, a mental health rehabilitation worker, mental health behavioral aide, or mental health practitioner required to receive the training according to section 245I.04, subdivision 4, must receive 30 hours of training about:

(1) mental illnesses;

(2) client recovery and resiliency;

(3) mental health de-escalation techniques;

(4) co-occurring mental illness and substance use disorders; and

(5) psychotropic medications and medication side effects, including tardive dyskinesia.

(d) Within 90 days of first providing direct contact services to an adult client, mental health practitioner, mental health certified peer specialist, or mental health rehabilitation worker must receive training about:

(1) trauma-informed care and secondary trauma;

(2) person-centered individual treatment plans, including seeking partnerships with family and other natural supports;

(3) co-occurring substance use disorders; and

(4) culturally responsive treatment practices.

(e) Within 90 days of first providing direct contact services to a child client, mental health practitioner, mental health certified family peer specialist, mental health certified peer specialist, or mental health behavioral aide must receive training about the topics in clauses (1) to (5). This training must address the developmental characteristics of each child served by the license holder and address the needs of each child in the context of the child's family, support system, and culture. Training topics must include:

(1) trauma-informed care and secondary trauma, including adverse childhood experiences (ACEs);

(2) family-centered treatment plan development, including seeking partnership with a child client's family and other natural supports;

(3) mental illness and co-occurring substance use disorders in family systems;

(4) culturally responsive treatment practices; and

(5) child development, including cognitive functioning, and physical and mental abilities.

(f) For a mental health behavioral aide, the training under paragraph (e) must include parent team training using a curriculum approved by the commissioner.

(c) Before providing direct contact services to a client, a mental health rehabilitation worker, mental health behavioral aide, or mental health practitioner required to receive the training according to section 245I.04, subdivision 4, must receive 30 hours of training about:

(1) mental illnesses;

(2) client recovery and resiliency;

(3) mental health de-escalation techniques;

(4) co-occurring mental illness and substance use disorders; and

(5) psychotropic medications and medication side effects, including tardive dyskinesia.

(d) Within 90 days of first providing direct contact services to an adult client, mental health practitioner, mental health certified peer specialist, or mental health rehabilitation worker must receive training about:

(1) trauma-informed care and secondary trauma;

(2) person-centered individual treatment plans, including seeking partnerships with family and other natural supports;

(3) co-occurring substance use disorders; and

(4) culturally responsive treatment practices.

(e) Within 90 days of first providing direct contact services to a child client, mental health practitioner, mental health certified family peer specialist, mental health certified peer specialist, or mental health behavioral aide must receive training about the topics in clauses (1) to (5). This training must address the developmental characteristics of each child served by the license holder and address the needs of each child in the context of the child's family, support system, and culture. Training topics must include:

(1) trauma-informed care and secondary trauma, including adverse childhood experiences (ACEs);

(2) family-centered treatment plan development, including seeking partnership with a child client's family and other natural supports;

(3) mental illness and co-occurring substance use disorders in family systems;

(4) culturally responsive treatment practices; and

(5) child development, including cognitive functioning, and physical and mental abilities.

(f) For a mental health behavioral aide, the training under paragraph (e) must include parent team training using a curriculum approved by the commissioner.

Sec. 20. Minnesota Statutes 2024, section 245I.05, subdivision 5, is amended to read:

Subd. 5. **Additional training for medication administration.** (a) Prior to administering medications to a client under delegated authority or observing a client self-administer medications, a staff person who is not a licensed prescriber, registered nurse, or licensed practical nurse qualified under section 148.171, subdivision 8, must receive training about psychotropic medications, side effects including tardive dyskinesia, and medication management.

(b) Prior to administering medications to a client under delegated authority, a staff person must successfully complete a:

(1) medication administration training program for unlicensed personnel through an accredited Minnesota postsecondary educational institution with completion of the course documented in writing and placed in the staff person's personnel file; or

(2) formalized training program taught by a registered nurse or licensed prescriber that is offered by the license holder. A staff person's successful completion of the formalized training program must include direct observation of the staff person to determine the staff person's areas of competency.

Sec. 21. Minnesota Statutes 2024, section 245I.06, subdivision 3, is amended to read:

Subd. 3. **Treatment supervision and direct observation of mental health rehabilitation workers and mental health behavioral aides.** (a) A mental health behavioral aide or a mental health rehabilitation worker must receive direct observation from a mental health professional, clinical trainee, certified rehabilitation specialist, or mental health practitioner while the mental health behavioral aide or mental health rehabilitation worker provides treatment services to clients, no less than twice per month for the first six months of employment and once per month thereafter. The staff person performing the direct observation must approve of the progress note ~~for the observed treatment service~~ twice per month for the first six months of employment and as needed and identified in a supervision plan thereafter. Approval may be given through an attestation that is stored in the employee file.

(b) For a mental health rehabilitation worker qualified under section 245I.04, subdivision 14, paragraph (a), clause (2), item (i), treatment supervision in the first 2,000 hours of work must at a minimum consist of:

(1) monthly individual supervision; and

(2) direct observation twice per month.

Sec. 22. Minnesota Statutes 2024, section 245I.11, subdivision 5, is amended to read:

Subd. 5. **Medication administration in residential programs.** If a license holder is licensed as a residential program, the license holder must:

Sec. 14. Minnesota Statutes 2024, section 245I.05, subdivision 5, is amended to read:

Subd. 5. **Additional training for medication administration.** (a) Prior to administering medications to a client under delegated authority or observing a client self-administer medications, a staff person who is not a licensed prescriber, registered nurse, or licensed practical nurse qualified under section 148.171, subdivision 8, must receive training about psychotropic medications, side effects including tardive dyskinesia, and medication management.

(b) Prior to administering medications to a client under delegated authority, a staff person must successfully complete a:

(1) medication administration training program for unlicensed personnel through an accredited Minnesota postsecondary educational institution with completion of the course documented in writing and placed in the staff person's personnel file; or

(2) formalized training program taught by a registered nurse or licensed prescriber that is offered by the license holder. A staff person's successful completion of the formalized training program must include direct observation of the staff person to determine the staff person's areas of competency.

Sec. 15. Minnesota Statutes 2024, section 245I.06, subdivision 3, is amended to read:

Subd. 3. **Treatment supervision and direct observation of mental health rehabilitation workers and mental health behavioral aides.** (a) A mental health behavioral aide or a mental health rehabilitation worker must receive direct observation from a mental health professional, clinical trainee, certified rehabilitation specialist, or mental health practitioner while the mental health behavioral aide or mental health rehabilitation worker provides treatment services to clients, no less than twice per month for the first six months of employment and once per month thereafter. ~~The staff person performing the direct observation must approve of the progress note for the observed treatment service.~~

(b) For a mental health rehabilitation worker qualified under section 245I.04, subdivision 14, paragraph (a), clause (2), item (i), treatment supervision in the first 2,000 hours of work must at a minimum consist of:

(1) monthly individual supervision; and

(2) direct observation twice per month.

Sec. 16. Minnesota Statutes 2024, section 245I.11, subdivision 5, is amended to read:

Subd. 5. **Medication administration in residential programs.** If a license holder is licensed as a residential program, the license holder must:

(1) assess and document each client's ability to self-administer medication. In the assessment, the license holder must evaluate the client's ability to: (i) comply with prescribed medication regimens; and (ii) store the client's medications safely and in a manner that protects other individuals in the facility. Through the assessment process, the license holder must assist the client in developing the skills necessary to safely self-administer medication;

(2) monitor the effectiveness of medications, side effects of medications, and adverse reactions to medications, including symptoms and signs of tardive dyskinesia, for each client. The license holder must address and document any concerns about a client's medications;

(3) ensure that no staff person or client gives a legend drug supply for one client to another client;

(4) have policies and procedures for: (i) keeping a record of each client's medication orders; (ii) keeping a record of any incident of deferring a client's medications; (iii) documenting any incident when a client's medication is omitted; and (iv) documenting when a client refuses to take medications as prescribed; and

(5) document and track medication errors, document whether the license holder notified anyone about the medication error, determine if the license holder must take any follow-up actions, and identify the staff persons who are responsible for taking follow-up actions.

Sec. 23. Minnesota Statutes 2024, section 245I.12, subdivision 5, is amended to read:

Subd. 5. **Client grievances.** (a) The license holder must have a grievance procedure that:

(1) describes to clients how the license holder will meet the requirements in this subdivision; and

(2) contains the current public contact information of the Department of Human Services, Licensing Division; the Office of Ombudsman for Mental Health and Developmental Disabilities; the Department of Health, Office of Health Facilities Complaints; and all applicable health-related licensing boards.

(b) On the day of each client's admission, the license holder must explain the grievance procedure to the client.

(c) The license holder must:

(1) post the grievance procedure in a place visible to clients and provide a copy of the grievance procedure upon request;

(2) allow clients, former clients, and their authorized representatives to submit a grievance to the license holder;

(3) within three business days of receiving a client's grievance, acknowledge in writing that the license holder received the client's grievance. If applicable, the license holder must

(1) assess and document each client's ability to self-administer medication. In the assessment, the license holder must evaluate the client's ability to: (i) comply with prescribed medication regimens; and (ii) store the client's medications safely and in a manner that protects other individuals in the facility. Through the assessment process, the license holder must assist the client in developing the skills necessary to safely self-administer medication;

(2) monitor the effectiveness of medications, side effects of medications, and adverse reactions to medications, including symptoms and signs of tardive dyskinesia, for each client. The license holder must address and document any concerns about a client's medications;

(3) ensure that no staff person or client gives a legend drug supply for one client to another client;

(4) have policies and procedures for: (i) keeping a record of each client's medication orders; (ii) keeping a record of any incident of deferring a client's medications; (iii) documenting any incident when a client's medication is omitted; and (iv) documenting when a client refuses to take medications as prescribed; and

(5) document and track medication errors, document whether the license holder notified anyone about the medication error, determine if the license holder must take any follow-up actions, and identify the staff persons who are responsible for taking follow-up actions.

Sec. 17. Minnesota Statutes 2024, section 245I.12, subdivision 5, is amended to read:

Subd. 5. **Client grievances.** (a) The license holder must have a grievance procedure that:

(1) describes to clients how the license holder will meet the requirements in this subdivision; and

(2) contains the current public contact information of the Department of Human Services, Licensing Division; the Office of Ombudsman for Mental Health and Developmental Disabilities; the Department of Health, Office of Health Facilities Complaints; and all applicable health-related licensing boards.

(b) On the day of each client's admission, the license holder must explain the grievance procedure to the client.

(c) The license holder must:

(1) post the grievance procedure in a place visible to clients and provide a copy of the grievance procedure upon request;

(2) allow clients, former clients, and their authorized representatives to submit a grievance to the license holder;

(3) within three business days of receiving a client's grievance, acknowledge in writing that the license holder received the client's grievance. If applicable, the license holder must

include a notice of the client's separate appeal rights for a managed care organization's reduction, termination, or denial of a covered service;

(4) within 15 business days of receiving a client's grievance, provide a written final response to the client's grievance containing the license holder's official response to the grievance; and

(5) allow the client to bring a grievance to the person with the highest level of authority in the program.

(d) Clients may voice grievances and recommend changes in policies and services to staff and others of their choice, free from restraint, interference, coercion, discrimination, or reprisal, including threat of discharge.

include a notice of the client's separate appeal rights for a managed care organization's reduction, termination, or denial of a covered service;

(4) within 15 business days of receiving a client's grievance, provide a written final response to the client's grievance containing the license holder's official response to the grievance; and

(5) allow the client to bring a grievance to the person with the highest level of authority in the program.

(d) Clients may voice grievances and recommend changes in policies and services to staff and others of their choice, free from restraint, interference, coercion, discrimination, or reprisal, including threat of discharge.

Sec. 18. Minnesota Statutes 2024, section 245I.23, subdivision 7, is amended to read:

Subd. 7. **Intensive residential treatment services assessment and treatment planning.** (a) Within 12 hours of a client's admission, the license holder must evaluate and document the client's immediate needs, including the client's:

(1) health and safety, including the client's need for crisis assistance;

(2) responsibilities for children, family and other natural supports, and employers; and

(3) housing and legal issues.

(b) Within 24 hours of the client's admission, the license holder must complete an initial treatment plan for the client. The license holder must:

(1) base the client's initial treatment plan on the client's referral information and an assessment of the client's immediate needs;

(2) consider crisis assistance strategies that have been effective for the client in the past;

(3) identify the client's initial treatment goals, measurable treatment objectives, and specific interventions that the license holder will use to help the client engage in treatment;

(4) identify the participants involved in the client's treatment planning. The client must be a participant; and

(5) ensure that a treatment supervisor approves of the client's initial treatment plan if a mental health practitioner or clinical trainee completes the client's treatment plan, notwithstanding section 245I.08, subdivision 3.

(c) According to section 245A.65, subdivision 2, paragraph (b), the license holder must complete an individual abuse prevention plan as part of a client's initial treatment plan.

(d) Within ~~five~~ ten days of the client's admission and again within 60 days after the client's admission, the license holder must complete a level of care assessment of the client. If the license holder determines that a client does not need a medically monitored level of

service, a treatment supervisor must document how the client's admission to and continued services in intensive residential treatment services are medically necessary for the client.

(e) Within ten days of a client's admission, the license holder must complete or review and update the client's standard diagnostic assessment.

(f) Within ten days of a client's admission, the license holder must complete the client's individual treatment plan, notwithstanding section 245I.10, subdivision 8. Within 40 days after the client's admission and again within 70 days after the client's admission, the license holder must update the client's individual treatment plan. The license holder must focus the client's treatment planning on preparing the client for a successful transition from intensive residential treatment services to another setting. In addition to the required elements of an individual treatment plan under section 245I.10, subdivision 8, the license holder must identify the following information in the client's individual treatment plan: (1) the client's referrals and resources for the client's health and safety; and (2) the staff persons who are responsible for following up with the client's referrals and resources. If the client does not receive a referral or resource that the client needs, the license holder must document the reason that the license holder did not make the referral or did not connect the client to a particular resource. The license holder is responsible for determining whether additional follow-up is required on behalf of the client.

(g) Within 30 days of the client's admission, the license holder must complete a functional assessment of the client. Within 60 days after the client's admission, the license holder must update the client's functional assessment to include any changes in the client's functioning and symptoms.

(h) For a client with a current substance use disorder diagnosis and for a client whose substance use disorder screening in the client's standard diagnostic assessment indicates the possibility that the client has a substance use disorder, the license holder must complete a written assessment of the client's substance use within 30 days of the client's admission. In the substance use assessment, the license holder must: (1) evaluate the client's history of substance use, relapses, and hospitalizations related to substance use; (2) assess the effects of the client's substance use on the client's relationships including with family member and others; (3) identify financial problems, health issues, housing instability, and unemployment; (4) assess the client's legal problems, past and pending incarceration, violence, and victimization; and (5) evaluate the client's suicide attempts, noncompliance with taking prescribed medications, and noncompliance with psychosocial treatment.

(i) On a weekly basis, a mental health professional or certified rehabilitation specialist must review each client's treatment plan and individual abuse prevention plan. The license holder must document in the client's file each weekly review of the client's treatment plan and individual abuse prevention plan.

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Sec. 6. Minnesota Statutes 2024, section 254A.03, subdivision 1, is amended to read:

Subdivision 1. **Alcohol and Other Drug Abuse Section.** There is hereby created an Alcohol and Other Drug Abuse Section in the Department of Human Services. This section shall be headed by a director. The commissioner may place the director's position in the unclassified service if the position meets the criteria established in section 43A.08, subdivision 1a. The section shall:

(1) conduct and foster basic research relating to the cause, prevention and methods of diagnosis, treatment and recovery of persons with substance misuse and substance use disorder;

~~(2) coordinate and review all activities and programs of all the various state departments as they relate to problems associated with substance misuse and substance use disorder;~~

~~(3)~~ (2) develop, demonstrate, and disseminate new methods and techniques for prevention, early intervention, treatment and recovery support for substance misuse and substance use disorder;

~~(4)~~ (3) gather facts and information about substance misuse and substance use disorder, and about the efficiency and effectiveness of prevention, treatment, and recovery support services from all comprehensive programs, including programs approved or licensed by the commissioner of human services or the commissioner of health or accredited by the Joint Commission on Accreditation of Hospitals. The state authority is authorized to require information from comprehensive programs which is reasonable and necessary to fulfill these duties. When required information has been previously furnished to a state or local governmental agency, the state authority shall collect the information from the governmental agency. The state authority shall disseminate facts and summary information about problems associated with substance misuse and substance use disorder to public and private agencies, local governments, local and regional planning agencies, and the courts for guidance to and assistance in prevention, treatment and recovery support;

~~(5)~~ (4) inform and educate the general public on substance misuse and substance use disorder;

~~(6)~~ (5) serve as the state authority concerning substance misuse and substance use disorder by monitoring the conduct of diagnosis and referral services, research and comprehensive programs. The state authority shall submit a biennial report to the governor containing a description of public services delivery and recommendations concerning increase of coordination and quality of services, and decrease of service duplication and cost;

~~(7) establish a state plan which shall set forth goals and priorities for a comprehensive continuum of care for substance misuse and substance use disorder for Minnesota. All state agencies operating substance misuse or substance use disorder programs or administering state or federal funds for such programs shall annually set their program goals and priorities~~

~~in accordance with the state plan. Each state agency shall annually submit its plans and budgets to the state authority for review. The state authority shall certify whether proposed services comply with the comprehensive state plan and advise each state agency of review findings;~~

~~(8)~~ (6) make contracts with and grants to public and private agencies and organizations, both profit and nonprofit, and individuals, using federal funds, and state funds as authorized to pay for costs of state administration, including evaluation, statewide programs and services, research and demonstration projects, and American Indian programs;

~~(9)~~ (7) receive and administer money available for substance misuse and substance use disorder programs under the alcohol, drug abuse, and mental health services block grant, United States Code, title 42, sections 300X to 300X-9;

~~(10)~~ (8) solicit and accept any gift of money or property for purposes of Laws 1973, chapter 572, and any grant of money, services, or property from the federal government, the state, any political subdivision thereof, or any private source; and

~~(11)~~ (9) with respect to substance misuse and substance use disorder programs serving the American Indian community, establish guidelines for the employment of personnel with considerable practical experience in substance misuse and substance use disorder, and understanding of social and cultural problems related to substance misuse and substance use disorder, in the American Indian community.

Sec. 24. Minnesota Statutes 2024, section 254A.19, subdivision 6, is amended to read:

Sec. 7. Minnesota Statutes 2024, section 254A.19, subdivision 6, is amended to read:

Subd. 6. **Assessments for detoxification programs.** For detoxification programs licensed under chapter 245A according to Minnesota Rules, parts 9530.6510 to 9530.6590, a "chemical use assessment" is a comprehensive assessment completed according to the requirements of section 245G.05 ~~and a "chemical dependency assessor" or "assessor" is an individual who meets the qualifications of section 245G.11, subdivisions 1 and 5~~.

Subd. 6. **Assessments for detoxification programs.** For detoxification programs licensed under chapter 245A according to Minnesota Rules, parts 9530.6510 to 9530.6590, a "chemical use assessment" is a comprehensive assessment completed according to the requirements of section 245G.05 ~~and a "chemical dependency assessor" or "assessor" is an individual who meets the qualifications of section 245G.11, subdivisions 1 and 5~~.

Sec. 8. Minnesota Statutes 2024, section 254A.19, subdivision 7, is amended to read:

Subd. 7. **Assessments for children's residential facilities.** For children's residential facilities licensed under chapter 245A according to Minnesota Rules, parts 2960.0010 to 2960.0220 and 2960.0430 to 2960.0490, a "chemical use assessment" is a comprehensive assessment completed according to the requirements of section 245G.05 ~~and must be completed by an individual who meets the qualifications of section 245G.11, subdivisions 1 and 5~~.

Sec. 25. Minnesota Statutes 2024, section 254B.05, subdivision 1, is amended to read:

Sec. 9. Minnesota Statutes 2024, section 254B.05, subdivision 1, is amended to read:

Subdivision 1. **Licensure or certification required.** (a) 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 that provide substance use disorder treatment, extended care, transitional residence, or outpatient treatment services, and are licensed by tribal government are eligible vendors.

Subdivision 1. **Licensure or certification required.** (a) 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 that provide substance use disorder treatment, extended care, transitional residence, or outpatient treatment services, and are licensed by tribal government are eligible vendors.

(b) A licensed professional in private practice as defined in section 245G.01, subdivision 17, who meets the requirements of section 245G.11, subdivisions 1 and 4, is an eligible vendor of a comprehensive assessment provided according to section 254A.19, subdivision 3, and treatment services provided according to sections 245G.06 and 245G.07, subdivision 1, paragraphs (a), clauses (1) to (5), and (b); and subdivision 2, clauses (1) to (6).

(c) A county is an eligible vendor for a comprehensive assessment when provided by an individual who meets the staffing credentials of section 245G.11, subdivisions 1 and 5, and completed according to the requirements of section 254A.19, subdivision 3. A county is an eligible vendor of care coordination services when provided by an individual who meets the staffing credentials of section 245G.11, subdivisions 1 and 7, and provided according to the requirements of section 245G.07, subdivision 1, paragraph (a), clause (5). A county is an eligible vendor of peer recovery services when the services are provided by an individual who meets the requirements of section 245G.11, subdivision 8.

(d) A recovery community organization that meets the requirements of clauses (1) to (14) and meets certification ~~or accreditation~~ requirements of the ~~Alliance for Recovery Centered Organizations, the Council on Accreditation of Peer Recovery Support Services, or a Minnesota statewide recovery organization identified by the commissioner~~ Minnesota Alliance of Recovery Community Organizations is an eligible vendor of peer recovery support services. ~~A Minnesota statewide recovery organization identified by the commissioner must update recovery community organization applicants for certification or accreditation on the status of the application within 45 days of receipt. If the approved statewide recovery organization denies an application, it must provide a written explanation for the denial to the recovery community organization.~~ Eligible vendors under this paragraph must:

(1) be nonprofit organizations under section 501(c)(3) of the Internal Revenue Code, be free from conflicting self-interests, and be autonomous in decision-making, program development, peer recovery support services provided, and advocacy efforts for the purpose of supporting the recovery community organization's mission;

(2) be led and governed by individuals in the recovery community, with more than 50 percent of the board of directors or advisory board members self-identifying as people in personal recovery from substance use disorders;

(3) have a mission statement and conduct corresponding activities indicating that the organization's primary purpose is to support recovery from substance use disorder;

(4) demonstrate ongoing community engagement with the identified primary region and population served by the organization, including individuals in recovery and their families, friends, and recovery allies;

(5) be accountable to the recovery community through documented priority-setting and participatory decision-making processes that promote the engagement of, and consultation with, people in recovery and their families, friends, and recovery allies;

(b) A licensed professional in private practice as defined in section 245G.01, subdivision 17, who meets the requirements of section 245G.11, subdivisions 1 and 4, is an eligible vendor of a comprehensive assessment provided according to section 254A.19, subdivision 3, and treatment services provided according to sections 245G.06 and 245G.07, subdivision 1, paragraphs (a), clauses (1) to (5), and (b); and subdivision 2, clauses (1) to (6).

(c) A county is an eligible vendor for a comprehensive assessment when provided by an individual who meets the staffing credentials of section 245G.11, subdivisions 1 and 5, and completed according to the requirements of section 254A.19, subdivision 3. A county is an eligible vendor of care coordination services when provided by an individual who meets the staffing credentials of section 245G.11, subdivisions 1 and 7, and provided according to the requirements of section 245G.07, subdivision 1, paragraph (a), clause (5). A county is an eligible vendor of peer recovery services when the services are provided by an individual who meets the requirements of section 245G.11, subdivision 8.

(d) A recovery community organization that meets the requirements of clauses (1) to ~~(14)~~ (15) and meets certification or accreditation requirements of the Alliance for Recovery Centered Organizations, the Council on Accreditation of Peer Recovery Support Services, or a Minnesota statewide recovery organization identified by the commissioner is an eligible vendor of peer recovery support services. A Minnesota statewide recovery organization identified by the commissioner must update recovery community organization applicants for certification or accreditation on the status of the application within 45 days of receipt. If the approved statewide recovery organization denies an application, it must provide a written explanation for the denial to the recovery community organization. Eligible vendors under this paragraph must:

(1) be nonprofit organizations under section 501(c)(3) of the Internal Revenue Code, be free from conflicting self-interests, and be autonomous in decision-making, program development, peer recovery support services provided, and advocacy efforts for the purpose of supporting the recovery community organization's mission;

(2) be led and governed by individuals in the recovery community, with more than 50 percent of the board of directors or advisory board members self-identifying as people in personal recovery from substance use disorders;

(3) have a mission statement and conduct corresponding activities indicating that the organization's primary purpose is to support recovery from substance use disorder;

(4) demonstrate ongoing community engagement with the identified primary region and population served by the organization, including individuals in recovery and their families, friends, and recovery allies;

(5) be accountable to the recovery community through documented priority-setting and participatory decision-making processes that promote the engagement of, and consultation with, people in recovery and their families, friends, and recovery allies;

(6) provide nonclinical peer recovery support services, including but not limited to recovery support groups, recovery coaching, telephone recovery support, skill-building, and harm-reduction activities, and provide recovery public education and advocacy;

(7) have written policies that allow for and support opportunities for all paths toward recovery and refrain from excluding anyone based on their chosen recovery path, which may include but is not limited to harm reduction paths, faith-based paths, and nonfaith-based paths;

(8) maintain organizational practices to meet the needs of Black, Indigenous, and people of color communities, LGBTQ+ communities, and other underrepresented or marginalized communities. Organizational practices may include board and staff training, service offerings, advocacy efforts, and culturally informed outreach and services;

(9) use recovery-friendly language in all media and written materials that is supportive of and promotes recovery across diverse geographical and cultural contexts and reduces stigma;

(10) establish and maintain a publicly available recovery community organization code of ethics and grievance policy and procedures;

(11) not classify or treat any recovery peer hired on or after July 1, 2024, as an independent contractor;

(12) not classify or treat any recovery peer as an independent contractor on or after January 1, 2025;

(13) provide an orientation for recovery peers that includes an overview of the consumer advocacy services provided by the Ombudsman for Mental Health and Developmental Disabilities and other relevant advocacy services; ~~and~~

(14) provide notice to peer recovery support services participants that includes the following statement: "If you have a complaint about the provider or the person providing your peer recovery support services, you may contact the Minnesota Alliance of Recovery Community Organizations. You may also contact the Office of Ombudsman for Mental Health and Developmental Disabilities." The statement must also include:

(i) the telephone number, website address, email address, and mailing address of the Minnesota Alliance of Recovery Community Organizations and the Office of Ombudsman for Mental Health and Developmental Disabilities;

(ii) the recovery community organization's name, address, email, telephone number, and name or title of the person at the recovery community organization to whom problems or complaints may be directed; and

(iii) a statement that the recovery community organization will not retaliate against a peer recovery support services participant because of a complaint; and

(15) comply with the requirements of section 245A.04, subdivision 15a.

(e) A recovery community organization approved by the commissioner before June 30, 2023, must have begun the application process as required by an approved certifying or accrediting entity and have begun the process to meet the requirements under paragraph (d) by September 1, 2024, in order to be considered as an eligible vendor of peer recovery support services.

(f) A recovery community organization that is aggrieved by ~~an accreditation,~~ a certification~~, or membership~~ determination and believes it meets the requirements under paragraph (d) may appeal the determination under section 256.045, subdivision 3, paragraph (a), clause (14), for reconsideration as an eligible vendor. If the human services judge determines that the recovery community organization meets the requirements under paragraph (d), the recovery community organization is an eligible vendor of peer recovery support services for up to two years from the date of the determination. After two years, the recovery community organization must apply for certification under paragraph (d) to continue to be an eligible vendor of peer recovery support services.

(g) All recovery community organizations must be certified ~~or accredited~~ by an entity listed in paragraph (d) by June 30, 2025.

(h) Detoxification programs licensed under Minnesota Rules, parts 9530.6510 to 9530.6590, are not eligible vendors. Programs that are not licensed as a residential or nonresidential substance use disorder treatment or withdrawal management program by the commissioner or by tribal government or do not meet the requirements of subdivisions 1a and 1b are not eligible vendors.

(i) Hospitals, federally qualified health centers, and rural health clinics are eligible vendors of a comprehensive assessment when the comprehensive assessment is completed according to section 254A.19, subdivision 3, and by an individual who meets the criteria of an alcohol and drug counselor according to section 245G.11, subdivision 5. The alcohol and drug counselor must be individually enrolled with the commissioner and reported on the claim as the individual who provided the service.

(j) Any complaints about a recovery community organization or peer recovery support services may be made to and reviewed or investigated by the ombudsperson for behavioral health and developmental disabilities under sections 245.91 and 245.94.

Sec. 26. Minnesota Statutes 2024, section 254B.05, subdivision 5, is amended to read:

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

(b) Eligible substance use disorder treatment services include:

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

(15) comply with the requirements of section 245A.04, subdivision 15a.

(e) A recovery community organization approved by the commissioner before June 30, 2023, must have begun the application process as required by an approved certifying or accrediting entity and have begun the process to meet the requirements under paragraph (d) by September 1, 2024, in order to be considered as an eligible vendor of peer recovery support services.

(f) A recovery community organization that is aggrieved by an accreditation, certification, or membership determination and believes it meets the requirements under paragraph (d) may appeal the determination under section 256.045, subdivision 3, paragraph (a), clause (14), for reconsideration as an eligible vendor. If the human services judge determines that the recovery community organization meets the requirements under paragraph (d), the recovery community organization is an eligible vendor of peer recovery support services.

(g) All recovery community organizations must be certified or accredited by an entity listed in paragraph (d) by June 30, 2025.

(h) Detoxification programs licensed under Minnesota Rules, parts 9530.6510 to 9530.6590, are not eligible vendors. Programs that are not licensed as a residential or nonresidential substance use disorder treatment or withdrawal management program by the commissioner or by tribal government or do not meet the requirements of subdivisions 1a and 1b are not eligible vendors.

(i) Hospitals, federally qualified health centers, and rural health clinics are eligible vendors of a comprehensive assessment when the comprehensive assessment is completed according to section 254A.19, subdivision 3, and by an individual who meets the criteria of an alcohol and drug counselor according to section 245G.11, subdivision 5. The alcohol and drug counselor must be individually enrolled with the commissioner and reported on the claim as the individual who provided the service.

(j) Any complaints about a recovery community organization or peer recovery support services may be made to and reviewed or investigated by the ombudsperson for behavioral health and developmental disabilities under sections 245.91 and 245.94.

Sec. 10. Minnesota Statutes 2024, section 254B.05, subdivision 5, is amended to read:

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

(b) Eligible substance use disorder treatment services include:

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

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

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

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

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

(v) ASAM level 3.1 clinically managed low-intensity residential services provided according to section 254B.19, subdivision 1, clause (5). The commissioner shall use the base payment rate of $79.84 per day for services provided under this item;

(vi) ASAM level 3.1 clinically managed low-intensity residential services provided according to section 254B.19, subdivision 1, clause (5), at 15 or more hours of skilled treatment services each week. The commissioner shall use the base payment rate of $166.13 per day for services provided under this item;

(vii) ASAM level 3.3 clinically managed population-specific high-intensity residential services provided according to section 254B.19, subdivision 1, clause (6). The commissioner shall use the specified base payment rate of $224.06 per day for services provided under this item; and

(viii) ASAM level 3.5 clinically managed high-intensity residential services provided according to section 254B.19, subdivision 1, clause (7). The commissioner shall use the specified base payment rate of $224.06 per day for services provided under this item;

(2) comprehensive assessments provided according to section 254A.19, subdivision 3;

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

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

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

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

(7) substance use disorder treatment services with medications for opioid use disorder provided in an opioid treatment program licensed according to sections 245G.01 to 245G.17 and 245G.22, or under an applicable Tribal license;

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

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

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

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

(v) ASAM level 3.1 clinically managed low-intensity residential services provided according to section 254B.19, subdivision 1, clause (5). The commissioner shall use the base payment rate of $79.84 per day for services provided under this item;

(vi) ASAM level 3.1 clinically managed low-intensity residential services provided according to section 254B.19, subdivision 1, clause (5), at 15 or more hours of skilled treatment services each week. The commissioner shall use the base payment rate of $166.13 per day for services provided under this item;

(vii) ASAM level 3.3 clinically managed population-specific high-intensity residential services provided according to section 254B.19, subdivision 1, clause (6). The commissioner shall use the specified base payment rate of $224.06 per day for services provided under this item; and

(viii) ASAM level 3.5 clinically managed high-intensity residential services provided according to section 254B.19, subdivision 1, clause (7). The commissioner shall use the specified base payment rate of $224.06 per day for services provided under this item;

(2) comprehensive assessments provided according to section 254A.19, subdivision 3;

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

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

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

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

(7) substance use disorder treatment services with medications for opioid use disorder provided in an opioid treatment program licensed according to sections 245G.01 to 245G.17 and 245G.22, or under an applicable Tribal license;

(8) medium-intensity residential treatment services that provide 15 hours of skilled treatment services each week and are licensed according to sections 245G.01 to 245G.17 and 245G.21 or applicable Tribal license;

(9) adolescent treatment programs that are licensed as outpatient treatment programs according to sections 245G.01 to 245G.18 or as residential treatment programs according to Minnesota Rules, parts 2960.0010 to 2960.0220, and 2960.0430 to 2960.0490, or applicable Tribal license;

(10) ASAM 3.5 clinically managed high-intensity residential services that are licensed according to sections 245G.01 to 245G.17 and 245G.21 or applicable Tribal license, which provide ASAM level of care 3.5 according to section 254B.19, subdivision 1, clause (7), and are provided by a state-operated vendor or to clients who have been civilly committed to the commissioner, present the most complex and difficult care needs, and are a potential threat to the community; and

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

(c) The commissioner shall establish higher rates for programs that meet the requirements of paragraph (b) and one of the following additional requirements:

(1) programs that serve parents with their children if the program:

(i) provides on-site child care during the hours of treatment activity that:

(A) is licensed under chapter 245A as a child care center under Minnesota Rules, chapter 9503; or

(B) is licensed under chapter 245A and sections 245G.01 to 245G.19; or

(ii) arranges for off-site child care during hours of treatment activity at a facility that is licensed under chapter 245A as:

(A) a child care center under Minnesota Rules, chapter 9503; or

(B) a family child care home under Minnesota Rules, chapter 9502;

(2) culturally specific or culturally responsive programs as defined in section 254B.01, subdivision 4a;

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

(4) programs that offer medical services delivered by appropriately credentialed health care staff in an amount equal to one hour per client per week if the medical needs of the client and the nature and provision of any medical services provided are documented in the client file; or

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

(8) medium-intensity residential treatment services that provide 15 hours of skilled treatment services each week and are licensed according to sections 245G.01 to 245G.17 and 245G.21 or applicable Tribal license;

(9) adolescent treatment programs that are licensed as outpatient treatment programs according to sections 245G.01 to 245G.18 or as residential treatment programs according to Minnesota Rules, parts 2960.0010 to 2960.0220, and 2960.0430 to 2960.0490, or applicable Tribal license;

(10) ASAM 3.5 clinically managed high-intensity residential services that are licensed according to sections 245G.01 to 245G.17 and 245G.21 or applicable Tribal license, which provide ASAM level of care 3.5 according to section 254B.19, subdivision 1, clause (7), and are provided by a state-operated vendor or to clients who have been civilly committed to the commissioner, present the most complex and difficult care needs, and are a potential threat to the community; and

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

(c) The commissioner shall establish higher rates for programs that meet the requirements of paragraph (b) and one of the following additional requirements:

(1) programs that serve parents with their children if the program:

(i) provides on-site child care during the hours of treatment activity that:

(A) is licensed under chapter 245A as a child care center under Minnesota Rules, chapter 9503; or

(B) is licensed under chapter 245A and sections 245G.01 to 245G.19; or

(ii) arranges for off-site child care during hours of treatment activity at a facility that is licensed under chapter 245A as:

(A) a child care center under Minnesota Rules, chapter 9503; or

(B) a family child care home under Minnesota Rules, chapter 9502;

(2) culturally specific or culturally responsive programs as defined in section 254B.01, subdivision 4a;

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

(4) programs that offer medical services delivered by appropriately credentialed health care staff in an amount equal to one hour per client per week if the medical needs of the client and the nature and provision of any medical services provided are documented in the client file; or

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

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

(ii) the program employs a mental health professional as defined in section 245I.04, subdivision 2;

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

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

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

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

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

(e) Adolescent residential programs that meet the requirements of Minnesota Rules, parts 2960.0430 to 2960.0490 and 2960.0580 to 2960.0690, are exempt from the requirements in paragraph (c), clause (5), items (i) to (iv).

(f) Substance use disorder services that are otherwise covered as direct face-to-face services may be provided via telehealth as defined in section 256B.0625, subdivision 3b. The use of telehealth to deliver services must be medically appropriate to the condition and needs of the person being served. Reimbursement shall be at the same rates and under the same conditions that would otherwise apply to direct face-to-face services.

(g) For the purpose of reimbursement under this section, substance use disorder treatment services provided in a group setting without a group participant maximum or maximum client to staff ratio under chapter 245G shall not exceed a client to staff ratio of 48 to one. At least one of the attending staff must meet the qualifications as established under this chapter for the type of treatment service provided. A recovery peer may not be included as part of the staff ratio.

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

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

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

(ii) the program employs a mental health professional as defined in section 245I.04, subdivision 2;

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

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

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

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

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

(e) Adolescent residential programs that meet the requirements of Minnesota Rules, parts 2960.0430 to 2960.0490 and 2960.0580 to 2960.0690, are exempt from the requirements in paragraph (c), clause (5), items (i) to (iv).

(f) Substance use disorder services that are otherwise covered as direct face-to-face services may be provided via telehealth as defined in section 256B.0625, subdivision 3b. The use of telehealth to deliver services must be medically appropriate to the condition and needs of the person being served. Reimbursement shall be at the same rates and under the same conditions that would otherwise apply to direct face-to-face services.

(g) For the purpose of reimbursement under this section, substance use disorder treatment services provided in a group setting without a group participant maximum or maximum client to staff ratio under chapter 245G shall not exceed a client to staff ratio of 48 to one. At least one of the attending staff must meet the qualifications as established under this chapter for the type of treatment service provided. A recovery peer may not be included as part of the staff ratio.

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

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

(j) A license holder that is unable to provide all residential treatment services because a client missed services remains eligible to bill for the client's intensity level of services under this paragraph if the license holder can document the reason the client missed services and the interventions done to address the client's absence.

(k) Hours in a treatment week may be reduced in observance of federally recognized holidays.

(l) Eligible vendors of peer recovery support services must:

(1) submit to a review by the commissioner of up to ten percent of all medical assistance and behavioral health fund claims to determine the medical necessity of peer recovery support services for entities billing for peer recovery support services individually and not receiving a daily rate; and

(2) limit an individual client to 14 hours per week for peer recovery support services from an individual provider of peer recovery support services.

(m) Peer recovery support services not provided in accordance with section 254B.052 are subject to monetary recovery under section 256B.064 as money improperly paid.

Sec. 27. Minnesota Statutes 2024, section 256B.0615, subdivision 4, is amended to read:

Subd. 4. **Peer support specialist program providers.** The commissioner shall develop a process to certify peer support specialist programs, in accordance with the federal guidelines, in order for the program to bill for reimbursable services. Peer support programs may be freestanding or within existing mental health community provider centers and services.

Sec. 28. Minnesota Statutes 2024, section 256B.0616, subdivision 4, is amended to read:

Subd. 4. **Family peer support ~~specialist~~ program providers.** The commissioner shall develop a process to certify family peer support ~~specialist~~ programs, in accordance with the federal guidelines, in order for the program to bill for reimbursable services. Family peer support programs must operate within an existing mental health community provider or center.

Sec. 29. Minnesota Statutes 2024, section 256B.0616, subdivision 5, is amended to read:

Subd. 5. **Certified family peer specialist training and certification.** (a) The commissioner shall develop ~~a~~ or approve the use of an existing training and certification process for ~~certified~~ certifying family peer specialists. ~~The~~ Family peer specialist candidates must have raised or be currently raising a child with a mental illness~~;~~, have ~~had~~ experience navigating the children's mental health system~~;~~, and ~~must~~ demonstrate leadership and advocacy skills and a strong dedication to family-driven and family-focused services. The

(j) A license holder that is unable to provide all residential treatment services because a client missed services remains eligible to bill for the client's intensity level of services under this paragraph if the license holder can document the reason the client missed services and the interventions done to address the client's absence.

(k) Hours in a treatment week may be reduced in observance of federally recognized holidays.

(l) Eligible vendors of peer recovery support services must:

(1) submit to a review by the commissioner of up to ten percent of all medical assistance and behavioral health fund claims to determine the medical necessity of peer recovery support services for entities billing for peer recovery support services individually and not receiving a daily rate; and

(2) limit an individual client to 14 hours per week for peer recovery support services from an individual provider of peer recovery support services.

(m) Peer recovery support services not provided in accordance with section 254B.052 are subject to monetary recovery under section 256B.064 as money improperly paid.

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Sec. 19. Minnesota Statutes 2024, section 256B.0616, subdivision 4, is amended to read:

Subd. 4. **Family peer support ~~specialist~~ program providers.** The commissioner shall develop a process to certify family peer support ~~specialist~~ programs, in accordance with the federal guidelines, in order for the program to bill for reimbursable services. Family peer support programs must operate within an existing mental health community provider or center.

Sec. 20. Minnesota Statutes 2024, section 256B.0616, subdivision 5, is amended to read:

Subd. 5. **Certified family peer specialist training and certification.** (a) The commissioner shall develop ~~a~~ or approve the use of an existing training and certification process for ~~certified~~ certifying family peer specialists. ~~The~~ Family peer specialist candidates must have raised or be currently raising a child with a mental illness, have ~~had~~ experience navigating the children's mental health system, and ~~must~~ demonstrate leadership and advocacy skills and a strong dedication to family-driven and family-focused services. The training

training curriculum must teach participating family peer ~~specialists~~ specialist candidates specific skills relevant to providing peer support to other parents and youth.

(b) In addition to initial training and certification, the commissioner shall develop ongoing continuing educational workshops on pertinent issues related to family peer support counseling.

(c) Initial training leading to certification as a family peer specialist and continuing education for certified family peer specialists must be delivered by the commissioner or a third-party organization approved by the commissioner. An approved third-party organization may also provide continuing education of certified family peer specialists.

Sec. 30. Minnesota Statutes 2024, section 256B.0622, subdivision 3a, is amended to read:

Subd. 3a. **Provider certification and contract requirements for assertive community treatment.** (a) The assertive community treatment provider must have each ACT team be certified by the state following the certification process and procedures developed by the commissioner. The certification process determines whether the ACT team meets the standards for assertive community treatment under this section, the standards in chapter 245I as required in section 245I.011, subdivision 5, and minimum program fidelity standards as measured by a nationally recognized fidelity tool approved by the commissioner. Recertification must occur at least every three years.

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

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

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

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

(4) keep all necessary records required by law;

(5) be an enrolled Medicaid provider; ~~and~~

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

(7) ensure that overall treatment supervision to the ACT team is provided by a qualified member of the ACT team and is available during and after regular business hours and on weekends and holidays.

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

curriculum must teach participating family peer ~~specialists~~ specialist candidates specific skills relevant to providing peer support to other parents and youth.

(b) In addition to initial training and certification, the commissioner shall develop ongoing continuing educational workshops on pertinent issues related to family peer support counseling.

(c) Initial training leading to certification as a family peer specialist and continuing education for certified family peer specialists must be delivered by the commissioner or a third-party organization approved by the commissioner. An approved third-party organization may also provide continuing education of certified family peer specialists.

Sec. 21. Minnesota Statutes 2024, section 256B.0622, subdivision 3a, is amended to read:

Subd. 3a. **Provider certification and contract requirements for assertive community treatment.** (a) The assertive community treatment provider must have each ACT team be certified by the state following the certification process and procedures developed by the commissioner. The certification process determines whether the ACT team meets the standards for assertive community treatment under this section, the standards in chapter 245I as required in section 245I.011, subdivision 5, and minimum program fidelity standards as measured by a nationally recognized fidelity tool approved by the commissioner. Recertification must occur at least every three years.

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

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

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

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

(4) keep all necessary records required by law;

(5) be an enrolled Medicaid provider; ~~and~~

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

(7) ensure that overall treatment supervision to the ACT team is provided by a qualified member of the ACT team and is available during and after regular business hours and on weekends and holidays.

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

Sec. 31. Minnesota Statutes 2024, section 256B.0622, subdivision 7a, is amended to read:

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

(1) the team leader:

(i) shall be a mental health professional~~. Individuals who are not licensed but who are eligible for licensure and are otherwise qualified may also fulfill this role~~;, clinical trainee, or mental health practitioner;

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

(iii) must be a single full-time staff member, dedicated to the ACT team, who is responsible for overseeing the administrative operations of the team and supervising team members to ensure delivery of best and ethical practices; and

(iv) must be available to ensure that overall treatment supervision to the ACT team is available after regular business hours and on weekends and holidays and is provided by a qualified member of the ACT team;

(2) the psychiatric care provider:

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

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

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

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

(v) shall have a minimum full-time equivalency that is prorated at a rate of 16 hours per 50 clients. Part-time psychiatric care providers shall have designated hours to work on the

Sec. 22. Minnesota Statutes 2024, section 256B.0622, subdivision 7a, is amended to read:

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

(1) the team leader:

(i) ~~shall~~ must be a mental health professional~~. Individuals who are not licensed but who are eligible for licensure and are otherwise qualified may also fulfill this role~~, clinical trainee, or mental health practitioner;

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

(iii) must be a single full-time staff member, dedicated to the ACT team, who is responsible for overseeing the administrative operations of the team and supervising team members to ensure delivery of best and ethical practices; and

(iv) must be available to ensure that overall treatment supervision to the ACT team is available after regular business hours and on weekends and holidays and is provided by a qualified member of the ACT team;

(2) the psychiatric care provider:

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

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

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

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

(v) shall have a minimum full-time equivalency that is prorated at a rate of 16 hours per 50 clients. Part-time psychiatric care providers shall have designated hours to work on the

team, with sufficient blocks of time on consistent days to carry out the provider's clinical, supervisory, and administrative responsibilities. No more than two psychiatric care providers may share this role; and

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

(3) the nursing staff:

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

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

(iii) shall develop strategies, in collaboration with clients, to maximize taking medications as prescribed; screen and monitor clients' mental and physical health conditions and medication side effects; engage in health promotion, prevention, and education activities; communicate and coordinate services with other medical providers; facilitate the development of the individual treatment plan for clients assigned; and educate the ACT team in monitoring psychiatric and physical health symptoms and medication side effects;

(4) the co-occurring disorder specialist:

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

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

(5) the vocational specialist:

(i) shall be a full-time vocational specialist who has at least one-year experience providing employment services or advanced education that involved field training in vocational services to individuals with mental illness. An individual who does not meet these qualifications

team, with sufficient blocks of time on consistent days to carry out the provider's clinical, supervisory, and administrative responsibilities. No more than two psychiatric care providers may share this role; and

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

(3) the nursing staff:

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

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

(iii) shall develop strategies, in collaboration with clients, to maximize taking medications as prescribed; screen and monitor clients' mental and physical health conditions and medication side effects; engage in health promotion, prevention, and education activities; communicate and coordinate services with other medical providers; facilitate the development of the individual treatment plan for clients assigned; and educate the ACT team in monitoring psychiatric and physical health symptoms and medication side effects;

(4) the co-occurring disorder specialist:

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

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

(5) the vocational specialist:

(i) shall be a full-time vocational specialist who has at least one-year experience providing employment services or advanced education that involved field training in vocational services to individuals with mental illness. An individual who does not meet these qualifications

may also serve as the vocational specialist upon completing a training plan approved by the commissioner;

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

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

(6) the mental health certified peer specialist:

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

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

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

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

(8) additional staff:

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

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

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

(c) Each ACT team member must serve as a primary team member for clients assigned by the team leader and are responsible for facilitating the individual treatment plan process for those clients. The primary team member for a client is the responsible team member knowledgeable about the client's life and circumstances and writes the individual treatment

may also serve as the vocational specialist upon completing a training plan approved by the commissioner;

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

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

(6) the mental health certified peer specialist:

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

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

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

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

(8) additional staff:

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

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

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

(c) Each ACT team member must serve as a primary team member for clients assigned by the team leader and are responsible for facilitating the individual treatment plan process for those clients. The primary team member for a client is the responsible team member knowledgeable about the client's life and circumstances and writes the individual treatment

plan. The primary team member provides individual supportive therapy or counseling, and provides primary support and education to the client's family and support system.

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

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

EFFECTIVE DATE. This section is effective upon federal approval. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 32. **[256G.061] WITHDRAWAL MANAGEMENT SERVICES.**

The county of financial responsibility for withdrawal management services is defined in section 256G.02, subdivision 4.

Sec. 33. Minnesota Statutes 2024, section 256L.03, subdivision 5, is amended to read:

Subd. 5. **Cost-sharing.** (a) Co-payments, coinsurance, and deductibles do not apply to children under the age of 21 and to American Indians as defined in Code of Federal Regulations, title 42, section 600.5.

(b) The commissioner must adjust co-payments, coinsurance, and deductibles for covered services in a manner sufficient to maintain the actuarial value of the benefit to 94 percent. The cost-sharing changes described in this paragraph do not apply to eligible recipients or services exempt from cost-sharing under state law. The cost-sharing changes described in this paragraph shall not be implemented prior to January 1, 2016.

(c) The cost-sharing changes authorized under paragraph (b) must satisfy the requirements for cost-sharing under the Basic Health Program as set forth in Code of Federal Regulations, title 42, sections 600.510 and 600.520.

(d) Cost-sharing for prescription drugs and related medical supplies to treat chronic disease must comply with the requirements of section 62Q.481.

(e) Co-payments, coinsurance, and deductibles do not apply to additional diagnostic services or testing that a health care provider determines an enrollee requires after a mammogram, as specified under section 62A.30, subdivision 5.

plan. The primary team member provides individual supportive therapy or counseling, and provides primary support and education to the client's family and support system.

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

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

EFFECTIVE DATE. This section is effective upon federal approval. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

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Sec. 11. **[256G.061] WITHDRAWAL MANAGEMENT SERVICES.**

The county of financial responsibility for withdrawal management services is defined in section 256G.02, subdivision 4.

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Sec. 23. Minnesota Statutes 2024, section 256L.03, subdivision 5, is amended to read:

Subd. 5. **Cost-sharing.** (a) Co-payments, coinsurance, and deductibles do not apply to children under the age of 21 and to American Indians as defined in Code of Federal Regulations, title 42, section 600.5.

(b) The commissioner must adjust co-payments, coinsurance, and deductibles for covered services in a manner sufficient to maintain the actuarial value of the benefit to 94 percent. The cost-sharing changes described in this paragraph do not apply to eligible recipients or services exempt from cost-sharing under state law. The cost-sharing changes described in this paragraph shall not be implemented prior to January 1, 2016.

(c) The cost-sharing changes authorized under paragraph (b) must satisfy the requirements for cost-sharing under the Basic Health Program as set forth in Code of Federal Regulations, title 42, sections 600.510 and 600.520.

(d) Cost-sharing for prescription drugs and related medical supplies to treat chronic disease must comply with the requirements of section 62Q.481.

(e) Co-payments, coinsurance, and deductibles do not apply to additional diagnostic services or testing that a health care provider determines an enrollee requires after a mammogram, as specified under section 62A.30, subdivision 5.

(f) Cost-sharing must not apply to drugs used for tobacco and nicotine cessation or to tobacco and nicotine cessation services covered under section 256B.0625, subdivision 68.

(g) Co-payments, coinsurance, and deductibles do not apply to pre-exposure prophylaxis (PrEP) and postexposure prophylaxis (PEP) medications when used for the prevention or treatment of the human immunodeficiency virus (HIV).

(h) Co-payments, coinsurance, and deductibles do not apply to mobile crisis intervention or crisis assessment as defined in section 256B.0624, subdivision 2.

EFFECTIVE DATE. This section is effective January 1, 2026, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 34. **REVISOR INSTRUCTION.**

The revisor of statutes shall substitute the term "substance use disorder assessment" or similar terms for "chemical dependency assessment" or similar terms, for "chemical use assessment" or similar terms, and for "comprehensive substance use disorder assessment" or similar terms wherever they appear in Minnesota Statutes, chapter 169A, and Minnesota Rules, chapter 7503, when referring to the assessments required under Minnesota Statutes, section 169A.70, or the charges or surcharges associated with those assessments.

(f) Cost-sharing must not apply to drugs used for tobacco and nicotine cessation or to tobacco and nicotine cessation services covered under section 256B.0625, subdivision 68.

(g) Co-payments, coinsurance, and deductibles do not apply to pre-exposure prophylaxis (PrEP) and postexposure prophylaxis (PEP) medications when used for the prevention or treatment of the human immunodeficiency virus (HIV).

(h) Co-payments, coinsurance, and deductibles do not apply to mobile crisis intervention, as defined in section 256B.0624, subdivision 2, paragraph (d).

EFFECTIVE DATE. This section is effective January 1, 2026, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.