

110.9 **ARTICLE 4**  
110.10 **BEHAVIORAL HEALTH**

276.2 **ARTICLE 9**  
276.3 **BEHAVIORAL HEALTH POLICY**  
UEH2115-1  
122.22 **ARTICLE 4**  
122.23 **SUBSTANCE USE DISORDER TREATMENT SERVICES POLICY**

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

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

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

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

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

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

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

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

111.10 Subd. 2. **Definitions.** For the purposes of this section, "patient" means a person who is  
111.11 admitted to an acute care inpatient facility for a continuous period longer than 24 hours, for  
111.12 the purpose of diagnosis or treatment bearing on the physical or mental health of that person.  
111.13 For purposes of subdivisions 4 to 9, 12, 13, 15, 16, and 18 to 20, "patient" also means a  
111.14 person who receives health care services at an outpatient surgical center or at a birth center  
111.15 licensed under section 144.615. "Patient" also means a minor who is admitted to a residential  
111.16 program as defined in section 253C.01. For purposes of subdivisions 1, 3 to 16, 18, 20 and  
111.17 30, "patient" also means any person who is receiving mental health treatment on an outpatient  
111.18 basis or in a community support program or other community-based program. "Resident"  
111.19 means a person who is admitted to a nonacute care facility including extended care facilities,  
111.20 nursing homes, and boarding care homes for care required because of prolonged mental or  
111.21 physical illness or disability, recovery from injury or disease, or advancing age. For purposes  
111.22 of all subdivisions except subdivisions 28 and 29, "resident" also means a person who is  
111.23 admitted to a facility licensed as a board and lodging facility under Minnesota Rules, parts  
111.24 4625.0100 to 4625.2355, a boarding care home under sections 144.50 to 144.56, or a  
111.25 supervised living facility under Minnesota Rules, parts 4665.0100 to 4665.9900, and which  
111.26 operates a rehabilitation program licensed under chapter 245G or 245I, or Minnesota Rules,  
111.27 parts 9530.6510 to 9530.6590. For purposes of all subdivisions except subdivisions 20, 28,  
111.28 29, 32, and 33, "resident" also means a person who is admitted to a facility licensed to  
111.29 provide intensive residential treatment services or residential crisis stabilization under section  
111.30 245I.23.

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

276.5 Subd. 2. **Definitions.** For the purposes of this section, "patient" means a person who is  
276.6 admitted to an acute care inpatient facility for a continuous period longer than 24 hours, for  
276.7 the purpose of diagnosis or treatment bearing on the physical or mental health of that person.  
276.8 For purposes of subdivisions 4 to 9, 12, 13, 15, 16, and 18 to 20, "patient" also means a  
276.9 person who receives health care services at an outpatient surgical center or at a birth center  
276.10 licensed under section 144.615. "Patient" also means a minor who is admitted to a residential  
276.11 program as defined in section 253C.01. For purposes of subdivisions 1, 3 to 16, 18, 20 and  
276.12 30, "patient" also means any person who is receiving mental health treatment on an outpatient  
276.13 basis or in a community support program or other community-based program. "Resident"  
276.14 means a person who is admitted to a nonacute care facility including extended care facilities,  
276.15 nursing homes, and boarding care homes for care required because of prolonged mental or  
276.16 physical illness or disability, recovery from injury or disease, or advancing age. For purposes  
276.17 of all subdivisions except subdivisions 28 and 29, "resident" also means a person who is  
276.18 admitted to a facility licensed as a board and lodging facility under Minnesota Rules, parts  
276.19 4625.0100 to 4625.2355, a boarding care home under sections 144.50 to 144.56, or a  
276.20 supervised living facility under Minnesota Rules, parts 4665.0100 to 4665.9900, and which  
276.21 operates a rehabilitation program licensed under chapter 245G or 245I, or Minnesota Rules,  
276.22 parts 9530.6510 to 9530.6590. For purposes of all subdivisions except subdivisions 20, 28,  
276.23 29, 32, and 33, resident also means a person who is admitted to a facility licensed to provide  
276.24 intensive residential treatment services or residential crisis stabilization under section  
276.25 245I.23.

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

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

122.26 (1) the commissioner of human services;

122.27 (2) the commissioner of health;

122.28 (3) the commissioner of education;

123.1 (4) the commissioner of public safety;

123.2 (5) the commissioner of corrections;

123.3 (6) the commissioner of management and budget;

123.4 (7) the commissioner of higher education;

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

- 123.6 (9) the chief executive officer of direct care and treatment;
- 123.7 (10) the commissioner of commerce;
- 123.8 (11) the director of the Office of Cannabis Management;
- 123.9 ~~(8)~~ (12) the chair of the Interagency Council on Homelessness; and
- 123.10 ~~(9)~~ (13) the governor's director of addiction and recovery, who shall serve as chair of  
123.11 the subcabinet.
- 123.12 Sec. 2. Minnesota Statutes 2024, section 4.046, subdivision 3, is amended to read:
- 123.13 Subd. 3. **Policy and strategy development.** The subcabinet must engage in the following  
123.14 duties related to the development of opioid use, substance use, and addiction policy and  
123.15 strategy:
- 123.16 (1) identify challenges and opportunities that exist relating to accessing treatment and  
123.17 support services and develop recommendations to overcome these barriers for all  
123.18 Minnesotans;
- 123.19 (2) with input from affected communities, develop policies and strategies that will reduce  
123.20 barriers and gaps in service for all Minnesotans seeking treatment for opioid or substance  
123.21 use disorder, particularly for those Minnesotans who are members of communities  
123.22 disproportionately impacted by substance use and addiction;
- 123.23 (3) develop policies and strategies that the state may adopt to expand Minnesota's recovery  
123.24 infrastructure, including detoxification or withdrawal management facilities, treatment  
123.25 facilities, and sober housing;
- 123.26 (4) identify innovative services and strategies for effective treatment and support;
- 123.27 (5) develop policies and strategies to expand services and support for people in Minnesota  
123.28 suffering from opioid or substance use disorder through partnership with the Opioid Epidemic  
123.29 Response Advisory Council and other relevant partnerships;
- 124.1 (6) develop policies and strategies for agencies to manage addiction and the relationship  
124.2 it has with co-occurring conditions;
- 124.3 (7) identify policies and strategies to address opioid or substance use disorder among  
124.4 Minnesotans experiencing homelessness; ~~and~~
- 124.5 (8) submit recommendations to the legislature addressing opioid use, substance use, and  
124.6 addiction in Minnesota; and
- 124.7 (9) develop and publish a comprehensive substance use and addiction plan for the state.  
124.8 The plan must establish goals and priorities for a comprehensive continuum of care for  
124.9 substance misuse and substance use disorder for Minnesota. All state agencies' operating  
124.10 programs related to substance use prevention, harm reduction, treatment, or recovery or  
124.11 that are administering state or federal funds for those programs shall set program goals and

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

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

112.2 **169A.284 CHEMICAL DEPENDENCY COMPREHENSIVE ASSESSMENT**  
112.3 **CHARGE; SURCHARGE.**

112.4 Subdivision 1. **When required.** (a) When a court sentences a person convicted of an  
112.5 offense enumerated in section 169A.70, subdivision 2 (~~chemical use comprehensive~~  
112.6 assessment; requirement; form), except as provided in paragraph (c), it shall order the person  
112.7 to pay the cost of the comprehensive assessment directly to the entity conducting the  
112.8 assessment or providing the assessment services in an amount determined by the entity  
112.9 conducting or providing the service and shall impose a ~~chemical dependency comprehensive~~  
112.10 assessment charge of \$25. The court may waive the \$25 comprehensive assessment charge,  
112.11 but may not waive the cost for the assessment paid directly to the entity conducting the  
112.12 assessment or providing assessment services. A person shall pay an additional surcharge  
112.13 of \$5 if the person is convicted of a violation of section 169A.20 (driving while impaired)  
112.14 within five years of a prior impaired driving conviction or a prior conviction for an offense  
112.15 arising out of an arrest for a violation of section 169A.20 or Minnesota Statutes 1998, section  
112.16 169.121 (driver under influence of alcohol or controlled substance) or 169.129 (aggravated  
112.17 DWI-related violations; penalty). This section applies when the sentence is executed, stayed,  
112.18 or suspended. The court may not waive payment of or authorize payment in installments  
112.19 of the comprehensive assessment charge and surcharge ~~in installments~~ unless it makes  
112.20 written findings on the record that the convicted person is indigent or that the comprehensive  
112.21 assessment charge and surcharge would create undue hardship for the convicted person or  
112.22 that person's immediate family.

112.23 (b) The ~~chemical dependency comprehensive~~ assessment charge and surcharge required  
112.24 under this section are in addition to the surcharge required by section 357.021, subdivision  
112.25 6 (surcharges on criminal and traffic offenders).

112.26 (c) The court must not order the person convicted of an offense enumerated in section  
112.27 169A.70, subdivision 2 (comprehensive assessment; requirement; form), to pay the cost of  
112.28 the comprehensive assessment if the individual is eligible for payment of the comprehensive  
112.29 assessment under chapter 254B or 256B.

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

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

113.2 Subd. 4. **Case management service provider.** (a) "Case management service provider"

113.3 means a case manager or case manager associate employed by the county or other entity

113.4 authorized by the county board to provide case management services specified in section

113.5 245.4711.

113.6 (b) A case manager must:

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

113.8 (2) be knowledgeable about local community resources and how to use those resources

113.9 for the benefit of the client;

113.10 (3) be a mental health practitioner as defined in section 2451.04, subdivision 4, or have

113.11 a bachelor's degree in one of the behavioral sciences or related fields including, but not

113.12 limited to, social work, psychology, or nursing from an accredited college or university. A

113.13 case manager who is not a mental health practitioner ~~and~~ or who does not have a bachelor's

113.14 degree in one of the behavioral sciences or related fields must meet the requirements of

113.15 paragraph (c); and

113.16 (4) meet the supervision and continuing education requirements described in paragraphs

113.17 (d), (e), and (f), as applicable.

113.18 (c) Case managers without a bachelor's degree or with a bachelor's degree that is not in

113.19 one of the behavioral sciences or related fields must meet one of the requirements in clauses

113.20 (1) to ~~(3)~~ (5):

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

113.22 section;

113.23 (2) be a registered nurse without a bachelor's degree and have a combination of

113.24 specialized training in psychiatry and work experience consisting of community interaction

113.25 and involvement or community discharge planning in a mental health setting totaling three

113.26 years; ~~or~~

113.27 (3) be a person who qualified as a case manager under the 1998 Department of Human

113.28 Service waiver provision and meet the continuing education and mentoring requirements

113.29 in this section;

113.30 (4) prior to direct service delivery, complete at least 80 hours of specific training on the

113.31 characteristics and needs of adults with serious and persistent mental illness that is consistent

113.32 with national ~~practices~~ standards; or

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

276.27 Subd. 4. **Case management service provider.** (a) "Case management service provider"

276.28 means a case manager or case manager associate employed by the county or other entity

276.29 authorized by the county board to provide case management services specified in section

276.30 245.4711.

276.31 (b) A case manager must:

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

277.1 (2) be knowledgeable about local community resources and how to use those resources

277.2 for the benefit of the client;

277.3 (3) be a mental health practitioner as defined in section 2451.04, subdivision 4, or have

277.4 a bachelor's degree in one of the behavioral sciences or related fields including, but not

277.5 limited to, social work, psychology, or nursing from an accredited college or university. A

277.6 case manager who is not a mental health practitioner ~~and~~ or who does not have a bachelor's

277.7 degree in one of the behavioral sciences or related fields must meet the requirements of

277.8 paragraph (c); and

277.9 (4) meet the supervision and continuing education requirements described in paragraphs

277.10 (d), (e), and (f), as applicable.

277.11 (c) Case managers without a bachelor's degree or with a bachelor's degree that is not in

277.12 one of the behavioral sciences or related fields must meet one of the requirements in clauses

277.13 (1) to ~~(3)~~ (5):

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

277.15 section;

277.16 (2) be a registered nurse without a bachelor's degree and have a combination of

277.17 specialized training in psychiatry and work experience consisting of community interaction

277.18 and involvement or community discharge planning in a mental health setting totaling three

277.19 years; ~~or~~

277.20 (3) be a person who qualified as a case manager under the 1998 Department of Human

277.21 Service waiver provision and meet the continuing education and mentoring requirements

277.22 in this section;

277.23 (4) prior to direct service delivery, complete at least 80 hours of specific training on the

277.24 characteristics and needs of adults with serious and persistent mental illness that is consistent

277.25 with national ~~practice~~ standards; or

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

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

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

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

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

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

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

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

114.23 (2) be at least 21 years of age;

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

114.25 (4) meet one of the following criteria:

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

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

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

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

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

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

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

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

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

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

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

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

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

278.15 (2) be at least 21 years of age;

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

278.17 (4) meet one of the following criteria:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

- 280.1 Sec. 3. Minnesota Statutes 2024, section 245.4661, subdivision 9, is amended to read:
- 280.2 Subd. 9. **Services and programs.** (a) The following three distinct grant programs are
- 280.3 funded under this section:
- 280.4 (1) mental health crisis services;
- 280.5 (2) housing with supports for adults with serious mental illness; and
- 280.6 (3) projects for assistance in transitioning from homelessness (PATH program).
- 280.7 (b) In addition, the following are eligible for grant funds:
- 280.8 (1) community education and prevention;
- 280.9 (2) client outreach;
- 280.10 (3) early identification and intervention;
- 280.11 (4) adult outpatient diagnostic assessment and psychological testing;
- 280.12 (5) peer support services;
- 280.13 (6) community support program services (CSP);
- 280.14 (7) adult residential crisis stabilization;
- 280.15 (8) supported employment;
- 280.16 (9) assertive community treatment (ACT);
- 280.17 (10) housing subsidies;
- 280.18 (11) basic living, social skills, and community intervention;
- 280.19 (12) emergency response services;
- 280.20 (13) adult outpatient psychotherapy;
- 280.21 (14) adult outpatient medication management;
- 280.22 (15) adult mobile crisis services, including the purchase and renovation of vehicles by
- 280.23 mobile crisis teams in order to provide protected transport under section 256B.0625,
- 280.24 subdivision 17, paragraph (1), clause (6);
- 280.25 (16) adult day treatment;
- 280.26 (17) partial hospitalization;
- 280.27 (18) adult residential treatment;
- 280.28 (19) adult mental health targeted case management; and
- 281.1 (20) transportation.



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

116.11 **245.469 EMERGENCY SERVICES.**

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

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

116.21 (2) minimize further deterioration of each client;

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

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

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

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

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

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

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

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

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

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

281.3 **245.469 EMERGENCY SERVICES.**

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

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

281.13 (2) minimize further deterioration of each client;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

118.27 **245.481 FEES FOR MENTAL HEALTH SERVICES.**

118.28 A client or, in the case of a child, the child or the child's parent may be required to pay  
118.29 a fee for mental health services provided under sections 245.461 to 245.4682, 245.470 to  
118.30 245.486, and 245.487 to 245.4889. The fee must be based on the person's ability to pay  
118.31 according to the fee schedule adopted by the county board. In adopting the fee schedule for  
118.32 mental health services, the county board may adopt the fee schedule provided by the  
119.1 commissioner or adopt a fee schedule recommended by the county board and approved by  
119.2 the commissioner. Agencies or individuals under contract with a county board to provide  
119.3 mental health services under sections 245.461 to 245.486 and 245.487 to 245.4889 must  
119.4 not charge clients whose mental health services are paid wholly or in part from public funds  
119.5 fees which exceed the county board's adopted fee schedule. This section does not apply to  
119.6 regional treatment center fees, which are governed by sections 246.50 to 246.55.

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

119.8 Subd. 4. **Case management service provider.** (a) "Case management service provider"  
119.9 means a case manager or case manager associate employed by the county or other entity  
119.10 authorized by the county board to provide case management services specified in subdivision  
119.11 3 for the child with severe emotional disturbance and the child's family.

119.12 (b) A case manager must:

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

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

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

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

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

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

283.17 Subd. 4. **Case management service provider.** (a) "Case management service provider"  
283.18 means a case manager or case manager associate employed by the county or other entity  
283.19 authorized by the county board to provide case management services specified in subdivision  
283.20 3 for the child with severe emotional disturbance and the child's family.

283.21 (b) A case manager must:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

121.5 (2) be at least 21 years of age;

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

121.7 (4) meet one of the following criteria:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

285.14 (2) be at least 21 years of age;

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

285.16 (4) meet one of the following criteria:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

123.28 (6) provide for case management services to each child with ~~severe emotional disturbance~~  
123.29 serious mental illness according to sections 245.486; 245.4871, subdivisions 3 and 4; and  
123.30 245.4881, subdivisions 1, 3, and 5;

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

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

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

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

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

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

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

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

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

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

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

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

325.7 (6) provide for case management services to each child with ~~severe emotional disturbance~~  
325.8 serious mental illness according to sections 245.486; 245.4871, subdivisions 3 and 4; and  
325.9 245.4881, subdivisions 1, 3, and 5;

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

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

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

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

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

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

124.17 (i) a child receiving child protective services;

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

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

124.20 (iv) a child found to be delinquent; or

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

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

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

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

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

125.11 (1) training in the administration of the instrument;

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

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

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

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

325.26 (i) a child receiving child protective services;

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

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

325.29 (iv) a child found to be delinquent; or

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

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

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

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

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

326.21 (1) training in the administration of the instrument;

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



125.13 (3) the state and federal data practices laws and confidentiality standards;  
125.14 (4) the parental consent requirement; and  
125.15 (5) providing respect for families and cultural values.

125.16 If the screen indicates a need for assessment, the child's family, or if the family lacks  
125.17 mental health insurance, the local social services agency, in consultation with the child's  
125.18 family, shall have conducted a diagnostic assessment, including a functional assessment.  
125.19 The administration of the screening shall safeguard the privacy of children receiving the  
125.20 screening and their families and shall comply with the Minnesota Government Data Practices  
125.21 Act, chapter 13, and the federal Health Insurance Portability and Accountability Act of  
125.22 1996, Public Law 104-191. Screening results are classified as private data on individuals,  
125.23 as defined by section 13.02, subdivision 12. The county board or Tribal nation may provide  
125.24 the commissioner with access to the screening results for the purposes of program evaluation  
125.25 and improvement.

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

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

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

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

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

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

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

326.23 (3) the state and federal data practices laws and confidentiality standards;  
326.24 (4) the parental consent requirement; and  
326.25 (5) providing respect for families and cultural values.

326.26 If the screen indicates a need for assessment, the child's family, or if the family lacks  
326.27 mental health insurance, the local social services agency, in consultation with the child's  
326.28 family, shall have conducted a diagnostic assessment, including a functional assessment.  
326.29 The administration of the screening shall safeguard the privacy of children receiving the  
326.30 screening and their families and shall comply with the Minnesota Government Data Practices  
326.31 Act, chapter 13, and the federal Health Insurance Portability and Accountability Act of  
326.32 1996, Public Law 104-191. Screening results are classified as private data on individuals,  
326.33 as defined by section 13.02, subdivision 12. The county board or Tribal nation may provide  
327.1 the commissioner with access to the screening results for the purposes of program evaluation  
327.2 and improvement.

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

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

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

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

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

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

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

126.19 (2) delivering mental health and substance use disorder treatment and services to students  
126.20 and their families, including via telehealth consistent with section 256B.0625, subdivision  
126.21 3b;

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

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

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

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

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

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

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

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

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

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

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

127.19 (4) a provider of children's therapeutic services and supports as defined in section  
127.20 256B.0943;

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

287.19 (2) delivering mental health and substance use disorder treatment and services to students  
287.20 and their families, including via telehealth consistent with section 256B.0625, subdivision  
287.21 3b;

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

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

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

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

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

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

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

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

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

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

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

288.19 (4) a provider of children's therapeutic services and supports as defined in section  
288.20 256B.0943;

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

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

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

127.28 (7) a licensed professional in private practice as defined in section 245G.01, subdivision  
127.29 17, who meets the requirements of section 254B.05, subdivision 1, paragraph (b).

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

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

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

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

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

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

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

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

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

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

128.21 (b) The commissioner must calculate the share of the appropriation to be used in each  
128.22 qualifying school unit by multiplying the total appropriation going to the grantees by the  
128.23 qualifying school unit's average daily membership in a setting of federal instructional level  
128.24 4 or higher and then dividing the product by the total average daily membership in a setting  
128.25 of federal instructional level 4 or higher for the same year for all qualifying school units.

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

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

288.28 (7) a licensed professional in private practice as defined in section 245G.01, subdivision  
288.29 17, who meets the requirements of section 254B.05, subdivision 1, paragraph (b).

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

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

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

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

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

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

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

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

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

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

289.21 (b) The commissioner must calculate the share of the appropriation to be used in each  
289.22 qualifying school unit by multiplying the total appropriation going to the grantees by the  
289.23 qualifying school unit's average daily membership in a setting of federal instructional level  
289.24 4 or higher and then dividing by the total average daily membership in a setting of federal  
289.25 instructional level 4 or higher for the same year for all qualifying school units.

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

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

128.31 Subd. 3. **Allowable grant activities.** Grantees must use grant funding to provide training  
128.32 for mental health ~~certified~~ family peer ~~specialists~~ specialist candidates and continuing  
129.1 education to certified family peer specialists as specified in section 256B.0616, subdivision  
129.2 5.

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

129.4 Subd. 3b. **Exemptions to host county approval.** Notwithstanding any other law that  
129.5 requires a county contract or other form of county approval for a service listed in subdivision  
129.6 3, paragraph (d), clause (8), a CCBHC that meets the requirements of this section may enroll  
129.7 as a provider of mental health crisis response services under section 256B.0624 and receive  
129.8 the prospective payment under section 256B.0625, subdivision 5m, for that service without  
129.9 a county contract or county approval.

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

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

289.31 Subd. 3. **Allowable grant activities.** Grantees must use grant funding to provide training  
289.32 for mental health ~~certified~~ family peer ~~specialists~~ specialist candidates and continuing  
290.1 education to certified family peer specialists as specified in section 256B.0616, subdivision  
290.2 5.

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

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

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

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

290.8 ~~(2)~~ (2) are the subject of a presentence investigation; or

290.9 ~~(4)~~ (3) have been committed involuntarily in Minnesota under chapter 253B for treatment  
290.10 of mental illness or chemical dependency, except as provided under subdivision 5.

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

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

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

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

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

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

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

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

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

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

130.4 (b) A comprehensive assessment must be administered by:

130.5 (1) an alcohol and drug counselor;

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

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

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

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

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

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

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

125.5 (b) A comprehensive assessment must be administered by:

125.6 (1) an alcohol and drug counselor;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

126.8 (i) has a high school diploma or equivalent;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

132.17 (1) mental illnesses;

132.18 (2) client recovery and resiliency;

132.19 (3) mental health de-escalation techniques;

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

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

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

132.25 (1) trauma-informed care and secondary trauma;

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

132.28 (3) co-occurring substance use disorders; and

132.29 (4) culturally responsive treatment practices.

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

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

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

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

133.12 (4) culturally responsive treatment practices; and

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

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

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

291.14 (1) mental illnesses;

291.15 (2) client recovery and resiliency;

291.16 (3) mental health de-escalation techniques;

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

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

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

291.22 (1) trauma-informed care and secondary trauma;

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

291.25 (3) co-occurring substance use disorders; and

291.26 (4) culturally responsive treatment practices.

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

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

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

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

292.8 (4) culturally responsive treatment practices; and

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

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



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

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

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

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

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

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

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

134.13 (b) For a mental health rehabilitation worker qualified under section 245I.04, subdivision  
134.14 14, paragraph (a), clause (2), item (i), treatment supervision in the first 2,000 hours of work  
134.15 must at a minimum consist of:

134.16 (1) monthly individual supervision; and

134.17 (2) direct observation twice per month.

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

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

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

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

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

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

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

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

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

293.6 (b) For a mental health rehabilitation worker qualified under section 245I.04, subdivision  
293.7 14, paragraph (a), clause (2), item (i), treatment supervision in the first 2,000 hours of work  
293.8 must at a minimum consist of:

293.9 (1) monthly individual supervision; and

293.10 (2) direct observation twice per month.

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

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

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

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

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

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

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

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

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

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

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

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

135.19 (c) The license holder must:

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

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

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

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

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

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

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

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

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

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

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

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

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

294.12 (c) The license holder must:

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

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

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

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

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

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

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

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

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

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

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

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

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

295.5 (1) health and safety, including the client's need for crisis assistance;  
295.6 (2) responsibilities for children, family and other natural supports, and employers; and  
295.7 (3) housing and legal issues.

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

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

295.12 (2) consider crisis assistance strategies that have been effective for the client in the past;  
295.13 (3) identify the client's initial treatment goals, measurable treatment objectives, and  
295.14 specific interventions that the license holder will use to help the client engage in treatment;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

127.8 ~~(3)~~ (2) develop, demonstrate, and disseminate new methods and techniques for prevention,  
127.9 early intervention, treatment and recovery support for substance misuse and substance use  
127.10 disorder;

127.11 ~~(4)~~ (3) gather facts and information about substance misuse and substance use disorder,  
127.12 and about the efficiency and effectiveness of prevention, treatment, and recovery support  
127.13 services from all comprehensive programs, including programs approved or licensed by the  
127.14 commissioner of human services or the commissioner of health or accredited by the Joint  
127.15 Commission on Accreditation of Hospitals. The state authority is authorized to require  
127.16 information from comprehensive programs which is reasonable and necessary to fulfill  
127.17 these duties. When required information has been previously furnished to a state or local  
127.18 governmental agency, the state authority shall collect the information from the governmental  
127.19 agency. The state authority shall disseminate facts and summary information about problems  
127.20 associated with substance misuse and substance use disorder to public and private agencies,  
127.21 local governments, local and regional planning agencies, and the courts for guidance to and  
127.22 assistance in prevention, treatment and recovery support;

127.23 ~~(5)~~ (4) inform and educate the general public on substance misuse and substance use  
127.24 disorder;

127.25 ~~(6)~~ (5) serve as the state authority concerning substance misuse and substance use disorder  
127.26 by monitoring the conduct of diagnosis and referral services, research and comprehensive  
127.27 programs. The state authority shall submit a biennial report to the governor containing a  
127.28 description of public services delivery and recommendations concerning increase of  
127.29 coordination and quality of services, and decrease of service duplication and cost;

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

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

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

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

136.11 Subdivision 1. **Licensure or certification required.** (a) Programs licensed by the  
136.12 commissioner are eligible vendors. Hospitals may apply for and receive licenses to be  
136.13 eligible vendors, notwithstanding the provisions of section 245A.03. American Indian  
136.14 programs that provide substance use disorder treatment, extended care, transitional residence,  
136.15 or outpatient treatment services, and are licensed by tribal government are eligible vendors.

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

128.4 ~~(8)~~ (6) make contracts with and grants to public and private agencies and organizations,  
128.5 both profit and nonprofit, and individuals, using federal funds, and state funds as authorized  
128.6 to pay for costs of state administration, including evaluation, statewide programs and services,  
128.7 research and demonstration projects, and American Indian programs;

128.8 ~~(9)~~ (7) receive and administer money available for substance misuse and substance use  
128.9 disorder programs under the alcohol, drug abuse, and mental health services block grant,  
128.10 United States Code, title 42, sections 300X to 300X-9;

128.11 ~~(10)~~ (8) solicit and accept any gift of money or property for purposes of Laws 1973,  
128.12 chapter 572, and any grant of money, services, or property from the federal government,  
128.13 the state, any political subdivision thereof, or any private source; and

128.14 ~~(11)~~ (9) with respect to substance misuse and substance use disorder programs serving  
128.15 the American Indian community, establish guidelines for the employment of personnel with  
128.16 considerable practical experience in substance misuse and substance use disorder, and  
128.17 understanding of social and cultural problems related to substance misuse and substance  
128.18 use disorder, in the American Indian community.

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

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

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

128.26 Subd. 7. **Assessments for children's residential facilities.** For children's residential  
128.27 facilities licensed under chapter 245A according to Minnesota Rules, parts 2960.0010 to  
128.28 2960.0220 and 2960.0430 to 2960.0490, a "chemical use assessment" is a comprehensive  
128.29 assessment completed according to the requirements of section 245G.05 and must be  
128.30 completed by an individual who meets the qualifications of section 245G.11, subdivisions  
128.31 1 and 5.

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

129.2 Subdivision 1. **Licensure or certification required.** (a) Programs licensed by the  
129.3 commissioner are eligible vendors. Hospitals may apply for and receive licenses to be  
129.4 eligible vendors, notwithstanding the provisions of section 245A.03. American Indian  
129.5 programs that provide substance use disorder treatment, extended care, transitional residence,  
129.6 or outpatient treatment services, and are licensed by tribal government are eligible vendors.

136.16 (b) A licensed professional in private practice as defined in section 245G.01, subdivision  
136.17 17, who meets the requirements of section 245G.11, subdivisions 1 and 4, is an eligible  
136.18 vendor of a comprehensive assessment provided according to section 254A.19, subdivision  
136.19 3, and treatment services provided according to sections 245G.06 and 245G.07, subdivision  
136.20 1, paragraphs (a), clauses (1) to (5), and (b); and subdivision 2, clauses (1) to (6).

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

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

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

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

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

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

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

129.7 (b) A licensed professional in private practice as defined in section 245G.01, subdivision  
129.8 17, who meets the requirements of section 245G.11, subdivisions 1 and 4, is an eligible  
129.9 vendor of a comprehensive assessment provided according to section 254A.19, subdivision  
129.10 3, and treatment services provided according to sections 245G.06 and 245G.07, subdivision  
129.11 1, paragraphs (a), clauses (1) to (5), and (b); and subdivision 2, clauses (1) to (6).

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

129.20 (d) A recovery community organization that meets the requirements of clauses (1) to  
129.21 ~~(14)~~ (15) and meets certification or accreditation requirements of the Alliance for Recovery  
129.22 Centered Organizations, the Council on Accreditation of Peer Recovery Support Services,  
129.23 or a Minnesota statewide recovery organization identified by the commissioner is an eligible  
129.24 vendor of peer recovery support services. A Minnesota statewide recovery organization  
129.25 identified by the commissioner must update recovery community organization applicants  
129.26 for certification or accreditation on the status of the application within 45 days of receipt.  
129.27 If the approved statewide recovery organization denies an application, it must provide a  
129.28 written explanation for the denial to the recovery community organization. Eligible vendors  
129.29 under this paragraph must:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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



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

138.27 (e) A recovery community organization approved by the commissioner before June 30,  
138.28 2023, must have begun the application process as required by an approved certifying or  
138.29 accrediting entity and have begun the process to meet the requirements under paragraph (d)  
138.30 by September 1, 2024, in order to be considered as an eligible vendor of peer recovery  
138.31 support services.

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

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

139.12 (h) Detoxification programs licensed under Minnesota Rules, parts 9530.6510 to  
139.13 9530.6590, are not eligible vendors. Programs that are not licensed as a residential or  
139.14 nonresidential substance use disorder treatment or withdrawal management program by the  
139.15 commissioner or by tribal government or do not meet the requirements of subdivisions 1a  
139.16 and 1b are not eligible vendors.

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

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

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

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

139.29 (b) Eligible substance use disorder treatment services include:

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

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

131.18 (e) A recovery community organization approved by the commissioner before June 30,  
131.19 2023, must have begun the application process as required by an approved certifying or  
131.20 accrediting entity and have begun the process to meet the requirements under paragraph (d)  
131.21 by September 1, 2024, in order to be considered as an eligible vendor of peer recovery  
131.22 support services.

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

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

131.31 (h) Detoxification programs licensed under Minnesota Rules, parts 9530.6510 to  
131.32 9530.6590, are not eligible vendors. Programs that are not licensed as a residential or  
131.33 nonresidential substance use disorder treatment or withdrawal management program by the  
132.1 commissioner or by tribal government or do not meet the requirements of subdivisions 1a  
132.2 and 1b are not eligible vendors.

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

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

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

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

132.15 (b) Eligible substance use disorder treatment services include:

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

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

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

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

140.5 (iv) ASAM level 2.5 partial hospitalization services provided according to section  
140.6 254B.19, subdivision 1, clause (4);

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

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

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

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

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

140.22 (3) treatment coordination services provided according to section 245G.07, subdivision  
140.23 1, paragraph (a), clause (5);

140.24 (4) peer recovery support services provided according to section 245G.07, subdivision  
140.25 2, clause (8);

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

140.27 (6) hospital-based treatment services that are licensed according to sections 245G.01 to  
140.28 245G.17 or applicable Tribal license and licensed as a hospital under sections 144.50 to  
140.29 144.56;

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

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

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

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

132.24 (iv) ASAM level 2.5 partial hospitalization services provided according to section  
132.25 254B.19, subdivision 1, clause (4);

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

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

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

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

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

133.9 (3) treatment coordination services provided according to section 245G.07, subdivision  
133.10 1, paragraph (a), clause (5);

133.11 (4) peer recovery support services provided according to section 245G.07, subdivision  
133.12 2, clause (8);

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

133.14 (6) hospital-based treatment services that are licensed according to sections 245G.01 to  
133.15 245G.17 or applicable Tribal license and licensed as a hospital under sections 144.50 to  
133.16 144.56;

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

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

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

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

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

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

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

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

141.19 (A) is licensed under chapter 245A as a child care center under Minnesota Rules, chapter  
141.20 9503; or

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

134.6 (A) is licensed under chapter 245A as a child care center under Minnesota Rules, chapter  
134.7 9503; or

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

144.24 Subd. 3a. **Provider certification and contract requirements for assertive community**  
144.25 **treatment.** (a) The assertive community treatment provider must have each ACT team be  
144.26 certified by the state following the certification process and procedures developed by the  
144.27 commissioner. The certification process determines whether the ACT team meets the  
144.28 standards for assertive community treatment under this section, the standards in chapter  
144.29 245I as required in section 245I.011, subdivision 5, and minimum program fidelity standards  
144.30 as measured by a nationally recognized fidelity tool approved by the commissioner.  
144.31 Recertification must occur at least every three years.

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

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

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

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

145.5 (4) keep all necessary records required by law;

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

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

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

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

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

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

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

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

297.20 Subd. 3a. **Provider certification and contract requirements for assertive community**  
297.21 **treatment.** (a) The assertive community treatment provider must have each ACT team be  
297.22 certified by the state following the certification process and procedures developed by the  
297.23 commissioner. The certification process determines whether the ACT team meets the  
297.24 standards for assertive community treatment under this section, the standards in chapter  
297.25 245I as required in section 245I.011, subdivision 5, and minimum program fidelity standards  
297.26 as measured by a nationally recognized fidelity tool approved by the commissioner.  
297.27 Recertification must occur at least every three years.

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

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

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

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

298.1 (4) keep all necessary records required by law;

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

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

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

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

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

145.19 Subd. 7a. **Assertive community treatment team staff requirements and roles.** (a)

145.20 The required treatment staff qualifications and roles for an ACT team are:

145.21 (1) the team leader:

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

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

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

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

146.4 (2) the psychiatric care provider:

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

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

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

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

146.23 (v) shall have a minimum full-time equivalency that is prorated at a rate of 16 hours per  
146.24 50 clients. Part-time psychiatric care providers shall have designated hours to work on the

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

298.15 Subd. 7a. **Assertive community treatment team staff requirements and roles.** (a)

298.16 The required treatment staff qualifications and roles for an ACT team are:

298.17 (1) the team leader:

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

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

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

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

298.29 (2) the psychiatric care provider:

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

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

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

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

299.17 (v) shall have a minimum full-time equivalency that is prorated at a rate of 16 hours per  
299.18 50 clients. Part-time psychiatric care providers shall have designated hours to work on the

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

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

146.31 (3) the nursing staff:

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

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

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

147.11 (4) the co-occurring disorder specialist:

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

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

147.25 (5) the vocational specialist:

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

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

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

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299.27 of whom at least one has a minimum of one-year experience working with adults with  
299.28 serious mental illness and a working knowledge of psychiatric medications. No more than  
299.29 two individuals can share a full-time equivalent position;

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

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299.33 as prescribed; screen and monitor clients' mental and physical health conditions and  
300.1 medication side effects; engage in health promotion, prevention, and education activities;  
300.2 communicate and coordinate services with other medical providers; facilitate the development  
300.3 of the individual treatment plan for clients assigned; and educate the ACT team in monitoring  
300.4 psychiatric and physical health symptoms and medication side effects;

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300.7 specific training on co-occurring disorders that is consistent with national evidence-based  
300.8 practices. The training must include practical knowledge of common substances and how  
300.9 they affect mental illnesses, the ability to assess substance use disorders and the client's  
300.10 stage of treatment, motivational interviewing, and skills necessary to provide counseling to  
300.11 clients at all different stages of change and treatment. The co-occurring disorder specialist  
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300.13 section 148F.01, subdivision 5, or a counselor who otherwise meets the training, experience,  
300.14 and other requirements in section 245G.11, subdivision 5. No more than two co-occurring  
300.15 disorder specialists may occupy this role; and

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

300.19 (5) the vocational specialist:

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



147.29 may also serve as the vocational specialist upon completing a training plan approved by the  
147.30 commissioner;

147.31 (ii) shall provide or facilitate the provision of vocational services to clients. The vocational  
147.32 specialist serves as a consultant and educator to fellow ACT team members on these services;  
147.33 and

148.1 (iii) must not refer individuals to receive any type of vocational services or linkage by  
148.2 providers outside of the ACT team;

148.3 (6) the mental health certified peer specialist:

148.4 (i) shall be a full-time equivalent. No more than two individuals can share this position.  
148.5 The mental health certified peer specialist is a fully integrated team member who provides  
148.6 highly individualized services in the community and promotes the self-determination and  
148.7 shared decision-making abilities of clients. This requirement may be waived due to workforce  
148.8 shortages upon approval of the commissioner;

148.9 (ii) must provide coaching, mentoring, and consultation to the clients to promote recovery,  
148.10 self-advocacy, and self-direction, promote wellness management strategies, and assist clients  
148.11 in developing advance directives; and

148.12 (iii) must model recovery values, attitudes, beliefs, and personal action to encourage  
148.13 wellness and resilience, provide consultation to team members, promote a culture where  
148.14 the clients' points of view and preferences are recognized, understood, respected, and  
148.15 integrated into treatment, and serve in a manner equivalent to other team members;

148.16 (7) the program administrative assistant shall be a full-time office-based program  
148.17 administrative assistant position assigned to solely work with the ACT team, providing a  
148.18 range of supports to the team, clients, and families; and

148.19 (8) additional staff:

148.20 (i) shall be based on team size. Additional treatment team staff may include mental  
148.21 health professionals; clinical trainees; certified rehabilitation specialists; mental health  
148.22 practitioners; or mental health rehabilitation workers. These individuals shall have the  
148.23 knowledge, skills, and abilities required by the population served to carry out rehabilitation  
148.24 and support functions; and

148.25 (ii) shall be selected based on specific program needs or the population served.

148.26 (b) Each ACT team must clearly document schedules for all ACT team members.

148.27 (c) Each ACT team member must serve as a primary team member for clients assigned  
148.28 by the team leader and are responsible for facilitating the individual treatment plan process  
148.29 for those clients. The primary team member for a client is the responsible team member  
148.30 knowledgeable about the client's life and circumstances and writes the individual treatment

300.23 may also serve as the vocational specialist upon completing a training plan approved by the  
300.24 commissioner;

300.25 (ii) shall provide or facilitate the provision of vocational services to clients. The vocational  
300.26 specialist serves as a consultant and educator to fellow ACT team members on these services;  
300.27 and

300.28 (iii) must not refer individuals to receive any type of vocational services or linkage by  
300.29 providers outside of the ACT team;

300.30 (6) the mental health certified peer specialist:

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300.33 highly individualized services in the community and promotes the self-determination and  
301.1 shared decision-making abilities of clients. This requirement may be waived due to workforce  
301.2 shortages upon approval of the commissioner;

301.3 (ii) must provide coaching, mentoring, and consultation to the clients to promote recovery,  
301.4 self-advocacy, and self-direction, promote wellness management strategies, and assist clients  
301.5 in developing advance directives; and

301.6 (iii) must model recovery values, attitudes, beliefs, and personal action to encourage  
301.7 wellness and resilience, provide consultation to team members, promote a culture where  
301.8 the clients' points of view and preferences are recognized, understood, respected, and  
301.9 integrated into treatment, and serve in a manner equivalent to other team members;

301.10 (7) the program administrative assistant shall be a full-time office-based program  
301.11 administrative assistant position assigned to solely work with the ACT team, providing a  
301.12 range of supports to the team, clients, and families; and

301.13 (8) additional staff:

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301.15 health professionals; clinical trainees; certified rehabilitation specialists; mental health  
301.16 practitioners; or mental health rehabilitation workers. These individuals shall have the  
301.17 knowledge, skills, and abilities required by the population served to carry out rehabilitation  
301.18 and support functions; and

301.19 (ii) shall be selected based on specific program needs or the population served.

301.20 (b) Each ACT team must clearly document schedules for all ACT team members.

301.21 (c) Each ACT team member must serve as a primary team member for clients assigned  
301.22 by the team leader and are responsible for facilitating the individual treatment plan process  
301.23 for those clients. The primary team member for a client is the responsible team member  
301.24 knowledgeable about the client's life and circumstances and writes the individual treatment

148.31 plan. The primary team member provides individual supportive therapy or counseling, and  
148.32 provides primary support and education to the client's family and support system.

149.1 (d) Members of the ACT team must have strong clinical skills, professional qualifications,  
149.2 experience, and competency to provide a full breadth of rehabilitation services. Each staff  
149.3 member shall be proficient in their respective discipline and be able to work collaboratively  
149.4 as a member of a multidisciplinary team to deliver the majority of the treatment,  
149.5 rehabilitation, and support services clients require to fully benefit from receiving assertive  
149.6 community treatment.

149.7 (e) Each ACT team member must fulfill training requirements established by the  
149.8 commissioner.

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

149.11 Sec. 32. **[256G.061] WITHDRAWAL MANAGEMENT SERVICES.**

149.12 The county of financial responsibility for withdrawal management services is defined  
149.13 in section 256G.02, subdivision 4.

149.14 Sec. 33. Minnesota Statutes 2024, section 256L.03, subdivision 5, is amended to read:

149.15 Subd. 5. **Cost-sharing.** (a) Co-payments, coinsurance, and deductibles do not apply to  
149.16 children under the age of 21 and to American Indians as defined in Code of Federal  
149.17 Regulations, title 42, section 600.5.

149.18 (b) The commissioner must adjust co-payments, coinsurance, and deductibles for covered  
149.19 services in a manner sufficient to maintain the actuarial value of the benefit to 94 percent.  
149.20 The cost-sharing changes described in this paragraph do not apply to eligible recipients or  
149.21 services exempt from cost-sharing under state law. The cost-sharing changes described in  
149.22 this paragraph shall not be implemented prior to January 1, 2016.

149.23 (c) The cost-sharing changes authorized under paragraph (b) must satisfy the requirements  
149.24 for cost-sharing under the Basic Health Program as set forth in Code of Federal Regulations,  
149.25 title 42, sections 600.510 and 600.520.

149.26 (d) Cost-sharing for prescription drugs and related medical supplies to treat chronic  
149.27 disease must comply with the requirements of section 62Q.481.

149.28 (e) Co-payments, coinsurance, and deductibles do not apply to additional diagnostic  
149.29 services or testing that a health care provider determines an enrollee requires after a  
149.30 mammogram, as specified under section 62A.30, subdivision 5.

301.25 plan. The primary team member provides individual supportive therapy or counseling, and  
301.26 provides primary support and education to the client's family and support system.

301.27 (d) Members of the ACT team must have strong clinical skills, professional qualifications,  
301.28 experience, and competency to provide a full breadth of rehabilitation services. Each staff  
301.29 member shall be proficient in their respective discipline and be able to work collaboratively  
301.30 as a member of a multidisciplinary team to deliver the majority of the treatment,  
301.31 rehabilitation, and support services clients require to fully benefit from receiving assertive  
301.32 community treatment.

302.1 (e) Each ACT team member must fulfill training requirements established by the  
302.2 commissioner.

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

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136.12 Sec. 11. **[256G.061] WITHDRAWAL MANAGEMENT SERVICES.**

136.13 The county of financial responsibility for withdrawal management services is defined  
136.14 in section 256G.02, subdivision 4.

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302.5 Sec. 23. Minnesota Statutes 2024, section 256L.03, subdivision 5, is amended to read:

302.6 Subd. 5. **Cost-sharing.** (a) Co-payments, coinsurance, and deductibles do not apply to  
302.7 children under the age of 21 and to American Indians as defined in Code of Federal  
302.8 Regulations, title 42, section 600.5.

302.9 (b) The commissioner must adjust co-payments, coinsurance, and deductibles for covered  
302.10 services in a manner sufficient to maintain the actuarial value of the benefit to 94 percent.  
302.11 The cost-sharing changes described in this paragraph do not apply to eligible recipients or  
302.12 services exempt from cost-sharing under state law. The cost-sharing changes described in  
302.13 this paragraph shall not be implemented prior to January 1, 2016.

302.14 (c) The cost-sharing changes authorized under paragraph (b) must satisfy the requirements  
302.15 for cost-sharing under the Basic Health Program as set forth in Code of Federal Regulations,  
302.16 title 42, sections 600.510 and 600.520.

302.17 (d) Cost-sharing for prescription drugs and related medical supplies to treat chronic  
302.18 disease must comply with the requirements of section 62Q.481.

302.19 (e) Co-payments, coinsurance, and deductibles do not apply to additional diagnostic  
302.20 services or testing that a health care provider determines an enrollee requires after a  
302.21 mammogram, as specified under section 62A.30, subdivision 5.

150.1 (f) Cost-sharing must not apply to drugs used for tobacco and nicotine cessation or to  
150.2 tobacco and nicotine cessation services covered under section 256B.0625, subdivision 68.

150.3 (g) Co-payments, coinsurance, and deductibles do not apply to pre-exposure prophylaxis  
150.4 (PrEP) and postexposure prophylaxis (PEP) medications when used for the prevention or  
150.5 treatment of the human immunodeficiency virus (HIV).

150.6 (h) Co-payments, coinsurance, and deductibles do not apply to mobile crisis intervention  
150.7 or crisis assessment as defined in section 256B.0624, subdivision 2.

150.8 EFFECTIVE DATE. This section is effective January 1, 2026, or upon federal approval,  
150.9 whichever is later. The commissioner of human services shall notify the revisor of statutes  
150.10 when federal approval is obtained.

150.11 Sec. 34. **REVISOR INSTRUCTION.**

150.12 The revisor of statutes shall substitute the term "substance use disorder assessment" or  
150.13 similar terms for "chemical dependency assessment" or similar terms, for "chemical use  
150.14 assessment" or similar terms, and for "comprehensive substance use disorder assessment"  
150.15 or similar terms wherever they appear in Minnesota Statutes, chapter 169A, and Minnesota  
150.16 Rules, chapter 7503, when referring to the assessments required under Minnesota Statutes,  
150.17 section 169A.70, or the charges or surcharges associated with those assessments.

302.22 (f) Cost-sharing must not apply to drugs used for tobacco and nicotine cessation or to  
302.23 tobacco and nicotine cessation services covered under section 256B.0625, subdivision 68.

302.24 (g) Co-payments, coinsurance, and deductibles do not apply to pre-exposure prophylaxis  
302.25 (PrEP) and postexposure prophylaxis (PEP) medications when used for the prevention or  
302.26 treatment of the human immunodeficiency virus (HIV).

302.27 (h) Co-payments, coinsurance, and deductibles do not apply to mobile crisis intervention,  
302.28 as defined in section 256B.0624, subdivision 2, paragraph (d).

302.29 EFFECTIVE DATE. This section is effective January 1, 2026, or upon federal approval,  
302.30 whichever is later. The commissioner of human services shall notify the revisor of statutes  
302.31 when federal approval is obtained.