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ARTICLE 10

BEHAVIORAL HEALTH

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ARTICLE 4

BEHAVIORAL HEALTH

Section 1. Minnesota Statutes 2020, section 13.46, subdivision 7, is amended to read:

Subd. 7. **Mental health data.** (a) Mental health data are private data on individuals and shall not be disclosed, except:

(1) pursuant to section 13.05, as determined by the responsible authority for the community mental health center, mental health division, or provider;

(2) pursuant to court order;

(3) pursuant to a statute specifically authorizing access to or disclosure of mental health data or as otherwise provided by this subdivision;

(4) to personnel of the welfare system working in the same program or providing services to the same individual or family to the extent necessary to coordinate services, provided that a health record may be disclosed only as provided under section 144.293;

(5) to a health care provider governed by sections 144.291 to 144.298, to the extent necessary to coordinate services; or

(6) with the consent of the client or patient.

(b) An agency of the welfare system may not require an individual to consent to the release of mental health data as a condition for receiving services or for reimbursing a community mental health center, mental health division of a county, or provider under contract to deliver mental health services.

(c) Notwithstanding section 245.69, subdivision 2, paragraph (f), or any other law to the contrary, ~~the responsible authority for~~ a community mental health center, mental health division of a county, or a mental health provider must disclose mental health data to a law enforcement agency if the law enforcement agency provides the name of a client or patient and communicates that the:

(1) client or patient is currently involved in ~~an emergency interaction with~~ a mental health crisis as defined in section 256B.0624, subdivision 2, paragraph (j), to which the law enforcement agency has responded; and

(2) data is necessary to protect the health or safety of the client or patient or of another person.

The scope of disclosure under this paragraph is limited to the minimum necessary for law enforcement to safely respond to the ~~emergency~~ mental health crisis. Disclosure under this paragraph may include~~, but is not limited to,~~ the name and telephone number of the psychiatrist, psychologist, therapist, mental health professional, practitioner, or case manager of the client or patient, if known; and strategies to address the mental health crisis. A law

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Section 1. Minnesota Statutes 2020, section 62N.25, subdivision 5, is amended to read:

Subd. 5. **Benefits.** Community integrated service networks must offer the health maintenance organization benefit set, as defined in chapter 62D, and other laws applicable to entities regulated under chapter 62D. Community networks and chemical dependency facilities under contract with a community network shall use the assessment criteria in ~~Minnesota Rules, parts 9530.6600 to 9530.6655,~~ section 245G.05 when assessing enrollees for chemical dependency treatment.

EFFECTIVE DATE. This section is effective July 1, 2022.

Sec. 2. Minnesota Statutes 2020, section 62Q.1055, is amended to read:

62Q.1055 CHEMICAL DEPENDENCY.

All health plan companies shall use the assessment criteria in ~~Minnesota Rules, parts 9530.6600 to 9530.6655,~~ section 245G.05 when assessing and ~~placing~~ treating enrollees for chemical dependency treatment.

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enforcement agency that obtains mental health data under this paragraph shall maintain a record of the requestor, the provider of the ~~information~~ data, and the client or patient name. Mental health data obtained by a law enforcement agency under this paragraph are private data on individuals and must not be used by the law enforcement agency for any other purpose. A law enforcement agency that obtains mental health data under this paragraph shall inform the subject of the data that mental health data was obtained.

(d) In the event of a request under paragraph (a), clause (6), a community mental health center, county mental health division, or provider must release mental health data to Criminal Mental Health Court personnel in advance of receiving a copy of a consent if the Criminal Mental Health Court personnel communicate that the:

(1) client or patient is a defendant in a criminal case pending in the district court;

(2) data being requested is limited to information that is necessary to assess whether the defendant is eligible for participation in the Criminal Mental Health Court; and

(3) client or patient has consented to the release of the mental health data and a copy of the consent will be provided to the community mental health center, county mental health division, or provider within 72 hours of the release of the data.

For purposes of this paragraph, "Criminal Mental Health Court" refers to a specialty criminal calendar of the Hennepin County District Court for defendants with mental illness and brain injury where a primary goal of the calendar is to assess the treatment needs of the defendants and to incorporate those treatment needs into voluntary case disposition plans. The data released pursuant to this paragraph may be used for the sole purpose of determining whether the person is eligible for participation in mental health court. This paragraph does not in any way limit or otherwise extend the rights of the court to obtain the release of mental health data pursuant to court order or any other means allowed by law.

Sec. 2. Minnesota Statutes 2020, section 62N.25, subdivision 5, is amended to read:

Subd. 5. **Benefits.** Community integrated service networks must offer the health maintenance organization benefit set, as defined in chapter 62D, and other laws applicable to entities regulated under chapter 62D. Community networks and chemical dependency facilities under contract with a community network shall use the assessment criteria in ~~Minnesota Rules, parts 9530.6600 to 9530.6655,~~ section 245G.05 when assessing enrollees for chemical dependency treatment.

EFFECTIVE DATE. This section is effective July 1, 2022.

Sec. 3. Minnesota Statutes 2020, section 62Q.1055, is amended to read:

62Q.1055 CHEMICAL DEPENDENCY.

All health plan companies shall use the assessment criteria in ~~Minnesota Rules, parts 9530.6600 to 9530.6655,~~ section 245G.05 when assessing and ~~placing~~ treating enrollees for chemical dependency treatment.

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EFFECTIVE DATE. This section is effective July 1, 2022.

Sec. 3. Minnesota Statutes 2020, section 62Q.47, is amended to read:

62Q.47 ALCOHOLISM, MENTAL HEALTH, AND CHEMICAL DEPENDENCY SERVICES.

(a) All health plans, as defined in section 62Q.01, that provide coverage for alcoholism, mental health, or chemical dependency services, must comply with the requirements of this section.

(b) Cost-sharing requirements and benefit or service limitations for outpatient mental health and outpatient chemical dependency and alcoholism services, except for persons ~~placed in~~ seeking chemical dependency services under ~~Minnesota Rules, parts 9530.6600 to 9530.6655~~ section 245G.05, must not place a greater financial burden on the insured or enrollee, or be more restrictive than those requirements and limitations for outpatient medical services.

(c) Cost-sharing requirements and benefit or service limitations for inpatient hospital mental health and inpatient hospital and residential chemical dependency and alcoholism services, except for persons ~~placed in~~ seeking chemical dependency services under ~~Minnesota Rules, parts 9530.6600 to 9530.6655~~ section 245G.05, must not place a greater financial burden on the insured or enrollee, or be more restrictive than those requirements and limitations for inpatient hospital medical services.

(d) A health plan company must not impose an NQTL with respect to mental health and substance use disorders in any classification of benefits unless, under the terms of the health plan as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the NQTL to mental health and substance use disorders in the classification are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the NQTL with respect to medical and surgical benefits in the same classification.

(e) All health plans must meet the requirements of the federal Mental Health Parity Act of 1996, Public Law 104-204; Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008; the Affordable Care Act; and any amendments to, and federal guidance or regulations issued under, those acts.

(f) The commissioner may require information from health plan companies to confirm that mental health parity is being implemented by the health plan company. Information required may include comparisons between mental health and substance use disorder treatment and other medical conditions, including a comparison of prior authorization requirements, drug formulary design, claim denials, rehabilitation services, and other information the commissioner deems appropriate.

(g) Regardless of the health care provider's professional license, if the service provided is consistent with the provider's scope of practice and the health plan company's credentialing

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EFFECTIVE DATE. This section is effective July 1, 2022.

Sec. 4. Minnesota Statutes 2020, section 62Q.47, is amended to read:

62Q.47 ALCOHOLISM, MENTAL HEALTH, AND CHEMICAL DEPENDENCY SERVICES.

(a) All health plans, as defined in section 62Q.01, that provide coverage for alcoholism, mental health, or chemical dependency services, must comply with the requirements of this section.

(b) Cost-sharing requirements and benefit or service limitations for outpatient mental health and outpatient chemical dependency and alcoholism services, except for persons ~~placed in~~ seeking chemical dependency services under ~~Minnesota Rules, parts 9530.6600 to 9530.6655~~ section 245G.05, must not place a greater financial burden on the insured or enrollee, or be more restrictive than those requirements and limitations for outpatient medical services.

(c) Cost-sharing requirements and benefit or service limitations for inpatient hospital mental health and inpatient hospital and residential chemical dependency and alcoholism services, except for persons ~~placed in~~ seeking chemical dependency services under ~~Minnesota Rules, parts 9530.6600 to 9530.6655~~ section 245G.05, must not place a greater financial burden on the insured or enrollee, or be more restrictive than those requirements and limitations for inpatient hospital medical services.

(d) A health plan company must not impose an NQTL with respect to mental health and substance use disorders in any classification of benefits unless, under the terms of the health plan as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the NQTL to mental health and substance use disorders in the classification are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the NQTL with respect to medical and surgical benefits in the same classification.

(e) All health plans must meet the requirements of the federal Mental Health Parity Act of 1996, Public Law 104-204; Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008; the Affordable Care Act; and any amendments to, and federal guidance or regulations issued under, those acts.

(f) The commissioner may require information from health plan companies to confirm that mental health parity is being implemented by the health plan company. Information required may include comparisons between mental health and substance use disorder treatment and other medical conditions, including a comparison of prior authorization requirements, drug formulary design, claim denials, rehabilitation services, and other information the commissioner deems appropriate.

(g) Regardless of the health care provider's professional license, if the service provided is consistent with the provider's scope of practice and the health plan company's credentialing

and contracting provisions, mental health therapy visits and medication maintenance visits shall be considered primary care visits for the purpose of applying any enrollee cost-sharing requirements imposed under the enrollee's health plan.

(h) By June 1 of each year, beginning June 1, 2021, the commissioner of commerce, in consultation with the commissioner of health, shall submit a report on compliance and oversight to the chairs and ranking minority members of the legislative committees with jurisdiction over health and commerce. The report must:

(1) describe the commissioner's process for reviewing health plan company compliance with United States Code, title 42, section 18031(j), any federal regulations or guidance relating to compliance and oversight, and compliance with this section and section 62Q.53;

(2) identify any enforcement actions taken by either commissioner during the preceding 12-month period regarding compliance with parity for mental health and substance use disorders benefits under state and federal law, summarizing the results of any market conduct examinations. The summary must include: (i) the number of formal enforcement actions taken; (ii) the benefit classifications examined in each enforcement action; and (iii) the subject matter of each enforcement action, including quantitative and nonquantitative treatment limitations;

(3) detail any corrective action taken by either commissioner to ensure health plan company compliance with this section, section 62Q.53, and United States Code, title 42, section 18031(j); and

(4) describe the information provided by either commissioner to the public about alcoholism, mental health, or chemical dependency parity protections under state and federal law.

The report must be written in nontechnical, readily understandable language and must be made available to the public by, among other means as the commissioners find appropriate, posting the report on department websites. Individually identifiable information must be excluded from the report, consistent with state and federal privacy protections.

EFFECTIVE DATE. This section is effective July 1, 2022.

and contracting provisions, mental health therapy visits and medication maintenance visits shall be considered primary care visits for the purpose of applying any enrollee cost-sharing requirements imposed under the enrollee's health plan.

(h) By June 1 of each year, beginning June 1, 2021, the commissioner of commerce, in consultation with the commissioner of health, shall submit a report on compliance and oversight to the chairs and ranking minority members of the legislative committees with jurisdiction over health and commerce. The report must:

(1) describe the commissioner's process for reviewing health plan company compliance with United States Code, title 42, section 18031(j), any federal regulations or guidance relating to compliance and oversight, and compliance with this section and section 62Q.53;

(2) identify any enforcement actions taken by either commissioner during the preceding 12-month period regarding compliance with parity for mental health and substance use disorders benefits under state and federal law, summarizing the results of any market conduct examinations. The summary must include: (i) the number of formal enforcement actions taken; (ii) the benefit classifications examined in each enforcement action; and (iii) the subject matter of each enforcement action, including quantitative and nonquantitative treatment limitations;

(3) detail any corrective action taken by either commissioner to ensure health plan company compliance with this section, section 62Q.53, and United States Code, title 42, section 18031(j); and

(4) describe the information provided by either commissioner to the public about alcoholism, mental health, or chemical dependency parity protections under state and federal law.

The report must be written in nontechnical, readily understandable language and must be made available to the public by, among other means as the commissioners find appropriate, posting the report on department websites. Individually identifiable information must be excluded from the report, consistent with state and federal privacy protections.

EFFECTIVE DATE. This section is effective July 1, 2022.

Sec. 5. Minnesota Statutes 2020, section 144.294, subdivision 2, is amended to read:

Subd. 2. **Disclosure to law enforcement agency.** Notwithstanding section 144.293, subdivisions 2 and 4, a provider must disclose health records relating to a patient's mental health to a law enforcement agency if the law enforcement agency provides the name of the patient and communicates that the:

(1) patient is currently involved in ~~an emergency interaction with~~ a mental health crisis as defined in section 256B.0624, subdivision 2, paragraph (j), to which the law enforcement agency has responded; and

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Sec. 4. Minnesota Statutes 2020, section 169A.70, subdivision 3, is amended to read:

Subd. 3. **Assessment report.** (a) The assessment report must be on a form prescribed by the commissioner and shall contain an evaluation of the convicted defendant concerning the defendant's prior traffic and criminal record, characteristics and history of alcohol and chemical use problems, and amenability to rehabilitation through the alcohol safety program. The report is classified as private data on individuals as defined in section 13.02, subdivision 12.

(b) The assessment report must include:

(1) a diagnosis of the nature of the offender's chemical and alcohol involvement;

(2) an assessment of the severity level of the involvement;

(3) a recommended level of care for the offender in accordance with the criteria contained in ~~rules adopted by the commissioner of human services under section 254A.03, subdivision 3 (chemical dependency treatment rules)~~ section 245G.05;

(4) an assessment of the offender's placement needs;

(5) recommendations for other appropriate remedial action or care, including aftercare services in section 254B.01, subdivision 3, that may consist of educational programs, one-on-one counseling, a program or type of treatment that addresses mental health concerns, or a combination of them; and

(6) a specific explanation why no level of care or action was recommended, if applicable.

EFFECTIVE DATE. This section is effective July 1, 2022.

Sec. 5. Minnesota Statutes 2020, section 169A.70, subdivision 4, is amended to read:

Subd. 4. **Assessor standards; rules; assessment time limits.** A chemical use assessment required by this section must be conducted by an assessor appointed by the court. The

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(2) disclosure of the records is necessary to protect the health or safety of the patient or of another person.

The scope of disclosure under this subdivision is limited to the minimum necessary for law enforcement to safely respond to the ~~emergency~~ mental health crisis. The disclosure may include the name and telephone number of the psychiatrist, psychologist, therapist, mental health professional, practitioner, or case manager of the patient, if known; and strategies to address the mental health crisis. A law enforcement agency that obtains health records under this subdivision shall maintain a record of the requestor, the provider of the information, and the patient's name. Health records obtained by a law enforcement agency under this subdivision are private data on individuals as defined in section 13.02, subdivision 12, and must not be used by law enforcement for any other purpose. A law enforcement agency that obtains health records under this subdivision shall inform the patient that health records were obtained.

Sec. 6. Minnesota Statutes 2020, section 169A.70, subdivision 3, is amended to read:

Subd. 3. **Assessment report.** (a) The assessment report must be on a form prescribed by the commissioner and shall contain an evaluation of the convicted defendant concerning the defendant's prior traffic and criminal record, characteristics and history of alcohol and chemical use problems, and amenability to rehabilitation through the alcohol safety program. The report is classified as private data on individuals as defined in section 13.02, subdivision 12.

(b) The assessment report must include:

(1) a diagnosis of the nature of the offender's chemical and alcohol involvement;

(2) an assessment of the severity level of the involvement;

(3) a recommended level of care for the offender in accordance with the criteria contained in ~~rules adopted by the commissioner of human services under section 254A.03, subdivision 3 (chemical dependency treatment rules)~~ section 245G.05;

(4) an assessment of the offender's placement needs;

(5) recommendations for other appropriate remedial action or care, including aftercare services in section 254B.01, subdivision 3, that may consist of educational programs, one-on-one counseling, a program or type of treatment that addresses mental health concerns, or a combination of them; and

(6) a specific explanation why no level of care or action was recommended, if applicable.

EFFECTIVE DATE. This section is effective July 1, 2022.

Sec. 7. Minnesota Statutes 2020, section 169A.70, subdivision 4, is amended to read:

Subd. 4. **Assessor standards; rules; assessment time limits.** A chemical use assessment required by this section must be conducted by an assessor appointed by the court. The

assessor must meet the training and qualification requirements of ~~rules adopted by the commissioner of human services under section 254A.03, subdivision 3 (chemical dependency treatment rules)~~ section 245G.11, subdivisions 1 and 5. Notwithstanding section 13.82 (law enforcement data), the assessor shall have access to any police reports, laboratory test results, and other law enforcement data relating to the current offense or previous offenses that are necessary to complete the evaluation. ~~An assessor providing an assessment under this section may not have any direct or shared financial interest or referral relationship resulting in shared financial gain with a treatment provider, except as authorized under section 254A.19, subdivision 3. If an independent assessor is not available, the court may use the services of an assessor authorized to perform assessments for the county social services agency under a variance granted under rules adopted by the commissioner of human services under section 254A.03, subdivision 3.~~ An appointment for the defendant to undergo the assessment must be made by the court, a court services probation officer, or the court administrator as soon as possible but in no case more than one week after the defendant's court appearance. The assessment must be completed no later than three weeks after the defendant's court appearance. If the assessment is not performed within this time limit, the county where the defendant is to be sentenced shall perform the assessment. The county of financial responsibility must be determined under chapter 256G.

EFFECTIVE DATE. This section is effective July 1, 2022.

Sec. 6. **[245.4866] CHILDREN'S MENTAL HEALTH COMMUNITY OF PRACTICE.**

Subdivision 1. **Establishment; purpose.** The commissioner of human services, in consultation with children's mental health subject matter experts, shall establish a children's mental health community of practice. The purposes of the community of practice are to improve treatment outcomes for children and adolescents with mental illness and reduce disparities. The community of practice shall use evidence-based and best practices through peer-to-peer and person-to-provider sharing.

Subd. 2. **Participants; meetings.** (a) The community of practice must include the following participants:

(1) researchers or members of the academic community who are children's mental health subject matter experts who do not have financial relationships with treatment providers;

(2) children's mental health treatment providers;

(3) a representative from a mental health advocacy organization;

(4) a representative from the Department of Human Services;

(5) a representative from the Department of Health;

(6) a representative from the Department of Education;

assessor must meet the training and qualification requirements of ~~rules adopted by the commissioner of human services under section 254A.03, subdivision 3 (chemical dependency treatment rules)~~ section 245G.11, subdivisions 1 and 5. Notwithstanding section 13.82 (law enforcement data), the assessor shall have access to any police reports, laboratory test results, and other law enforcement data relating to the current offense or previous offenses that are necessary to complete the evaluation. ~~An assessor providing an assessment under this section may not have any direct or shared financial interest or referral relationship resulting in shared financial gain with a treatment provider, except as authorized under section 254A.19, subdivision 3. If an independent assessor is not available, the court may use the services of an assessor authorized to perform assessments for the county social services agency under a variance granted under rules adopted by the commissioner of human services under section 254A.03, subdivision 3.~~ An appointment for the defendant to undergo the assessment must be made by the court, a court services probation officer, or the court administrator as soon as possible but in no case more than one week after the defendant's court appearance. The assessment must be completed no later than three weeks after the defendant's court appearance. If the assessment is not performed within this time limit, the county where the defendant is to be sentenced shall perform the assessment. The county of financial responsibility must be determined under chapter 256G.

EFFECTIVE DATE. This section is effective July 1, 2022.

(7) representatives from county social services agencies;

(8) representatives from Tribal nations or Tribal social services providers; and

(9) representatives from managed care organizations.

(b) The community of practice must include, to the extent possible, individuals and family members who have used mental health treatment services and must highlight the voices and experiences of individuals who are Black, Indigenous, people of color, and people from other communities that are disproportionately impacted by mental illness.

(c) The community of practice must meet regularly and must hold its first meeting before January 1, 2023.

(d) Compensation and reimbursement for expenses for participants in paragraph (b) are governed by section 15.059, subdivision 3.

Subd. 3. **Duties.** (a) The community of practice must:

(1) identify gaps in children's mental health treatment services;

(2) enhance collective knowledge of issues related to children's mental health;

(3) understand evidence-based practices, best practices, and promising approaches to address children's mental health;

(4) use knowledge gathered through the community of practice to develop strategic plans to improve outcomes for children who participate in mental health treatment and related services in Minnesota;

(5) increase knowledge about the challenges and opportunities learned by implementing strategies; and

(6) develop capacity for community advocacy.

(b) The commissioner, in collaboration with subject matter experts and other participants, may issue reports and recommendations to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services policy and finance and to local and regional governments.

Sec. 7. Minnesota Statutes 2020, section 245.4882, is amended by adding a subdivision to read:

Subd. 2a. **Assessment requirements.** (a) A residential treatment service provider must complete a diagnostic assessment of a child within ten calendar days of the child's admission. If a diagnostic assessment has been completed by a mental health professional within the past 180 days, a new diagnostic assessment need not be completed unless in the opinion of the current treating mental health professional the child's mental health status has changed markedly since the assessment was completed.

(b) The service provider must complete the screenings required by Minnesota Rules, part 2960.0070, subpart 5, within ten calendar days.

Sec. 8. Minnesota Statutes 2020, section 245.4882, is amended by adding a subdivision to read:

Subd. 6. **Crisis admissions and stabilization.** (a) A child may be referred for residential treatment services under this section for the purpose of crisis stabilization by:

(1) a mental health professional as defined in section 245I.04, subdivision 2;

(2) a physician licensed under chapter 147 who is assessing a child in an emergency department; or

(3) a member of a mobile crisis team who meets the qualifications under section 256B.0624, subdivision 5.

(b) A provider making a referral under paragraph (a) must conduct an assessment of the child's mental health needs and make a determination that the child is experiencing a mental health crisis and is in need of residential treatment services under this section.

(c) A child may receive services under this subdivision for up to 30 days and must be subject to the screening and admissions criteria and processes under section 245.4885 thereafter.

Sec. 9. Minnesota Statutes 2021 Supplement, section 245.4885, subdivision 1, is amended to read:

Subdivision 1. **Admission criteria.** (a) Prior to admission or placement, except in the case of an emergency, all children referred for treatment of severe emotional disturbance in a treatment foster care setting, residential treatment facility, or informally admitted to a regional treatment center shall undergo an assessment to determine the appropriate level of care if county funds are used to pay for the child's services. An emergency includes when a child is in need of and has been referred for crisis stabilization services under section 245.4882, subdivision 6. A child who has been referred to residential treatment for crisis stabilization services in a residential treatment center is not required to undergo an assessment under this section.

(b) The county board shall determine the appropriate level of care for a child when county-controlled funds are used to pay for the child's residential treatment under this chapter, including residential treatment provided in a qualified residential treatment program as defined in section 260C.007, subdivision 26d. When a county board does not have responsibility for a child's placement and the child is enrolled in a prepaid health program under section 256B.69, the enrolled child's contracted health plan must determine the appropriate level of care for the child. When Indian Health Services funds or funds of a tribally owned facility funded under the Indian Self-Determination and Education Assistance Act, Public Law 93-638, are used for the child, the Indian Health Services or 638 tribal health facility must determine the appropriate level of care for the child. When more than

one entity bears responsibility for a child's coverage, the entities shall coordinate level of care determination activities for the child to the extent possible.

(c) The child's level of care determination shall determine whether the proposed treatment:

(1) is necessary;

(2) is appropriate to the child's individual treatment needs;

(3) cannot be effectively provided in the child's home; and

(4) provides a length of stay as short as possible consistent with the individual child's needs.

(d) When a level of care determination is conducted, the county board or other entity may not determine that a screening of a child, referral, or admission to a residential treatment facility is not appropriate solely because services were not first provided to the child in a less restrictive setting and the child failed to make progress toward or meet treatment goals in the less restrictive setting. The level of care determination must be based on a diagnostic assessment of a child that evaluates the child's family, school, and community living situations; and an assessment of the child's need for care out of the home using a validated tool which assesses a child's functional status and assigns an appropriate level of care to the child. The validated tool must be approved by the commissioner of human services and may be the validated tool approved for the child's assessment under section 260C.704 if the juvenile treatment screening team recommended placement of the child in a qualified residential treatment program. If a diagnostic assessment has been completed by a mental health professional within the past 180 days, a new diagnostic assessment need not be completed unless in the opinion of the current treating mental health professional the child's mental health status has changed markedly since the assessment was completed. The child's parent shall be notified if an assessment will not be completed and of the reasons. A copy of the notice shall be placed in the child's file. Recommendations developed as part of the level of care determination process shall include specific community services needed by the child and, if appropriate, the child's family, and shall indicate whether these services are available and accessible to the child and the child's family. The child and the child's family must be invited to any meeting where the level of care determination is discussed and decisions regarding residential treatment are made. The child and the child's family may invite other relatives, friends, or advocates to attend these meetings.

(e) During the level of care determination process, the child, child's family, or child's legal representative, as appropriate, must be informed of the child's eligibility for case management services and family community support services and that an individual family community support plan is being developed by the case manager, if assigned.

(f) The level of care determination, placement decision, and recommendations for mental health services must be documented in the child's record and made available to the child's family, as appropriate.

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Sec. 10. Minnesota Statutes 2021 Supplement, section 245.4889, subdivision 1, is amended to read:

Subdivision 1. **Establishment and authority.** (a) The commissioner is authorized to make grants from available appropriations to assist:

(1) counties;

(2) Indian tribes;

(3) children's collaboratives under section 124D.23 or 245.493; ~~or~~

(4) mental health service providers~~.~~; or

(5) school districts and charter schools.

(b) The following services are eligible for grants under this section:

(1) services to children with emotional disturbances as defined in section 245.4871, subdivision 15, and their families;

(2) transition services under section 245.4875, subdivision 8, for young adults under age 21 and their families;

(3) respite care services for children with emotional disturbances or severe emotional disturbances who are at risk of out-of-home placement or already in out-of-home placement and at risk of change in placement or a higher level of care. Allowable activities and expenses for respite care services are defined under subdivision 4. A child is not required to have case management services to receive respite care services;

(4) children's mental health crisis services;

(5) mental health services for people from cultural and ethnic minorities, including supervision of clinical trainees who are Black, indigenous, or people of color;

(6) children's mental health screening and follow-up diagnostic assessment and treatment;

(7) services to promote and develop the capacity of providers to use evidence-based practices in providing children's mental health services;

(8) school-linked mental health services under section 245.4901;

(9) building evidence-based mental health intervention capacity for children birth to age five;

(10) suicide prevention and counseling services that use text messaging statewide;

(11) mental health first aid training;

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Sec. 8. Minnesota Statutes 2021 Supplement, section 245.4889, subdivision 1, is amended to read:

Subdivision 1. **Establishment and authority.** (a) The commissioner is authorized to make grants from available appropriations to assist:

(1) counties;

(2) Indian tribes;

(3) children's collaboratives under section 124D.23 or 245.493; or

(4) mental health service providers.

(b) The following services are eligible for grants under this section:

(1) services to children with emotional disturbances as defined in section 245.4871, subdivision 15, and their families;

(2) transition services under section 245.4875, subdivision 8, for young adults under age 21 and their families;

(3) respite care services for children with emotional disturbances or severe emotional disturbances who are at risk of out-of-home placement or already in out-of-home placement in family foster settings as defined in chapter 245A and at risk of change in out-of-home placement or placement in a residential facility or other higher level of care. Allowable activities and expenses for respite care services are defined under subdivision 4. A child is not required to have case management services to receive respite care services;

(4) children's mental health crisis services;

(5) mental health services for people from cultural and ethnic minorities, including supervision of clinical trainees who are Black, indigenous, or people of color;

(6) children's mental health screening and follow-up diagnostic assessment and treatment;

(7) services to promote and develop the capacity of providers to use evidence-based practices in providing children's mental health services;

(8) school-linked mental health services under section 245.4901;

(9) building evidence-based mental health intervention capacity for children birth to age five;

(10) suicide prevention and counseling services that use text messaging statewide;

(11) mental health first aid training;

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(12) training for parents, collaborative partners, and mental health providers on the impact of adverse childhood experiences and trauma and development of an interactive website to share information and strategies to promote resilience and prevent trauma;

(13) transition age services to develop or expand mental health treatment and supports for adolescents and young adults 26 years of age or younger;

(14) early childhood mental health consultation;

(15) evidence-based interventions for youth at risk of developing or experiencing a first episode of psychosis, and a public awareness campaign on the signs and symptoms of psychosis;

(16) psychiatric consultation for primary care practitioners; ~~and~~

(17) providers to begin operations and meet program requirements when establishing a new children's mental health program. These may be start-up grants~~.~~; and

(18) intensive developmentally appropriate and culturally informed interventions for youth who are at risk of developing a mood disorder or experiencing a first episode of a mood disorder and a public awareness campaign on the signs and symptoms of mood disorders in youth.

(c) Services under paragraph (b) must be designed to help each child to function and remain with the child's family in the community and delivered consistent with the child's treatment plan. Transition services to eligible young adults under this paragraph must be designed to foster independent living in the community.

(d) As a condition of receiving grant funds, a grantee shall obtain all available third-party reimbursement sources, if applicable.

Sec. 11. Minnesota Statutes 2020, section 245.4889, is amended by adding a subdivision to read:

Subd. 4. **Covered respite care services.** Respite care services under subdivision 1, paragraph (b), clause (3), include hourly or overnight stays at a licensed foster home or with a qualified and approved family member or friend and may occur at a child's or a provider's home. Respite care services may also include the following activities and expenses:

(1) recreational, sport, and nonsport extracurricular activities and programs for the child such as camps, clubs, activities, lessons, group outings, sports, or other activities and programs;

(2) family activities, camps, and retreats that the whole family does together that provide a break from the family's circumstances;

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(12) training for parents, collaborative partners, and mental health providers on the impact of adverse childhood experiences and trauma and development of an interactive website to share information and strategies to promote resilience and prevent trauma;

(13) transition age services to develop or expand mental health treatment and supports for adolescents and young adults 26 years of age or younger;

(14) early childhood mental health consultation;

(15) evidence-based interventions for youth at risk of developing or experiencing a first episode of psychosis, and a public awareness campaign on the signs and symptoms of psychosis;

(16) psychiatric consultation for primary care practitioners; and

(17) providers to begin operations and meet program requirements when establishing a new children's mental health program. These may be start-up grants.

(c) Services under paragraph (b) must be designed to help each child to function and remain with the child's family in the community and delivered consistent with the child's treatment plan. Transition services to eligible young adults under this paragraph must be designed to foster independent living in the community.

(d) As a condition of receiving grant funds, a grantee shall obtain all available third-party reimbursement sources, if applicable.

EFFECTIVE DATE. This section is effective July 1, 2022.

Sec. 9. Minnesota Statutes 2020, section 245.4889, is amended by adding a subdivision to read:

Subd. 4. **Respite care services.** Respite care services under subdivision 1, paragraph (b), clause (3), include hourly or overnight stays at a licensed foster home or with a qualified and approved family member or friend and may occur at a child's or provider's home. Respite care services may also include the following activities and expenses:

(1) recreational, sport, and nonsport extracurricular activities and programs for the child including camps, clubs, lessons, group outings, sports, or other activities and programs;

(2) family activities, camps, and retreats that the family does together and provide a break from the family's circumstance;

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(3) cultural programs and activities for the child and family designed to address the unique needs of individuals who share a common language or racial, ethnic, or social background; and

(4) costs of transportation, food, supplies, and equipment directly associated with approved respite care services and expenses necessary for the child and family to access and participate in respite care services.

EFFECTIVE DATE. This section is effective July 1, 2022.

Sec. 12. **[245.4903] CULTURAL AND ETHNIC MINORITY INFRASTRUCTURE GRANT PROGRAM.**

Subdivision 1. **Establishment.** The commissioner of human services shall establish a cultural and ethnic minority infrastructure grant program to ensure that mental health and substance use disorder treatment supports and services are culturally specific and culturally responsive to meet the cultural needs of the communities served.

Subd. 2. **Eligible applicants.** An eligible applicant is a licensed entity or provider from a cultural or ethnic minority population who:

(1) provides mental health or substance use disorder treatment services and supports to individuals from cultural and ethnic minority populations, including individuals who are lesbian, gay, bisexual, transgender, or queer, from cultural and ethnic minority populations;

(2) provides or is qualified and has the capacity to provide clinical supervision and support to members of culturally diverse and ethnic minority communities to qualify as mental health and substance use disorder treatment providers; or

(3) has the capacity and experience to provide training for mental health and substance use disorder treatment providers on cultural competency and cultural humility.

Subd. 3. **Allowable grant activities.** (a) The cultural and ethnic minority infrastructure grant program grantees must engage in activities and provide supportive services to ensure and increase equitable access to culturally specific and responsive care and to build organizational and professional capacity for licensure and certification for the communities served. Allowable grant activities include but are not limited to:

(1) workforce development activities focused on recruiting, supporting, training, and supervision activities for mental health and substance use disorder practitioners and professionals from diverse racial, cultural, and ethnic communities;

(2) supporting members of culturally diverse and ethnic minority communities to qualify as mental health and substance use disorder professionals, practitioners, clinical supervisors, recovery peer specialists, mental health certified peer specialists, and mental health certified family peer specialists;

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(3) cultural programs and activities for the child and family designed to address the unique needs of individuals who share a common language, racial, ethnic, or social background; and

(4) costs of transportation, food, supplies, and equipment directly associated with approved respite care services and expenses necessary for the child and family to access and participate in respite care services.

EFFECTIVE DATE. This section is effective July 1, 2022.

(3) culturally specific outreach, early intervention, trauma-informed services, and recovery support in mental health and substance use disorder services;

(4) provision of trauma-informed, culturally responsive mental health and substance use disorder supports and services for children and families, youth, or adults who are from cultural and ethnic minority backgrounds and are uninsured or underinsured;

(5) mental health and substance use disorder service expansion and infrastructure improvement activities, particularly in greater Minnesota;

(6) training for mental health and substance use disorder treatment providers on cultural competency and cultural humility; and

(7) activities to increase the availability of culturally responsive mental health and substance use disorder services for children and families, youth, or adults or to increase the availability of substance use disorder services for individuals from cultural and ethnic minorities in the state.

(b) The commissioner must assist grantees with meeting third-party credentialing requirements, and grantees must obtain all available third-party reimbursement sources as a condition of receiving grant funds. Grantees must serve individuals from cultural and ethnic minority communities regardless of health coverage status or ability to pay.

Subd. 4. **Data collection and outcomes.** Grantees must provide regular data summaries to the commissioner for purposes of evaluating the effectiveness of the cultural and ethnic minority infrastructure grant program. The commissioner must use identified culturally appropriate outcome measures instruments to evaluate outcomes and must evaluate program activities by analyzing whether the program:

(1) increased access to culturally specific services for individuals from cultural and ethnic minority communities across the state;

(2) increased number of individuals from cultural and ethnic minority communities served by grantees;

(3) increased cultural responsiveness and cultural competency of mental health and substance use disorder treatment providers;

(4) increased number of mental health and substance use disorder treatment providers and clinical supervisors from cultural and ethnic minority communities;

(5) increased number of mental health and substance use disorder treatment organizations owned, managed, or led by individuals who are Black, Indigenous, or people of color;

(6) reduced in health disparities through improved clinical and functional outcomes for those accessing services; and

(7) led to an overall increase in culturally specific mental health and substance use disorder service availability.

Sec. 13. **[245.4904] EMERGING MOOD DISORDER GRANT PROGRAM.**

Subdivision 1. **Creation.** (a) The emerging mood disorder grant program is established in the Department of Human Services to fund:

(1) evidence-informed interventions for youth and young adults who are at risk of developing a mood disorder or are experiencing an emerging mood disorder, including major depression and bipolar disorders; and

(2) a public awareness campaign on the signs and symptoms of mood disorders in youth and young adults.

(b) Emerging mood disorder services are eligible for children's mental health grants as specified in section 245.4889, subdivision 1, paragraph (b), clause (18).

Subd. 2. **Activities.** (a) All emerging mood disorder grant programs must:

(1) provide intensive treatment and support to adolescents and young adults experiencing or at risk of experiencing an emerging mood disorder. Intensive treatment and support includes medication management, psychoeducation for the individual and the individual's family, case management, employment support, education support, cognitive behavioral approaches, social skills training, peer support, crisis planning, and stress management;

(2) conduct outreach and provide training and guidance to mental health and health care professionals, including postsecondary health clinicians, on early symptoms of mood disorders, screening tools, and best practices;

(3) ensure access for individuals to emerging mood disorder services under this section, including ensuring access for individuals who live in rural areas; and

(4) use all available funding streams.

(b) Grant money may also be used to pay for housing or travel expenses for individuals receiving services or to address other barriers preventing individuals and their families from participating in emerging mood disorder services.

(c) Grant money may be used by the grantee to evaluate the efficacy of providing intensive services and supports to people with emerging mood disorders.

Subd. 3. **Eligibility.** Program activities must be provided to youth and young adults with early signs of an emerging mood disorder.

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

(1) whether individuals experience a reduction in mood disorder symptoms; and

(2) whether individuals experience a decrease in inpatient mental health hospitalizations.

Sec. 14. **[245.4905] FIRST EPISODE OF PSYCHOSIS GRANT PROGRAM.**

Subdivision 1. **Creation.** The first episode of psychosis grant program is established in the Department of Human Services to fund evidence-based interventions for youth at risk of developing or experiencing a first episode of psychosis and a public awareness campaign on the signs and symptoms of psychosis. First episode of psychosis services are eligible for children's mental health grants as specified in section 245.4889, subdivision 1, paragraph (b), clause (15).

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

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

(2) conduct outreach and provide training and guidance to mental health and health care professionals, including postsecondary health clinicians, on early psychosis symptoms, screening tools, and best practices;

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

(4) use all available funding streams.

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

Subd. 3. **Eligibility.** Program activities must be provided to people 15 to 40 years old with early signs of psychosis.

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

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

(2) whether individuals experience a decrease in inpatient mental health hospitalizations; and

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

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

Sec. 15. Minnesota Statutes 2020, section 245.713, subdivision 2, is amended to read:

Subd. 2. **Total funds available; allocation.** Funds granted to the state by the federal government under United States Code, title 42, sections 300X to 300X-9 each federal fiscal year for mental health services must be allocated as follows:

(a) Any amount set aside by the commissioner of human services for American Indian organizations within the state, which funds shall not duplicate any direct federal funding of American Indian organizations and which funds shall be at least 25 percent of the total federal allocation to the state for mental health services~~; provided that sufficient applications for funding are received by the commissioner which meet the specifications contained in requests for proposals~~. Money from this source may be used for special committees to advise the commissioner on mental health programs and services for American Indians and other minorities or underserved groups. For purposes of this subdivision, "American Indian organization" means an American Indian tribe or band or an organization providing mental health services that is legally incorporated as a nonprofit organization registered with the secretary of state and governed by a board of directors having at least a majority of American Indian directors.

(b) An amount not to exceed five percent of the federal block grant allocation for mental health services to be retained by the commissioner for administration.

(c) Any amount permitted under federal law which the commissioner approves for demonstration or research projects for severely disturbed children and adolescents, the underserved, special populations or multiply disabled mentally ill persons. The groups to be served, the extent and nature of services to be provided, the amount and duration of any grant awards are to be based on criteria set forth in the Alcohol, Drug Abuse and Mental Health Block Grant Law, United States Code, title 42, sections 300X to 300X-9, and on state policies and procedures determined necessary by the commissioner. Grant recipients must comply with applicable state and federal requirements and demonstrate fiscal and program management capabilities that will result in provision of quality, cost-effective services.

(d) The amount required under federal law, for federally mandated expenditures.

(e) An amount not to exceed 15 percent of the federal block grant allocation for mental health services to be retained by the commissioner for planning and evaluation.

EFFECTIVE DATE. This section is effective July 1, 2022.

Sec. 16. **[245.991] PROJECTS FOR ASSISTANCE IN TRANSITION FROM HOMELESSNESS PROGRAM.**

Subdivision 1. **Creation.** The projects for assistance in transition from homelessness program is established in the Department of Human Services to prevent or end homelessness for people with serious mental illness and substance use disorders and ensure the

commissioner may achieve the goals of the housing mission statement in section 245.461, subdivision 4.

Subd. 2. **Activities.** All projects for assistance in transition from homelessness must provide homeless outreach and case management services. Projects may provide clinical assessment, habilitation and rehabilitation services, community mental health services, substance use disorder treatment, housing transition and sustaining services, direct assistance funding, and other activities as determined by the commissioner.

Subd. 3. **Eligibility.** Program activities must be provided to people with serious mental illness or a substance use disorder who meet homeless criteria determined by the commissioner. People receiving homeless outreach may be presumed eligible until a serious mental illness or a substance use disorder can be verified.

Subd. 4. **Outcomes.** Evaluation of each project must include the following outcome evaluation criteria:

(1) whether people are contacted through homeless outreach services;

(2) whether people are enrolled in case management services;

(3) whether people access behavioral health services; and

(4) whether people transition from homelessness to housing.

Subd. 5. **Federal aid or grants.** The commissioner of human services must comply with all conditions and requirements necessary to receive federal aid or grants with respect to homeless services or programs as specified in section 245.70.

Sec. 17. **[245.992] HOUSING WITH SUPPORT FOR BEHAVIORAL HEALTH.**

Subdivision 1. **Creation.** The housing with support for behavioral health program is established in the Department of Human Services to prevent or end homelessness for people with serious mental illness and substance use disorders, increase the availability of housing with support, and ensure the commissioner may achieve the goals of the housing mission statement in section 245.461, subdivision 4.

Subd. 2. **Activities.** The housing with support for behavioral health program may provide a range of activities and supportive services to ensure that people obtain and retain permanent supportive housing. Program activities may include case management, site-based housing services, housing transition and sustaining services, outreach services, community support services, direct assistance funding, and other activities as determined by the commissioner.

Subd. 3. **Eligibility.** Program activities must be provided to people with a serious mental illness or a substance use disorder who meet homeless criteria determined by the commissioner.

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

(1) whether housing and activities utilize evidence-based practices;

(2) whether people transition from homelessness to housing;

(3) whether people retain housing; and

(4) whether people are satisfied with their current housing.

Sec. 18. Minnesota Statutes 2021 Supplement, section 245A.043, subdivision 3, is amended to read:

Subd. 3. **Change of ownership process.** (a) When a change in ownership is proposed and the party intends to assume operation without an interruption in service longer than 60 days after acquiring the program or service, the license holder must provide the commissioner with written notice of the proposed change on a form provided by the commissioner at least 60 days before the anticipated date of the change in ownership. For purposes of this subdivision and subdivision 4, "party" means the party that intends to operate the service or program.

(b) The party must submit a license application under this chapter on the form and in the manner prescribed by the commissioner at least 30 days before the change in ownership is complete, and must include documentation to support the upcoming change. The party must comply with background study requirements under chapter 245C and shall pay the application fee required under section 245A.10. A party that intends to assume operation without an interruption in service longer than 60 days after acquiring the program or service is exempt from the requirements of sections 245G.03, subdivision 2, paragraph (b), and 254B.03, subdivision 2, paragraphs ~~(d)~~ (c) and ~~(e)~~ (d).

(c) The commissioner may streamline application procedures when the party is an existing license holder under this chapter and is acquiring a program licensed under this chapter or service in the same service class as one or more licensed programs or services the party operates and those licenses are in substantial compliance. For purposes of this subdivision, "substantial compliance" means within the previous 12 months the commissioner did not (1) issue a sanction under section 245A.07 against a license held by the party, or (2) make a license held by the party conditional according to section 245A.06.

(d) Except when a temporary change in ownership license is issued pursuant to subdivision 4, the existing license holder is solely responsible for operating the program according to applicable laws and rules until a license under this chapter is issued to the party.

(e) If a licensing inspection of the program or service was conducted within the previous 12 months and the existing license holder's license record demonstrates substantial compliance with the applicable licensing requirements, the commissioner may waive the party's inspection required by section 245A.04, subdivision 4. The party must submit to the

commissioner (1) proof that the premises was inspected by a fire marshal or that the fire marshal deemed that an inspection was not warranted, and (2) proof that the premises was inspected for compliance with the building code or that no inspection was deemed warranted.

(f) If the party is seeking a license for a program or service that has an outstanding action under section 245A.06 or 245A.07, the party must submit a letter as part of the application process identifying how the party has or will come into full compliance with the licensing requirements.

(g) The commissioner shall evaluate the party's application according to section 245A.04, subdivision 6. If the commissioner determines that the party has remedied or demonstrates the ability to remedy the outstanding actions under section 245A.06 or 245A.07 and has determined that the program otherwise complies with all applicable laws and rules, the commissioner shall issue a license or conditional license under this chapter. The conditional license remains in effect until the commissioner determines that the grounds for the action are corrected or no longer exist.

(h) The commissioner may deny an application as provided in section 245A.05. An applicant whose application was denied by the commissioner may appeal the denial according to section 245A.05.

(i) This subdivision does not apply to a licensed program or service located in a home where the license holder resides.

Sec. 19. **[245A.26] CHILDREN'S RESIDENTIAL FACILITY CRISIS STABILIZATION SERVICES.**

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

(b) "Clinical trainee" means a staff person who is qualified under section 245I.04, subdivision 6.

(c) "License holder" means an individual, organization, or government entity that was issued a license by the commissioner of human services under this chapter for residential mental health treatment for children with emotional disturbance according to Minnesota Rules, parts 2960.0010 to 2960.0220 and 2960.0580 to 2960.0700, or shelter care services according to Minnesota Rules, parts 2960.0010 to 2960.0120 and 2960.0510 to 2960.0530.

(d) "Mental health professional" means an individual who is qualified under section 245I.04, subdivision 2.

Subd. 2. **Scope and applicability.** (a) This section establishes additional licensing requirements for a children's residential facility to provide children's residential crisis stabilization services to a child who is experiencing a mental health crisis and is in need of residential treatment services.

(b) A children's residential facility may provide residential crisis stabilization services only if the facility is licensed to provide:

(1) residential mental health treatment for children with emotional disturbance according to Minnesota Rules, parts 2960.0010 to 2960.0220 and 2960.0580 to 2960.0700; or

(2) shelter care services according to Minnesota Rules, parts 2960.0010 to 2960.0120 and 2960.0510 to 2960.0530.

(c) If a child receives residential crisis stabilization services for 35 days or fewer in a facility licensed according to paragraph (b), clause (1), the facility is not required to complete a diagnostic assessment or treatment plan under Minnesota Rules, part 2960.0180, subpart 2, and part 2960.0600.

(d) If a child receives residential crisis stabilization services for 35 days or fewer in a facility licensed according to paragraph (b), clause (2), the facility is not required to develop a plan for meeting the child's immediate needs under Minnesota Rules, part 2960.0520, subpart 3.

Subd. 3. **Eligibility for services.** An individual is eligible for children's residential crisis stabilization services if the individual is under 19 years of age and meets the eligibility criteria for crisis services under section 256B.0624, subdivision 3.

Subd. 4. **Required services; providers.** (a) A license holder providing residential crisis stabilization services must continually follow a child's individual crisis treatment plan to improve the child's functioning.

(b) The license holder must offer and have the capacity to directly provide the following treatment services to a child:

(1) crisis stabilization services as described in section 256B.0624, subdivision 7;

(2) mental health services as specified in the child's individual crisis treatment plan, according to the child's treatment needs;

(3) health services and medication administration, if applicable; and

(4) referrals for the child to community-based treatment providers and support services for the child's transition from residential crisis stabilization to another treatment setting.

(c) Children's residential crisis stabilization services must be provided by a qualified staff person listed in section 256B.0624, subdivision 8, according to the scope of practice for the individual staff person's position.

Subd. 5. **Assessment and treatment planning.** (a) Within 24 hours of a child's admission for residential crisis stabilization, the license holder must assess the child and document the child's immediate needs, including the child's:

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

(2) need for connection to family and other natural supports.

(b) Within 24 hours of a child's admission for residential crisis stabilization, the license holder must complete a crisis treatment plan for the child, according to the requirements for a crisis treatment plan under section 256B.0624, subdivision 11. The license holder must base the child's crisis treatment plan on the child's referral information and the assessment of the child's immediate needs under paragraph (a). A mental health professional or a clinical trainee under the supervision of a mental health professional must complete the crisis treatment plan. A crisis treatment plan completed by a clinical trainee must contain documentation of approval, as defined in section 245I.02, subdivision 2, by a mental health professional within five business days of initial completion by the clinical trainee.

(c) A mental health professional must review a child's crisis treatment plan each week and document the weekly reviews in the child's client file.

(d) For a client receiving children's residential crisis stabilization services who is 18 years of age or older, the license holder must complete an individual abuse prevention plan for the client, pursuant to section 245A.65, subdivision 2, as part of the client's crisis treatment plan.

Subd. 6. **Staffing requirements.** Staff members of facilities providing services under this section must have access to a mental health professional or clinical trainee within 30 minutes, either in person or by telephone. The license holder must maintain a current schedule of available mental health professionals or clinical trainees and include contact information for each mental health professional or clinical trainee. The schedule must be readily available to all staff members.

Sec. 20. Minnesota Statutes 2020, section 245F.03, is amended to read:

245F.03 APPLICATION.

(a) This chapter establishes minimum standards for withdrawal management programs licensed by the commissioner that serve one or more unrelated persons.

(b) This chapter does not apply to a withdrawal management program licensed as a hospital under sections 144.50 to 144.581. A withdrawal management program located in a hospital licensed under sections 144.50 to 144.581 that chooses to be licensed under this chapter is deemed to be in compliance with section 245F.13.

~~(c) Minnesota Rules, parts 9530.6600 to 9530.6655, do not apply to withdrawal management programs licensed under this chapter.~~

EFFECTIVE DATE. This section is effective July 1, 2022.

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Sec. 10. Minnesota Statutes 2020, section 245F.03, is amended to read:

245F.03 APPLICATION.

(a) This chapter establishes minimum standards for withdrawal management programs licensed by the commissioner that serve one or more unrelated persons.

(b) This chapter does not apply to a withdrawal management program licensed as a hospital under sections 144.50 to 144.581. A withdrawal management program located in a hospital licensed under sections 144.50 to 144.581 that chooses to be licensed under this chapter is deemed to be in compliance with section 245F.13.

~~(c) Minnesota Rules, parts 9530.6600 to 9530.6655, do not apply to withdrawal management programs licensed under this chapter.~~

EFFECTIVE DATE. This section is effective July 1, 2022.

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Sec. 21. Minnesota Statutes 2020, section 245G.05, subdivision 2, is amended to read:

Subd. 2. **Assessment summary.** (a) An alcohol and drug counselor must complete an assessment summary within three calendar days from the day of service initiation for a residential program and within three calendar days on which a treatment session has been provided from the day of service initiation for a client in a nonresidential program. The comprehensive assessment summary is complete upon a qualified staff member's dated signature. If the comprehensive assessment is used to authorize the treatment service, the alcohol and drug counselor must prepare an assessment summary on the same date the comprehensive assessment is completed. If the comprehensive assessment and assessment summary are to authorize treatment services, the assessor must determine appropriate level of care and services for the client using the ~~dimensions in Minnesota Rules, part 9530.6622~~ criteria established in section 254B.04, subdivision 4, and document the recommendations.

(b) An assessment summary must include:

(1) a risk description according to section 245G.05 for each dimension listed in paragraph (c);

(2) a narrative summary supporting the risk descriptions; and

(3) a determination of whether the client has a substance use disorder.

(c) An assessment summary must contain information relevant to treatment service planning and recorded in the dimensions in clauses (1) to (6). The license holder must consider:

(1) Dimension 1, acute intoxication/withdrawal potential; the client's ability to cope with withdrawal symptoms and current state of intoxication;

(2) Dimension 2, biomedical conditions and complications; the degree to which any physical disorder of the client would interfere with treatment for substance use, and the client's ability to tolerate any related discomfort. The license holder must determine the impact of continued substance use on the unborn child, if the client is pregnant;

(3) Dimension 3, emotional, behavioral, and cognitive conditions and complications; the degree to which any condition or complication is likely to interfere with treatment for substance use or with functioning in significant life areas and the likelihood of harm to self or others;

(4) Dimension 4, readiness for change; the support necessary to keep the client involved in treatment service;

(5) Dimension 5, relapse, continued use, and continued problem potential; the degree to which the client recognizes relapse issues and has the skills to prevent relapse of either substance use or mental health problems; and

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Sec. 11. Minnesota Statutes 2020, section 245G.05, subdivision 2, is amended to read:

Subd. 2. **Assessment summary.** (a) An alcohol and drug counselor must complete an assessment summary within three calendar days from the day of service initiation for a residential program and within three calendar days on which a treatment session has been provided from the day of service initiation for a client in a nonresidential program. The comprehensive assessment summary is complete upon a qualified staff member's dated signature. If the comprehensive assessment is used to authorize the treatment service, the alcohol and drug counselor must prepare an assessment summary on the same date the comprehensive assessment is completed. If the comprehensive assessment and assessment summary are to authorize treatment services, the assessor must determine appropriate level of care and services for the client using the ~~dimensions in Minnesota Rules, part 9530.6622~~ criteria established in section 254B.04, subdivision 4, and document the recommendations.

(b) An assessment summary must include:

(1) a risk description according to section 245G.05 for each dimension listed in paragraph (c);

(2) a narrative summary supporting the risk descriptions; and

(3) a determination of whether the client has a substance use disorder.

(c) An assessment summary must contain information relevant to treatment service planning and recorded in the dimensions in clauses (1) to (6). The license holder must consider:

(1) Dimension 1, acute intoxication/withdrawal potential; the client's ability to cope with withdrawal symptoms and current state of intoxication;

(2) Dimension 2, biomedical conditions and complications; the degree to which any physical disorder of the client would interfere with treatment for substance use, and the client's ability to tolerate any related discomfort. The license holder must determine the impact of continued substance use on the unborn child, if the client is pregnant;

(3) Dimension 3, emotional, behavioral, and cognitive conditions and complications; the degree to which any condition or complication is likely to interfere with treatment for substance use or with functioning in significant life areas and the likelihood of harm to self or others;

(4) Dimension 4, readiness for change; the support necessary to keep the client involved in treatment service;

(5) Dimension 5, relapse, continued use, and continued problem potential; the degree to which the client recognizes relapse issues and has the skills to prevent relapse of either substance use or mental health problems; and

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(6) Dimension 6, recovery environment; whether the areas of the client's life are supportive of or antagonistic to treatment participation and recovery.

EFFECTIVE DATE. This section is effective July 1, 2022.

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(6) Dimension 6, recovery environment; whether the areas of the client's life are supportive of or antagonistic to treatment participation and recovery.

EFFECTIVE DATE. This section is effective July 1, 2022.

Sec. 12. Minnesota Statutes 2020, section 245G.07, subdivision 1, is amended to read:

Subdivision 1. **Treatment service.** (a) A licensed residential treatment program must offer the treatment services in clauses (1) to (5) to each client, unless clinically inappropriate and the justifying clinical rationale is documented. A nonresidential treatment program must offer all treatment services in clauses (1) to (5) and document in the individual treatment plan the specific services for which a client has an assessed need and the plan to provide the services:

(1) individual and group counseling to help the client identify and address needs related to substance use and develop strategies to avoid harmful substance use after discharge and to help the client obtain the services necessary to establish a lifestyle free of the harmful effects of substance use disorder;

(2) client education strategies to avoid inappropriate substance use and health problems related to substance use and the necessary lifestyle changes to regain and maintain health. Client education must include information on tuberculosis education on a form approved by the commissioner, the human immunodeficiency virus according to section 245A.19, other sexually transmitted diseases, drug and alcohol use during pregnancy, and hepatitis. Client education must also include education on naloxone by a formalized training program or onsite registered nurse, and must include the process for the administration of naloxone, overdose awareness, and locations where naloxone can be obtained;

(3) a service to help the client integrate gains made during treatment into daily living and to reduce the client's reliance on a staff member for support;

(4) a service to address issues related to co-occurring disorders, including client education on symptoms of mental illness, the possibility of comorbidity, and the need for continued medication compliance while recovering from substance use disorder. A group must address co-occurring disorders, as needed. When treatment for mental health problems is indicated, the treatment must be integrated into the client's individual treatment plan; and

(5) treatment coordination provided one-to-one by an individual who meets the staff qualifications in section 245G.11, subdivision 7. Treatment coordination services include:

(i) assistance in coordination with significant others to help in the treatment planning process whenever possible;

(ii) assistance in coordination with and follow up for medical services as identified in the treatment plan;

(iii) facilitation of referrals to substance use disorder services as indicated by a client's medical provider, comprehensive assessment, or treatment plan;

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Sec. 22. Minnesota Statutes 2020, section 245G.22, subdivision 2, is amended to read:

Subd. 2. **Definitions.** (a) For purposes of this section, the terms defined in this subdivision have the meanings given them.

(b) "Diversion" means the use of a medication for the treatment of opioid addiction being diverted from intended use of the medication.

(c) "Guest dose" means administration of a medication used for the treatment of opioid addiction to a person who is not a client of the program that is administering or dispensing the medication.

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(iv) facilitation of referrals to mental health services as identified by a client's comprehensive assessment or treatment plan;

(v) assistance with referrals to economic assistance, social services, housing resources, and prenatal care according to the client's needs;

(vi) life skills advocacy and support accessing treatment follow-up, disease management, and education services, including referral and linkages to long-term services and supports as needed; and

(vii) documentation of the provision of treatment coordination services in the client's file.

(b) A treatment service provided to a client must be provided according to the individual treatment plan and must consider cultural differences and special needs of a client.

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

Sec. 13. Minnesota Statutes 2020, section 245G.08, subdivision 3, is amended to read:

Subd. 3. **Standing order protocol.** A license holder ~~that maintains~~ must maintain a proper supply of naloxone available for emergency treatment of opioid overdose on site in a conspicuous location and must have a written standing order protocol by a physician who is licensed under chapter 147 or advanced practice registered nurse who is licensed under chapter 148, that permits the license holder to maintain a supply of naloxone on site. A license holder must require staff to undergo training in the specific mode of administration used at the program, which may include intranasal administration, intramuscular injection, or both.

Sec. 14. Minnesota Statutes 2020, section 245G.21, is amended by adding a subdivision to read:

Subd. 9. **Denial of medication.** A license holder cannot deny medications and pharmacotherapies to a client if such medications and pharmacotherapies are prescribed by a licensed physician.

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

Sec. 15. Minnesota Statutes 2020, section 245G.22, subdivision 2, is amended to read:

Subd. 2. **Definitions.** (a) For purposes of this section, the terms defined in this subdivision have the meanings given them.

(b) "Diversion" means the use of a medication for the treatment of opioid addiction being diverted from intended use of the medication.

(c) "Guest dose" means administration of a medication used for the treatment of opioid addiction to a person who is not a client of the program that is administering or dispensing the medication.

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(d) "Medical director" means a practitioner licensed to practice medicine in the jurisdiction that the opioid treatment program is located who assumes responsibility for administering all medical services performed by the program, either by performing the services directly or by delegating specific responsibility to a practitioner of the opioid treatment program.

(e) "Medication used for the treatment of opioid use disorder" means a medication approved by the Food and Drug Administration for the treatment of opioid use disorder.

(f) "Minnesota health care programs" has the meaning given in section 256B.0636.

(g) "Opioid treatment program" has the meaning given in Code of Federal Regulations, title 42, section 8.12, and includes programs licensed under this chapter.

~~(h) "Placing authority" has the meaning given in Minnesota Rules, part 9530.6605, subpart 21a.~~

~~(i)~~ (h) "Practitioner" means a staff member holding a current, unrestricted license to practice medicine issued by the Board of Medical Practice or nursing issued by the Board of Nursing and is currently registered with the Drug Enforcement Administration to order or dispense controlled substances in Schedules II to V under the Controlled Substances Act, United States Code, title 21, part B, section 821. Practitioner includes an advanced practice registered nurse and physician assistant if the staff member receives a variance by the state opioid treatment authority under section 254A.03 and the federal Substance Abuse and Mental Health Services Administration.

~~(j)~~ (i) "Unsupervised use" means the use of a medication for the treatment of opioid use disorder dispensed for use by a client outside of the program setting.

EFFECTIVE DATE. This section is effective July 1, 2022.

Sec. 23. Minnesota Statutes 2020, section 245G.22, subdivision 15, is amended to read:

Subd. 15. **Nonmedication treatment services; documentation.** ~~(a) The program must offer at least 50 consecutive minutes of individual or group therapy treatment services as defined in section 245G.07, subdivision 1, paragraph (a), clause (1), per week, for the first ten weeks following the day of service initiation, and at least 50 consecutive minutes per month thereafter. As clinically appropriate, the program may offer these services cumulatively and not consecutively in increments of no less than 15 minutes over the required time period, and for a total of 60 minutes of treatment services over the time period, and must document the reason for providing services cumulatively in the client's record. The program may offer additional levels of service when deemed clinically necessary.~~

(a) The program must meet the requirements in section 245G.07, subdivision 1, paragraph (a), and must document each occurrence when the program offered the client an individual or group counseling service. If the program offered an individual or group counseling service but did not provide the service to the client, the program must document the reason the service was not provided. If the service is provided, the program must ensure that the staff

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(d) "Medical director" means a practitioner licensed to practice medicine in the jurisdiction that the opioid treatment program is located who assumes responsibility for administering all medical services performed by the program, either by performing the services directly or by delegating specific responsibility to a practitioner of the opioid treatment program.

(e) "Medication used for the treatment of opioid use disorder" means a medication approved by the Food and Drug Administration for the treatment of opioid use disorder.

(f) "Minnesota health care programs" has the meaning given in section 256B.0636.

(g) "Opioid treatment program" has the meaning given in Code of Federal Regulations, title 42, section 8.12, and includes programs licensed under this chapter.

~~(h) "Placing authority" has the meaning given in Minnesota Rules, part 9530.6605, subpart 21a.~~

~~(i)~~ (h) "Practitioner" means a staff member holding a current, unrestricted license to practice medicine issued by the Board of Medical Practice or nursing issued by the Board of Nursing and is currently registered with the Drug Enforcement Administration to order or dispense controlled substances in Schedules II to V under the Controlled Substances Act, United States Code, title 21, part B, section 821. Practitioner includes an advanced practice registered nurse and physician assistant if the staff member receives a variance by the state opioid treatment authority under section 254A.03 and the federal Substance Abuse and Mental Health Services Administration.

~~(j)~~ (i) "Unsupervised use" means the use of a medication for the treatment of opioid use disorder dispensed for use by a client outside of the program setting.

EFFECTIVE DATE. This section is effective July 1, 2022.

member who provides the treatment service documents in the client record the date, type, and amount of the treatment service and the client's response to the treatment service within seven days of providing the treatment service.

(b) Notwithstanding the requirements of comprehensive assessments in section 245G.05, the assessment must be completed within 21 days from the day of service initiation.

(c) Notwithstanding the requirements of individual treatment plans set forth in section 245G.06:

(1) treatment plan contents for a maintenance client are not required to include goals the client must reach to complete treatment and have services terminated;

(2) treatment plans for a client in a taper or detox status must include goals the client must reach to complete treatment and have services terminated; and

(3) for the ten weeks following the day of service initiation for all new admissions, readmissions, and transfers, a weekly treatment plan review must be documented once the treatment plan is completed. Subsequently, the counselor must document treatment plan reviews in the six dimensions at least once monthly or, when clinical need warrants, more frequently.

Sec. 24. Minnesota Statutes 2021 Supplement, section 245I.23, is amended by adding a subdivision to read:

Subd. 19a. **Additional requirements for locked program facility.** (a) A license holder that prohibits clients from leaving the facility by locking exit doors or other permissible methods must meet the additional requirements of this subdivision.

(b) The license holder must meet all applicable building and fire codes to operate a building with locked exit doors. The license holder must have the appropriate license from the Department of Health, as determined by the Department of Health, for operating a program with locked exit doors.

(c) The license holder's policies and procedures must clearly describe the types of court orders that authorize the license holder to prohibit clients from leaving the facility.

(d) For each client present in the facility under a court order, the license holder must maintain documentation of the court order authorizing the license holder to prohibit the client from leaving the facility.

(e) Upon a client's admission to a locked program facility, the license holder must document in the client file that the client was informed:

(1) that the client has the right to leave the facility according to the client's rights under section 144.651, subdivision 12, if the client is not subject to a court order authorizing the license holder to prohibit the client from leaving the facility; or

(2) that the client cannot leave the facility due to a court order authorizing the license holder to prohibit the client from leaving the facility.

(f) If the license holder prohibits a client from leaving the facility, the client's treatment plan must reflect this restriction.

Sec. 25. Minnesota Statutes 2021 Supplement, section 254A.03, subdivision 3, is amended to read:

Subd. 3. **Rules for substance use disorder care.** (a) ~~The commissioner of human services shall establish by rule criteria to be used in determining the appropriate level of chemical dependency care for each recipient of public assistance seeking treatment for substance misuse or substance use disorder. Upon federal approval of a comprehensive assessment as a Medicaid benefit, or on July 1, 2018, whichever is later, and notwithstanding the criteria in Minnesota Rules, parts 9530.6600 to 9530.6655,~~ An eligible vendor of comprehensive assessments under section 254B.05 may determine ~~and approve~~ the appropriate level of substance use disorder treatment for a recipient of public assistance. ~~The process for determining an individual's financial eligibility for the behavioral health fund or determining an individual's enrollment in or eligibility for a publicly subsidized health plan is not affected by the individual's choice to access a comprehensive assessment for placement.~~

(b) The commissioner shall develop and implement a utilization review process for publicly funded treatment placements to monitor and review the clinical appropriateness and timeliness of all publicly funded placements in treatment.

(c) If a screen result is positive for alcohol or substance misuse, a brief screening for alcohol or substance use disorder that is provided to a recipient of public assistance within a primary care clinic, hospital, or other medical setting or school setting establishes medical necessity and approval for an initial set of substance use disorder services identified in section 254B.05, subdivision 5. The initial set of services approved for a recipient whose screen result is positive may include any combination of up to four hours of individual or group substance use disorder treatment, two hours of substance use disorder treatment coordination, or two hours of substance use disorder peer support services provided by a qualified individual according to chapter 245G. A recipient must obtain an assessment pursuant to paragraph (a) to be approved for additional treatment services. ~~Minnesota Rules, parts 9530.6600 to 9530.6655, and~~ A comprehensive assessment pursuant to section 245G.05 ~~are not applicable~~ is not required to receive the initial set of services allowed under this subdivision. A positive screen result establishes eligibility for the initial set of services allowed under this subdivision.

(d) ~~Notwithstanding Minnesota Rules, parts 9530.6600 to 9530.6655,~~ An individual may choose to obtain a comprehensive assessment as provided in section 245G.05. Individuals obtaining a comprehensive assessment may access any enrolled provider that is licensed to provide the level of service authorized pursuant to section 254A.19, subdivision 3~~, paragraph (d)~~. If the individual is enrolled in a prepaid health plan, the individual must

Sec. 16. Minnesota Statutes 2021 Supplement, section 254A.03, subdivision 3, is amended to read:

Subd. 3. **Rules for substance use disorder care.** (a) ~~The commissioner of human services shall establish by rule criteria to be used in determining the appropriate level of chemical dependency care for each recipient of public assistance seeking treatment for substance misuse or substance use disorder. Upon federal approval of a comprehensive assessment as a Medicaid benefit, or on July 1, 2018, whichever is later, and notwithstanding the criteria in Minnesota Rules, parts 9530.6600 to 9530.6655,~~ An eligible vendor of comprehensive assessments under section 254B.05 may determine ~~and approve~~ the appropriate level of substance use disorder treatment for a recipient of public assistance. ~~The process for determining an individual's financial eligibility for the behavioral health fund or determining an individual's enrollment in or eligibility for a publicly subsidized health plan is not affected by the individual's choice to access a comprehensive assessment for placement.~~

(b) The commissioner shall develop and implement a utilization review process for publicly funded treatment placements to monitor and review the clinical appropriateness and timeliness of all publicly funded placements in treatment.

(c) If a screen result is positive for alcohol or substance misuse, a brief screening for alcohol or substance use disorder that is provided to a recipient of public assistance within a primary care clinic, hospital, or other medical setting or school setting establishes medical necessity and approval for an initial set of substance use disorder services identified in section 254B.05, subdivision 5. The initial set of services approved for a recipient whose screen result is positive may include any combination of up to four hours of individual or group substance use disorder treatment, two hours of substance use disorder treatment coordination, or two hours of substance use disorder peer support services provided by a qualified individual according to chapter 245G. A recipient must obtain an assessment pursuant to paragraph (a) to be approved for additional treatment services. ~~Minnesota Rules, parts 9530.6600 to 9530.6655, and~~ A comprehensive assessment pursuant to section 245G.05 ~~are not applicable~~ is not required to receive the initial set of services allowed under this subdivision. A positive screen result establishes eligibility for the initial set of services allowed under this subdivision.

(d) ~~Notwithstanding Minnesota Rules, parts 9530.6600 to 9530.6655,~~ An individual may choose to obtain a comprehensive assessment as provided in section 245G.05. Individuals obtaining a comprehensive assessment may access any enrolled provider that is licensed to provide the level of service authorized pursuant to section 254A.19, subdivision 3~~, paragraph (d)~~. If the individual is enrolled in a prepaid health plan, the individual must

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comply with any provider network requirements or limitations. ~~This paragraph expires July 1, 2022.~~

EFFECTIVE DATE. This section is effective July 1, 2022.

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comply with any provider network requirements or limitations. ~~This paragraph expires July 1, 2022.~~

EFFECTIVE DATE. This section is effective July 1, 2022.

Sec. 17. **[254A.087] SOBER HOUSES.**

Subdivision 1. **Definition.** "Sober house" means a cooperative living residence, a room and board residence, an apartment, or any other living accommodation that:

(1) provides temporary housing to persons with alcohol or other drug dependency or abuse problems in exchange for compensation;

(2) stipulates that residents must abstain from using alcohol or drugs not prescribed by a licensed physician, and meet other requirements as a condition of living in the residence;

(3) does not provide direct counseling or treatment services to the residents;

(4) does not deny medications or pharmacotherapies as prescribed by a licensed physician;

(5) provides lockboxes, controlled medication count, and urinalysis testing; and

(6) properly maintains a supply of naloxone on site in a conspicuous location.

Subd. 2. **Provision of counseling services.** Persons with alcohol or drug dependency or abuse problems residing in sober houses shall be:

(1) provided with naloxone training and education by a formalized training program or trained house manager. The training must include the process for administration of naloxone and a supply of naloxone must be kept on site in a conspicuous location; and

(2) provided with counseling and related services by alcohol and drug counselors licensed under chapter 148C, or referred by the sober house to counseling and related services provided by alcohol and drug counselors licensed under chapter 148C.

Subd. 3. **Notice; alternative living arrangements; referral for counseling.** Persons with alcohol or drug dependency or abuse problems receiving residential services shall be:

(1) provided with 48 hours written notice prior to discharge or termination of services, stating the reason for discharge and proposed alternative living arrangements as recommended by an assessment under Minnesota Rules, parts 9530.6600 to 9530.6655. Weekends and legal holidays are excluded when calculating the 48 hours' notice;

(2) provided alternative living arrangements to meet their needs as recommended by an assessment under Minnesota Rules, parts 9530.6600 to 9530.6655, if discharge from the program must occur prior to the expiration of 48 hours is deemed necessary by the facility;

(3) provided with information in writing who to contact to appeal the proposed discharge;

(4) informed of their right to request that designated individuals receive immediate notice of the proposed discharge by telephone, fax, or other means of communication. Weekends and legal holidays are excluded when calculating the 48 hours' notice; and

(5) referred to emergency services, detoxification services, or crisis facilities if relapse is the reason for discharge. The referral must be provided in a written form or by telephone, fax, or other means of communication.

Subd. 4. **Services by licensed providers.** (a) Residential or outpatient facilities licensed under chapter 245A shall only refer persons with alcohol or drug dependency or abuse problems, or their family members or others affected by the person's dependency or abuse, to persons licensed under chapter 148C or to facilities licensed under chapter 245A.

(b) If a referring facility has an economic interest in the referral, this interest shall be disclosed in writing and two alternative referrals shall be provided. A release of information for both parties must be presented to the person with alcohol or drug dependency or abuse or their family members or others affected by the person's dependency or abuse.

(c) Organizations and groups that do not receive compensation for their services, such as 12-step programs, are excluded from the requirements of this subdivision.

Subd. 5. **Resident property upon service termination.** Upon the service termination of a resident, a sober house must:

(1) return all property that belonged to a resident upon that resident's service termination regardless of that resident's service termination status;

(2) retain the resident's property for a minimum of seven days after the resident's service termination, if the resident did not claim the resident's property upon service termination; and

(3) retain the resident's property for a minimum of 30 days after the resident's service termination, if the resident did not claim the resident's property upon service termination and received room and board, emergency services, crisis services, detoxification services, or facility transfer.

Subd. 6. **Sober house management.** A sober house must:

(1) have written procedures for scheduled drug monitoring;

(2) have written procedures for counting and documenting a resident's controlled medications, including a standardized data collection tool for collecting, documenting, and filing daily controlled medications counts that includes the date, time, and the signature of the staff member taking the daily count of scheduled medications;

(3) have a statement that no medication supply for one resident shall be provided to another resident; and

Sec. 26. Minnesota Statutes 2020, section 254A.19, subdivision 1, is amended to read:

Subdivision 1. **Persons arrested outside of ~~home county~~ county of residence.** When a chemical use assessment is required ~~under Minnesota Rules, parts 9530.6600 to 9530.6655,~~ for a person who is arrested and taken into custody by a peace officer outside of the person's county of residence, the ~~assessment must be completed by the person's county of residence no later than three weeks after the assessment is initially requested. If the assessment is not performed within this time limit, the county where the person is to be sentenced shall perform the assessment~~ county where the person is detained must facilitate access to an assessor qualified under subdivision 3. The county of financial responsibility is determined under chapter 256G.

EFFECTIVE DATE. This section is effective July 1, 2022.

Sec. 27. Minnesota Statutes 2020, section 254A.19, subdivision 3, is amended to read:

Subd. 3. **~~Financial conflicts of interest~~ Comprehensive assessments.** ~~(a) Except as provided in paragraph (b), (c), or (d), an assessor conducting a chemical use assessment under Minnesota Rules, parts 9530.6600 to 9530.6655, may not have any direct or shared financial interest or referral relationship resulting in shared financial gain with a treatment provider.~~

~~(b) A county may contract with an assessor having a conflict described in paragraph (a) if the county documents that:~~

~~(1) the assessor is employed by a culturally specific service provider or a service provider with a program designed to treat individuals of a specific age, sex, or sexual preference;~~

~~(2) the county does not employ a sufficient number of qualified assessors and the only qualified assessors available in the county have a direct or shared financial interest or a referral relationship resulting in shared financial gain with a treatment provider; or~~

~~(3) the county social service agency has an existing relationship with an assessor or service provider and elects to enter into a contract with that assessor to provide both assessment and treatment under circumstances specified in the county's contract, provided the county retains responsibility for making placement decisions.~~

~~(c) The county may contract with a hospital to conduct chemical assessments if the requirements in subdivision 1a are met.~~

~~An assessor under this paragraph may not place clients in treatment. The assessor shall gather required information and provide it to the county along with any required~~

(4) file and store controlled medications counts for a minimum of two years.

EFFECTIVE DATE. This section is effective May 1, 2023.

Sec. 18. Minnesota Statutes 2020, section 254A.19, subdivision 1, is amended to read:

Subdivision 1. **Persons arrested outside of ~~home~~ county of residence.** When a chemical use assessment is required ~~under Minnesota Rules, parts 9530.6600 to 9530.6655,~~ for a person who is arrested and taken into custody by a peace officer outside of the person's county of residence, the ~~assessment must be completed by the person's county of residence no later than three weeks after the assessment is initially requested. If the assessment is not performed within this time limit, the county where the person is to be sentenced shall perform the assessment~~ county where the person is detained must facilitate access to an assessor qualified under subdivision 3. The county of financial responsibility is determined under chapter 256G.

EFFECTIVE DATE. This section is effective July 1, 2022.

Sec. 19. Minnesota Statutes 2020, section 254A.19, subdivision 3, is amended to read:

Subd. 3. **~~Financial conflicts of interest~~ Comprehensive assessments.** ~~(a) Except as provided in paragraph (b), (c), or (d), an assessor conducting a chemical use assessment under Minnesota Rules, parts 9530.6600 to 9530.6655, may not have any direct or shared financial interest or referral relationship resulting in shared financial gain with a treatment provider.~~

~~(b) A county may contract with an assessor having a conflict described in paragraph (a) if the county documents that:~~

~~(1) the assessor is employed by a culturally specific service provider or a service provider with a program designed to treat individuals of a specific age, sex, or sexual preference;~~

~~(2) the county does not employ a sufficient number of qualified assessors and the only qualified assessors available in the county have a direct or shared financial interest or a referral relationship resulting in shared financial gain with a treatment provider; or~~

~~(3) the county social service agency has an existing relationship with an assessor or service provider and elects to enter into a contract with that assessor to provide both assessment and treatment under circumstances specified in the county's contract, provided the county retains responsibility for making placement decisions.~~

~~(c) The county may contract with a hospital to conduct chemical assessments if the requirements in subdivision 1a are met.~~

~~An assessor under this paragraph may not place clients in treatment. The assessor shall gather required information and provide it to the county along with any required~~

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~~documentation. The county shall make all placement decisions for clients assessed by assessors under this paragraph.~~

~~(d)~~ An eligible vendor under section 254B.05 conducting a comprehensive assessment for an individual seeking treatment shall approve the nature, intensity level, and duration of treatment service if a need for services is indicated, but the individual assessed can access any enrolled provider that is licensed to provide the level of service authorized, including the provider or program that completed the assessment. If an individual is enrolled in a prepaid health plan, the individual must comply with any provider network requirements or limitations. An eligible vendor of a comprehensive assessment must provide information, in a format provided by the commissioner, on medical assistance and the behavioral health fund to individuals seeking an assessment.

EFFECTIVE DATE. This section is effective July 1, 2022.

Sec. 28. Minnesota Statutes 2021 Supplement, section 254A.19, subdivision 4, is amended to read:

Subd. 4. **Civil commitments.** ~~A Rule 25 assessment, under Minnesota Rules, part 9530.6615,~~ For the purposes of determining level of care, a comprehensive assessment does not need to be completed for an individual being committed as a chemically dependent person, as defined in section 253B.02, and for the duration of a civil commitment under section ~~253B.065,~~ 253B.09~~,~~ or 253B.095 in order for a county to access the behavioral health fund under section 254B.04. The county must determine if the individual meets the financial eligibility requirements for the behavioral health fund under section 254B.04. ~~Nothing in this subdivision prohibits placement in a treatment facility or treatment program governed under this chapter or Minnesota Rules, parts 9530.6600 to 9530.6655.~~

EFFECTIVE DATE. This section is effective July 1, 2022.

Sec. 29. Minnesota Statutes 2020, section 254A.19, is amended by adding a subdivision to read:

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

EFFECTIVE DATE. This section is effective July 1, 2022.

Sec. 30. Minnesota Statutes 2020, section 254A.19, is amended by adding a subdivision to read:

Subd. 7. **Assessments for children's residential facilities.** For children's residential facilities licensed under chapter 245A according to Minnesota Rules, parts 2960.0010 to 2960.0220 and 2960.0430 to 2960.0490, a "chemical use assessment" means a comprehensive

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~~documentation. The county shall make all placement decisions for clients assessed by assessors under this paragraph.~~

~~(d)~~ An eligible vendor under section 254B.05 conducting a comprehensive assessment for an individual seeking treatment shall approve the nature, intensity level, and duration of treatment service if a need for services is indicated, but the individual assessed can access any enrolled provider that is licensed to provide the level of service authorized, including the provider or program that completed the assessment. If an individual is enrolled in a prepaid health plan, the individual must comply with any provider network requirements or limitations. An eligible vendor of a comprehensive assessment must provide information, in a format provided by the commissioner, on medical assistance and the behavioral health fund to individuals seeking an assessment.

EFFECTIVE DATE. This section is effective July 1, 2022.

Sec. 20. Minnesota Statutes 2021 Supplement, section 254A.19, subdivision 4, is amended to read:

Subd. 4. **Civil commitments.** ~~A Rule 25 assessment, under Minnesota Rules, part 9530.6615,~~ For the purposes of determining level of care, a comprehensive assessment does not need to be completed for an individual being committed as a chemically dependent person, as defined in section 253B.02, and for the duration of a civil commitment under section ~~253B.065,~~ 253B.09~~,~~ or 253B.095 in order for a county to access the behavioral health fund under section 254B.04. The county must determine if the individual meets the financial eligibility requirements for the behavioral health fund under section 254B.04. ~~Nothing in this subdivision prohibits placement in a treatment facility or treatment program governed under this chapter or Minnesota Rules, parts 9530.6600 to 9530.6655.~~

EFFECTIVE DATE. This section is effective July 1, 2022.

Sec. 21. Minnesota Statutes 2020, section 254A.19, is amended by adding a subdivision to read:

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

EFFECTIVE DATE. This section is effective July 1, 2022.

Sec. 22. Minnesota Statutes 2020, section 254A.19, is amended by adding a subdivision to read:

Subd. 7. **Assessments for children's residential facilities.** For children's residential facilities licensed under chapter 245A according to Minnesota Rules, parts 2960.0010 to 2960.0220 and 2960.0430 to 2960.0500, a "chemical use assessment" means a comprehensive

assessment and assessment summary completed according to section 245G.05 by an individual who meets the qualifications of section 245G.11, subdivisions 1 and 5.

EFFECTIVE DATE. This section is effective July 1, 2022.

Sec. 31. Minnesota Statutes 2020, section 254B.01, is amended by adding a subdivision to read:

Subd. 2a. **Behavioral health fund.** "Behavioral health fund" means money allocated for payment of treatment services under this chapter.

EFFECTIVE DATE. This section is effective July 1, 2022.

Sec. 32. Minnesota Statutes 2020, section 254B.01, is amended by adding a subdivision to read:

Subd. 2b. **Client.** "Client" means an individual who has requested substance use disorder services, or for whom substance use disorder services have been requested.

EFFECTIVE DATE. This section is effective July 1, 2022.

Sec. 33. Minnesota Statutes 2020, section 254B.01, is amended by adding a subdivision to read:

Subd. 2c. **Co-payment.** "Co-payment" means the amount an insured person is obligated to pay before the person's third-party payment source is obligated to make a payment, or the amount an insured person is obligated to pay in addition to the amount the person's third-party payment source is obligated to pay.

EFFECTIVE DATE. This section is effective July 1, 2022.

Sec. 34. Minnesota Statutes 2020, section 254B.01, is amended by adding a subdivision to read:

Subd. 4c. **Department.** "Department" means the Department of Human Services.

EFFECTIVE DATE. This section is effective July 1, 2022.

Sec. 35. Minnesota Statutes 2020, section 254B.01, is amended by adding a subdivision to read:

Subd. 4d. **Drug and alcohol abuse normative evaluation system or DAANES.** "Drug and alcohol abuse normative evaluation system" or "DAANES" means the reporting system used to collect substance use disorder treatment data across all levels of care and providers.

EFFECTIVE DATE. This section is effective July 1, 2022.

Sec. 36. Minnesota Statutes 2020, section 254B.01, subdivision 5, is amended to read:

Subd. 5. **Local agency.** "Local agency" means the agency designated by a board of county commissioners, a local social services agency, or a human services board ~~to make~~

assessment and assessment summary completed according to section 245G.05 by an individual who meets the qualifications of section 245G.11, subdivisions 1 and 5.

EFFECTIVE DATE. This section is effective July 1, 2022.

Sec. 23. Minnesota Statutes 2020, section 254B.01, is amended by adding a subdivision to read:

Subd. 2a. **Behavioral health fund.** "Behavioral health fund" means money allocated for payment of treatment services under this chapter.

EFFECTIVE DATE. This section is effective July 1, 2022.

Sec. 24. Minnesota Statutes 2020, section 254B.01, is amended by adding a subdivision to read:

Subd. 2b. **Client.** "Client" means an individual who has requested substance use disorder services, or for whom substance use disorder services have been requested.

EFFECTIVE DATE. This section is effective July 1, 2022.

Sec. 25. Minnesota Statutes 2020, section 254B.01, is amended by adding a subdivision to read:

Subd. 2c. **Co-payment.** "Co-payment" means the amount an insured person is obligated to pay before the person's third-party payment source is obligated to make a payment, or the amount an insured person is obligated to pay in addition to the amount the person's third-party payment source is obligated to pay.

EFFECTIVE DATE. This section is effective July 1, 2022.

Sec. 26. Minnesota Statutes 2020, section 254B.01, is amended by adding a subdivision to read:

Subd. 4c. **Department.** "Department" means the Department of Human Services.

EFFECTIVE DATE. This section is effective July 1, 2022.

Sec. 27. Minnesota Statutes 2020, section 254B.01, is amended by adding a subdivision to read:

Subd. 4d. **Drug and alcohol abuse normative evaluation system or DAANES.** "Drug and alcohol abuse normative evaluation system" or "DAANES" means the reporting system used to collect substance use disorder treatment data across all levels of care and providers.

EFFECTIVE DATE. This section is effective July 1, 2022.

Sec. 28. Minnesota Statutes 2020, section 254B.01, subdivision 5, is amended to read:

Subd. 5. **Local agency.** "Local agency" means the agency designated by a board of county commissioners, a local social services agency, or a human services board ~~to make~~

~~placements and submit state invoices according to Laws 1986, chapter 394, sections 8 to 20~~ authorized under section 254B.03, subdivision 1, to determine financial eligibility for the behavioral health fund.

Sec. 37. Minnesota Statutes 2020, section 254B.01, is amended by adding a subdivision to read:

Subd. 6a. **Minor child.** "Minor child" means an individual under the age of 18 years.

EFFECTIVE DATE. This section is effective July 1, 2022.

Sec. 38. Minnesota Statutes 2020, section 254B.01, is amended by adding a subdivision to read:

Subd. 6b. **Policy holder.** "Policy holder" means a person who has a third-party payment policy under which a third-party payment source has an obligation to pay all or part of a client's treatment costs.

EFFECTIVE DATE. This section is effective July 1, 2022.

Sec. 39. Minnesota Statutes 2020, section 254B.01, is amended by adding a subdivision to read:

Subd. 9. **Responsible relative.** "Responsible relative" means a person who is a member of the client's household and is a client's spouse or the parent of a minor child who is a client.

EFFECTIVE DATE. This section is effective July 1, 2022.

Sec. 40. Minnesota Statutes 2020, section 254B.01, is amended by adding a subdivision to read:

Subd. 10. **Third-party payment source.** "Third-party payment source" means a person, entity, or public or private agency other than medical assistance or general assistance medical care that has a probable obligation to pay all or part of the costs of a client's substance use disorder treatment.

EFFECTIVE DATE. This section is effective July 1, 2022.

Sec. 41. Minnesota Statutes 2020, section 254B.01, is amended by adding a subdivision to read:

Subd. 11. **Vendor.** "Vendor" means a provider of substance use disorder treatment services that meets the criteria established in section 254B.05 and that has applied to participate as a provider in the medical assistance program according to Minnesota Rules, part 9505.0195.

EFFECTIVE DATE. This section is effective July 1, 2022.

~~placements and submit state invoices according to Laws 1986, chapter 394, sections 8 to 20~~ authorized under section 254B.03, subdivision 1, to determine financial eligibility for the behavioral health fund.

Sec. 29. Minnesota Statutes 2020, section 254B.01, is amended by adding a subdivision to read:

Subd. 6a. **Minor child.** "Minor child" means an individual under the age of 18 years.

EFFECTIVE DATE. This section is effective July 1, 2022.

Sec. 30. Minnesota Statutes 2020, section 254B.01, is amended by adding a subdivision to read:

Subd. 6b. **Policy holder.** "Policy holder" means a person who has a third-party payment policy under which a third-party payment source has an obligation to pay all or part of a client's treatment costs.

EFFECTIVE DATE. This section is effective July 1, 2022.

Sec. 31. Minnesota Statutes 2020, section 254B.01, is amended by adding a subdivision to read:

Subd. 9. **Responsible relative.** "Responsible relative" means a person who is a member of the client's household and is a client's spouse or the parent of a minor child who is a client.

EFFECTIVE DATE. This section is effective July 1, 2022.

Sec. 32. Minnesota Statutes 2020, section 254B.01, is amended by adding a subdivision to read:

Subd. 10. **Third-party payment source.** "Third-party payment source" means a person, entity, or public or private agency other than medical assistance or general assistance medical care that has a probable obligation to pay all or part of the costs of a client's substance use disorder treatment.

EFFECTIVE DATE. This section is effective July 1, 2022.

Sec. 33. Minnesota Statutes 2020, section 254B.01, is amended by adding a subdivision to read:

Subd. 11. **Vendor.** "Vendor" means a provider of substance use disorder treatment services that meets the criteria established in section 254B.05 and that has applied to participate as a provider in the medical assistance program according to Minnesota Rules, part 9505.0195.

EFFECTIVE DATE. This section is effective July 1, 2022.

House Language UES4410-2

Sec. 42. Minnesota Statutes 2020, section 254B.01, is amended by adding a subdivision to read:

Subd. 12. **American Society of Addiction Medicine criteria or ASAM criteria.** "American Society of Addiction Medicine criteria" or "ASAM criteria" means the clinical guidelines for purposes of the assessment, treatment, placement, and transfer or discharge of individuals with substance use disorders. The ASAM criteria are contained in the current edition of the ASAM Criteria: Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions.

EFFECTIVE DATE. This section is effective July 1, 2022.

Sec. 43. Minnesota Statutes 2020, section 254B.01, is amended by adding a subdivision to read:

Subd. 13. **Skilled treatment services.** "Skilled treatment services" means the "treatment services" described by section 245G.07, subdivisions 1, paragraph (a), clauses (1) to (4); and 2, clauses (1) to (6). Skilled treatment services must be provided by qualified professionals as identified in section 245G.07, subdivision 3.

EFFECTIVE DATE. This section is effective July 1, 2022.

Sec. 44. Minnesota Statutes 2020, section 254B.03, subdivision 1, is amended to read:

Subdivision 1. **Local agency duties.** (a) Every local agency ~~shall~~ must determine financial eligibility for substance use disorder services and provide ~~chemical dependency~~ substance use disorder services to persons residing within its jurisdiction who meet criteria established by the commissioner ~~for placement in a chemical dependency residential or nonresidential treatment service~~. Chemical dependency money must be administered by the local agencies according to law and rules adopted by the commissioner under sections 14.001 to 14.69.

(b) In order to contain costs, the commissioner of human services shall select eligible vendors of chemical dependency services who can provide economical and appropriate treatment. Unless the local agency is a social services department directly administered by a county or human services board, the local agency shall not be an eligible vendor under section 254B.05. The commissioner may approve proposals from county boards to provide services in an economical manner or to control utilization, with safeguards to ensure that necessary services are provided. If a county implements a demonstration or experimental medical services funding plan, the commissioner shall transfer the money as appropriate.

~~(c) A culturally specific vendor that provides assessments under a variance under Minnesota Rules, part 9530.6610, shall be allowed to provide assessment services to persons not covered by the variance.~~

~~(d) Notwithstanding Minnesota Rules, parts 9530.6600 to 9530.6655,~~ (c) An individual may choose to obtain a comprehensive assessment as provided in section 245G.05. Individuals obtaining a comprehensive assessment may access any enrolled provider that is licensed to provide the level of service authorized pursuant to section 254A.19, subdivision

Senate Language S4410-3

Sec. 34. Minnesota Statutes 2020, section 254B.01, is amended by adding a subdivision to read:

Subd. 12. **American Society of Addiction Medicine criteria or ASAM criteria.** "American Society of Addiction Medicine criteria" or "ASAM criteria" means the clinical guidelines for purposes of the assessment, treatment, placement, and transfer or discharge of individuals with substance use disorders. The ASAM criteria are contained in the current edition of the ASAM Criteria: Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions.

EFFECTIVE DATE. This section is effective July 1, 2022.

Sec. 35. Minnesota Statutes 2020, section 254B.01, is amended by adding a subdivision to read:

Subd. 13. **Skilled treatment services.** "Skilled treatment services" means the "treatment services" described by section 245G.07, subdivisions 1, paragraph (a), clauses (1) to (4); and 2, clauses (1) to (6). Skilled treatment services must be provided by qualified professionals as identified in section 245G.07, subdivision 3.

EFFECTIVE DATE. This section is effective July 1, 2022.

Sec. 36. Minnesota Statutes 2020, section 254B.03, subdivision 1, is amended to read:

Subdivision 1. **Local agency duties.** (a) Every local agency ~~shall~~ must determine financial eligibility for substance use disorder services and provide ~~chemical dependency~~ substance use disorder services to persons residing within its jurisdiction who meet criteria established by the commissioner ~~for placement in a chemical dependency residential or nonresidential treatment service~~. Chemical dependency money must be administered by the local agencies according to law and rules adopted by the commissioner under sections 14.001 to 14.69.

(b) In order to contain costs, the commissioner of human services shall select eligible vendors of chemical dependency services who can provide economical and appropriate treatment. Unless the local agency is a social services department directly administered by a county or human services board, the local agency shall not be an eligible vendor under section 254B.05. The commissioner may approve proposals from county boards to provide services in an economical manner or to control utilization, with safeguards to ensure that necessary services are provided. If a county implements a demonstration or experimental medical services funding plan, the commissioner shall transfer the money as appropriate.

~~(c) A culturally specific vendor that provides assessments under a variance under Minnesota Rules, part 9530.6610, shall be allowed to provide assessment services to persons not covered by the variance.~~

~~(d) Notwithstanding Minnesota Rules, parts 9530.6600 to 9530.6655,~~ (c) An individual may choose to obtain a comprehensive assessment as provided in section 245G.05. Individuals obtaining a comprehensive assessment may access any enrolled provider that is licensed to provide the level of service authorized pursuant to section 254A.19, subdivision

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3~~, paragraph (d)~~. If the individual is enrolled in a prepaid health plan, the individual must comply with any provider network requirements or limitations.

~~(c)~~ (d) Beginning July 1, 2022, local agencies shall not make placement location determinations.

EFFECTIVE DATE. This section is effective July 1, 2022.

Sec. 45. Minnesota Statutes 2021 Supplement, section 254B.03, subdivision 2, is amended to read:

Subd. 2. **Behavioral health fund payment.** (a) Payment from the behavioral health fund is limited to payments for services identified in section 254B.05, other than detoxification licensed under Minnesota Rules, parts 9530.6510 to 9530.6590, and detoxification provided in another state that would be required to be licensed as a chemical dependency program if the program were in the state. Out of state vendors must also provide the commissioner with assurances that the program complies substantially with state licensing requirements and possesses all licenses and certifications required by the host state to provide chemical dependency treatment. Vendors receiving payments from the behavioral health fund must not require co-payment from a recipient of benefits for services provided under this subdivision. The vendor is prohibited from using the client's public benefits to offset the cost of services paid under this section. The vendor shall not require the client to use public benefits for room or board costs. This includes but is not limited to cash assistance benefits under chapters 119B, 256D, and 256J, or SNAP benefits. Retention of SNAP benefits is a right of a client receiving services through the behavioral health fund or through state contracted managed care entities. Payment from the behavioral health fund shall be made for necessary room and board costs provided by vendors meeting the criteria under section 254B.05, subdivision 1a, or in a community hospital licensed by the commissioner of health according to sections 144.50 to 144.56 to a client who is:

(1) determined to meet the criteria for placement in a residential chemical dependency treatment program according to rules adopted under section 254A.03, subdivision 3; and

(2) concurrently receiving a chemical dependency treatment service in a program licensed by the commissioner and reimbursed by the behavioral health fund.

~~(b) A county may, from its own resources, provide chemical dependency services for which state payments are not made. A county may elect to use the same invoice procedures and obtain the same state payment services as are used for chemical dependency services for which state payments are made under this section if county payments are made to the state in advance of state payments to vendors. When a county uses the state system for payment, the commissioner shall make monthly billings to the county using the most recent available information to determine the anticipated services for which payments will be made in the coming month. Adjustment of any overestimate or underestimate based on actual~~

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3~~, paragraph (d)~~. If the individual is enrolled in a prepaid health plan, the individual must comply with any provider network requirements or limitations.

~~(c)~~ (d) Beginning July 1, 2022, local agencies shall not make placement location determinations.

EFFECTIVE DATE. This section is effective July 1, 2022.

Sec. 37. Minnesota Statutes 2021 Supplement, section 254B.03, subdivision 2, is amended to read:

Subd. 2. **Behavioral health fund payment.** (a) Payment from the behavioral health fund is limited to payments for services identified in section 254B.05, other than detoxification licensed under Minnesota Rules, parts 9530.6510 to 9530.6590, and detoxification provided in another state that would be required to be licensed as a chemical dependency program if the program were in the state. Out of state vendors must also provide the commissioner with assurances that the program complies substantially with state licensing requirements and possesses all licenses and certifications required by the host state to provide chemical dependency treatment. Vendors receiving payments from the behavioral health fund must not require co-payment from a recipient of benefits for services provided under this subdivision. The vendor is prohibited from using the client's public benefits to offset the cost of services paid under this section. The vendor shall not require the client to use public benefits for room or board costs. This includes but is not limited to cash assistance benefits under chapters 119B, 256D, and 256J, or SNAP benefits. Retention of SNAP benefits is a right of a client receiving services through the behavioral health fund or through state contracted managed care entities. Payment from the behavioral health fund shall be made for necessary room and board costs provided by vendors meeting the criteria under section 254B.05, subdivision 1a, or in a community hospital licensed by the commissioner of health according to sections 144.50 to 144.56 to a client who is:

(1) determined to meet the criteria for placement in a residential chemical dependency treatment program according to rules adopted under section 254A.03, subdivision 3; and

(2) concurrently receiving a chemical dependency treatment service in a program licensed by the commissioner and reimbursed by the behavioral health fund.

~~(b) A county may, from its own resources, provide chemical dependency services for which state payments are not made. A county may elect to use the same invoice procedures and obtain the same state payment services as are used for chemical dependency services for which state payments are made under this section if county payments are made to the state in advance of state payments to vendors. When a county uses the state system for payment, the commissioner shall make monthly billings to the county using the most recent available information to determine the anticipated services for which payments will be made in the coming month. Adjustment of any overestimate or underestimate based on actual~~

~~expenditures shall be made by the state agency by adjusting the estimate for any succeeding month.~~

~~(c)~~ (b) The commissioner shall coordinate chemical dependency services and determine whether there is a need for any proposed expansion of chemical dependency treatment services. The commissioner shall deny vendor certification to any provider that has not received prior approval from the commissioner for the creation of new programs or the expansion of existing program capacity. The commissioner shall consider the provider's capacity to obtain clients from outside the state based on plans, agreements, and previous utilization history, when determining the need for new treatment services.

~~(d)~~ (c) At least 60 days prior to submitting an application for new licensure under chapter 245G, the applicant must notify the county human services director in writing of the applicant's intent to open a new treatment program. The written notification must include, at a minimum:

(1) a description of the proposed treatment program; and

(2) a description of the target population to be served by the treatment program.

~~(e)~~ (d) The county human services director may submit a written statement to the commissioner, within 60 days of receiving notice from the applicant, regarding the county's support of or opposition to the opening of the new treatment program. The written statement must include documentation of the rationale for the county's determination. The commissioner shall consider the county's written statement when determining whether there is a need for the treatment program as required by paragraph ~~(c)~~ (b).

EFFECTIVE DATE. This section is effective July 1, 2022.

Sec. 46. Minnesota Statutes 2020, section 254B.03, subdivision 4, is amended to read:

Subd. 4. **Division of costs.** (a) Except for services provided by a county under section 254B.09, subdivision 1, or services provided under section 256B.69, the county shall, out of local money, pay the state for 22.95 percent of the cost of chemical dependency services, except for those services provided to persons enrolled in medical assistance under chapter 256B and room and board services under section 254B.05, subdivision 5, paragraph (b), clause ~~(12)~~ (11). Counties may use the indigent hospitalization levy for treatment and hospital payments made under this section.

(b) 22.95 percent of any state collections from private or third-party pay, less 15 percent for the cost of payment and collections, must be distributed to the county that paid for a portion of the treatment under this section.

Sec. 47. Minnesota Statutes 2020, section 254B.03, subdivision 5, is amended to read:

Subd. 5. **Rules; appeal.** The commissioner shall adopt rules as necessary to implement this chapter. ~~The commissioner shall establish an appeals process for use by recipients when services certified by the county are disputed. The commissioner shall adopt rules and~~

~~expenditures shall be made by the state agency by adjusting the estimate for any succeeding month.~~

~~(c)~~ (b) The commissioner shall coordinate chemical dependency services and determine whether there is a need for any proposed expansion of chemical dependency treatment services. The commissioner shall deny vendor certification to any provider that has not received prior approval from the commissioner for the creation of new programs or the expansion of existing program capacity. The commissioner shall consider the provider's capacity to obtain clients from outside the state based on plans, agreements, and previous utilization history, when determining the need for new treatment services.

~~(d)~~ (c) At least 60 days prior to submitting an application for new licensure under chapter 245G, the applicant must notify the county human services director in writing of the applicant's intent to open a new treatment program. The written notification must include, at a minimum:

(1) a description of the proposed treatment program; and

(2) a description of the target population to be served by the treatment program.

~~(e)~~ (d) The county human services director may submit a written statement to the commissioner, within 60 days of receiving notice from the applicant, regarding the county's support of or opposition to the opening of the new treatment program. The written statement must include documentation of the rationale for the county's determination. The commissioner shall consider the county's written statement when determining whether there is a need for the treatment program as required by paragraph ~~(c)~~ (b).

EFFECTIVE DATE. This section is effective July 1, 2022.

Sec. 38. Minnesota Statutes 2020, section 254B.03, subdivision 5, is amended to read:

Subd. 5. **Rules; appeal.** The commissioner shall adopt rules as necessary to implement this chapter. ~~The commissioner shall establish an appeals process for use by recipients when services certified by the county are disputed. The commissioner shall adopt rules and~~

~~standards for the appeal process to assure adequate redress for persons referred to inappropriate services.~~

EFFECTIVE DATE. This section is effective July 1, 2022.

Sec. 48. Minnesota Statutes 2021 Supplement, section 254B.04, subdivision 1, is amended to read:

Subdivision 1. **Client eligibility.** (a) Persons eligible for benefits under Code of Federal Regulations, title 25, part 20, who meet the income standards of section 256B.056, subdivision 4, and are not enrolled in medical assistance, are entitled to behavioral health fund services. State money appropriated for this paragraph must be placed in a separate account established for this purpose.

(b) Persons with dependent children who are determined to be in need of chemical dependency treatment pursuant to an assessment under section 260E.20, subdivision 1, or a case plan under section 260C.201, subdivision 6, or 260C.212, shall be assisted by the local agency to access needed treatment services. Treatment services must be appropriate for the individual or family, which may include long-term care treatment or treatment in a facility that allows the dependent children to stay in the treatment facility. The county shall pay for out-of-home placement costs, if applicable.

(c) Notwithstanding paragraph (a), persons enrolled in medical assistance are eligible for room and board services under section 254B.05, subdivision 5, paragraph (b), clause ~~(12)~~ (11).

(d) A client is eligible to have substance use disorder treatment paid for with funds from the behavioral health fund if:

(1) the client is eligible for MFIP as determined under chapter 256J;

(2) the client is eligible for medical assistance as determined under Minnesota Rules, parts 9505.0010 to 9505.0150;

(3) the client is eligible for general assistance, general assistance medical care, or work readiness as determined under Minnesota Rules, parts 9500.1200 to 9500.1272; or

(4) the client's income is within current household size and income guidelines for entitled persons, as defined in this subdivision and subdivision 7.

(e) Clients who meet the financial eligibility requirement in paragraph (a) and who have a third-party payment source are eligible for the behavioral health fund if the third-party payment source pays less than 100 percent of the cost of treatment services for eligible clients.

(f) A client is ineligible to have substance use disorder treatment services paid for by the behavioral health fund if the client:

~~standards for the appeal process to assure adequate redress for persons referred to inappropriate services.~~

EFFECTIVE DATE. This section is effective July 1, 2022.

Sec. 39. Minnesota Statutes 2021 Supplement, section 254B.04, subdivision 1, is amended to read:

Subdivision 1. **Client eligibility.** (a) Persons eligible for benefits under Code of Federal Regulations, title 25, part 20, who meet the income standards of section 256B.056, subdivision 4, and are not enrolled in medical assistance, are entitled to behavioral health fund services. State money appropriated for this paragraph must be placed in a separate account established for this purpose.

(b) Persons with dependent children who are determined to be in need of chemical dependency treatment pursuant to an assessment under section 260E.20, subdivision 1, or a case plan under section 260C.201, subdivision 6, or 260C.212, shall be assisted by the local agency to access needed treatment services. Treatment services must be appropriate for the individual or family, which may include long-term care treatment or treatment in a facility that allows the dependent children to stay in the treatment facility. The county shall pay for out-of-home placement costs, if applicable.

(c) Notwithstanding paragraph (a), persons enrolled in medical assistance are eligible for room and board services under section 254B.05, subdivision 5, paragraph (b), clause ~~(12)~~ (11).

(d) A client is eligible to have substance use disorder treatment paid for with funds from the behavioral health fund if:

(1) the client is eligible for MFIP as determined under chapter 256J;

(2) the client is eligible for medical assistance as determined under Minnesota Rules, parts 9505.0010 to 9505.0150;

(3) the client is eligible for general assistance or work readiness as determined under Minnesota Rules, parts 9500.1200 to 9500.1272; or

(4) the client's income is within current household size and income guidelines for entitled persons, as defined in this subdivision and subdivision 7.

(e) Clients who meet the financial eligibility requirement in paragraph (a) and who have a third-party payment source are eligible for the behavioral health fund if the third-party payment source pays less than 100 percent of the cost of treatment services for eligible clients.

(f) A client is ineligible to have substance use disorder treatment services paid for by the behavioral health fund if the client:

(1) has an income that exceeds current household size and income guidelines for entitled persons, as defined in this subdivision and subdivision 7; or

(2) has an available third-party payment source that will pay the total cost of the client's treatment.

(g) A client who is disenrolled from a state prepaid health plan during a treatment episode is eligible for continued treatment service paid for by the behavioral health fund until the treatment episode is completed or the client is re-enrolled in a state prepaid health plan if the client:

(1) continues to be enrolled in MinnesotaCare, medical assistance, or general assistance medical care; or

(2) is eligible according to paragraphs (a) and (b) and is determined eligible by a local agency under this section.

(h) If a county commits a client under chapter 253B to a regional treatment center for substance use disorder services and the client is ineligible for the behavioral health fund, the county is responsible for payment to the regional treatment center according to section 254B.05, subdivision 4.

EFFECTIVE DATE. This section is effective July 1, 2022.

Sec. 49. Minnesota Statutes 2020, section 254B.04, subdivision 2a, is amended to read:

Subd. 2a. **Eligibility for ~~treatment in residential settings~~ room and board services for persons in outpatient substance use disorder treatment.** ~~Notwithstanding provisions of Minnesota Rules, part 9530.6622, subparts 5 and 6, related to an assessor's discretion in making placements to residential treatment settings,~~ A person eligible for room and board services under ~~this~~ section 254B.05, subdivision 5, paragraph (b), clause (12), must score at level 4 on assessment dimensions related to readiness to change, relapse, continued use, or recovery environment ~~in order~~ to be assigned to services with a room and board component reimbursed under this section. Whether a treatment facility has been designated an institution for mental diseases under United States Code, title 42, section 1396d, shall not be a factor in making placements.

EFFECTIVE DATE. This section is effective July 1, 2022.

Sec. 50. Minnesota Statutes 2020, section 254B.04, is amended by adding a subdivision to read:

Subd. 4. **Assessment criteria and risk descriptions.** (a) The level of care determination must follow criteria approved by the commissioner.

(b) Dimension 1: the vendor must use the criteria in Dimension 1 to determine a client's acute intoxication and withdrawal potential.

(1) has an income that exceeds current household size and income guidelines for entitled persons, as defined in this subdivision and subdivision 7; or

(2) has an available third-party payment source that will pay the total cost of the client's treatment.

(g) A client who is disenrolled from a state prepaid health plan during a treatment episode is eligible for continued treatment service paid for by the behavioral health fund until the treatment episode is completed or the client is re-enrolled in a state prepaid health plan if the client:

(1) continues to be enrolled in MinnesotaCare, medical assistance, or general assistance medical care; or

(2) is eligible according to paragraphs (a) and (b) and is determined eligible by a local agency under this section.

(h) If a county commits a client under chapter 253B to a regional treatment center for substance use disorder services and the client is ineligible for the behavioral health fund, the county is responsible for payment to the regional treatment center according to section 254B.05, subdivision 4.

EFFECTIVE DATE. This section is effective July 1, 2022.

Sec. 40. Minnesota Statutes 2020, section 254B.04, subdivision 2a, is amended to read:

Subd. 2a. **Eligibility for ~~treatment in residential settings~~ room and board services for persons in outpatient substance use disorder treatment.** ~~Notwithstanding provisions of Minnesota Rules, part 9530.6622, subparts 5 and 6, related to an assessor's discretion in making placements to residential treatment settings,~~ A person eligible for room and board services under ~~this~~ section 254B.05, subdivision 5, paragraph (b), clause (12), must score at level 4 on assessment dimensions related to readiness to change, relapse, continued use, or recovery environment ~~in order~~ to be assigned to services with a room and board component reimbursed under this section. Whether a treatment facility has been designated an institution for mental diseases under United States Code, title 42, section 1396d, shall not be a factor in making placements.

EFFECTIVE DATE. This section is effective July 1, 2022.

Sec. 41. Minnesota Statutes 2020, section 254B.04, is amended by adding a subdivision to read:

Subd. 4. **Assessment criteria and risk descriptions.** (a) The level of care determination must follow criteria approved by the commissioner.

(b) Dimension 1: the vendor must use the criteria in Dimension 1 to determine a client's acute intoxication and withdrawal potential.

(1) "0" The client displays full functioning with good ability to tolerate and cope with withdrawal discomfort. The client displays no signs or symptoms of intoxication or withdrawal or diminishing signs or symptoms.

(2) "1" The client can tolerate and cope with withdrawal discomfort. The client displays mild to moderate intoxication or signs and symptoms interfering with daily functioning but does not immediately endanger self or others. The client poses minimal risk of severe withdrawal.

(3) "2" The client has some difficulty tolerating and coping with withdrawal discomfort. The client's intoxication may be severe, but the client responds to support and treatment such that the client does not immediately endanger self or others. The client displays moderate signs and symptoms with moderate risk of severe withdrawal.

(4) "3" The client tolerates and copes with withdrawal discomfort poorly. The client has severe intoxication, such that the client endangers self or others, or has intoxication that has not abated with less intensive services. The client displays severe signs and symptoms, risk of severe but manageable withdrawal, or worsening withdrawal despite detoxification at a less intensive level.

(5) "4" The client is incapacitated with severe signs and symptoms. The client displays severe withdrawal and is a danger to self or others.

(c) Dimension 2: the vendor must use the criteria in Dimension 2 to determine a client's biomedical conditions and complications.

(1) "0" The client displays full functioning with good ability to cope with physical discomfort.

(2) "1" The client tolerates and copes with physical discomfort and is able to get the services that the client needs.

(3) "2" The client has difficulty tolerating and coping with physical problems or has other biomedical problems that interfere with recovery and treatment. The client neglects or does not seek care for serious biomedical problems.

(4) "3" The client tolerates and copes poorly with physical problems or has poor general health. The client neglects the client's medical problems without active assistance.

(5) "4" The client is unable to participate in substance use disorder treatment and has severe medical problems, has a condition that requires immediate intervention, or is incapacitated.

(d) Dimension 3: the vendor must use the criteria in Dimension 3 to determine a client's emotional, behavioral, and cognitive conditions and complications.

(1) "0" The client displays full functioning with good ability to tolerate and cope with withdrawal discomfort. The client displays no signs or symptoms of intoxication or withdrawal or diminishing signs or symptoms.

(2) "1" The client can tolerate and cope with withdrawal discomfort. The client displays mild to moderate intoxication or signs and symptoms interfering with daily functioning but does not immediately endanger self or others. The client poses minimal risk of severe withdrawal.

(3) "2" The client has some difficulty tolerating and coping with withdrawal discomfort. The client's intoxication may be severe, but the client responds to support and treatment such that the client does not immediately endanger self or others. The client displays moderate signs and symptoms with moderate risk of severe withdrawal.

(4) "3" The client tolerates and copes with withdrawal discomfort poorly. The client has severe intoxication, such that the client endangers self or others, or has intoxication that has not abated with less intensive services. The client displays severe signs and symptoms, risk of severe but manageable withdrawal, or worsening withdrawal despite detoxification at a less intensive level.

(5) "4" The client is incapacitated with severe signs and symptoms. The client displays severe withdrawal and is a danger to self or others.

(c) Dimension 2: the vendor must use the criteria in Dimension 2 to determine a client's biomedical conditions and complications.

(1) "0" The client displays full functioning with good ability to cope with physical discomfort.

(2) "1" The client tolerates and copes with physical discomfort and is able to get the services that the client needs.

(3) "2" The client has difficulty tolerating and coping with physical problems or has other biomedical problems that interfere with recovery and treatment. The client neglects or does not seek care for serious biomedical problems.

(4) "3" The client tolerates and copes poorly with physical problems or has poor general health. The client neglects the client's medical problems without active assistance.

(5) "4" The client is unable to participate in substance use disorder treatment and has severe medical problems, has a condition that requires immediate intervention, or is incapacitated.

(d) Dimension 3: the vendor must use the criteria in Dimension 3 to determine a client's emotional, behavioral, and cognitive conditions and complications.

(1) "0" The client has good impulse control and coping skills and presents no risk of harm to self or others. The client functions in all life areas and displays no emotional, behavioral, or cognitive problems or the problems are stable.

(2) "1" The client has impulse control and coping skills. The client presents a mild to moderate risk of harm to self or others or displays symptoms of emotional, behavioral, or cognitive problems. The client has a mental health diagnosis and is stable. The client functions adequately in significant life areas.

(3) "2" The client has difficulty with impulse control and lacks coping skills. The client has thoughts of suicide or harm to others without means; however, the thoughts may interfere with participation in some activities. The client has difficulty functioning in significant life areas. The client has moderate symptoms of emotional, behavioral, or cognitive problems. The client is able to participate in most treatment activities.

(4) "3" The client has a severe lack of impulse control and coping skills. The client also has frequent thoughts of suicide or harm to others, including a plan and the means to carry out the plan. In addition, the client is severely impaired in significant life areas and has severe symptoms of emotional, behavioral, or cognitive problems that interfere with the client's participation in treatment activities.

(5) "4" The client has severe emotional or behavioral symptoms that place the client or others at acute risk of harm. The client also has intrusive thoughts of harming self or others. The client is unable to participate in treatment activities.

(e) Dimension 4: the vendor must use the criteria in Dimension 4 to determine a client's readiness for change.

(1) "0" The client admits to problems and is cooperative, motivated, ready to change, committed to change, and engaged in treatment as a responsible participant.

(2) "1" The client is motivated with active reinforcement to explore treatment and strategies for change but ambivalent about the client's illness or need for change.

(3) "2" The client displays verbal compliance but lacks consistent behaviors, has low motivation for change, and is passively involved in treatment.

(4) "3" The client displays inconsistent compliance, has minimal awareness of either the client's addiction or mental disorder, and is minimally cooperative.

(5) "4" The client is:

(i) noncompliant with treatment and has no awareness of addiction or mental disorder and does not want or is unwilling to explore change or is in total denial of the client's illness and its implications; or

(1) "0" The client has good impulse control and coping skills and presents no risk of harm to self or others. The client functions in all life areas and displays no emotional, behavioral, or cognitive problems or the problems are stable.

(2) "1" The client has impulse control and coping skills. The client presents a mild to moderate risk of harm to self or others or displays symptoms of emotional, behavioral, or cognitive problems. The client has a mental health diagnosis and is stable. The client functions adequately in significant life areas.

(3) "2" The client has difficulty with impulse control and lacks coping skills. The client has thoughts of suicide or harm to others without means; however, the thoughts may interfere with participation in some activities. The client has difficulty functioning in significant life areas. The client has moderate symptoms of emotional, behavioral, or cognitive problems. The client is able to participate in most treatment activities.

(4) "3" The client has a severe lack of impulse control and coping skills. The client also has frequent thoughts of suicide or harm to others, including a plan and the means to carry out the plan. In addition, the client is severely impaired in significant life areas and has severe symptoms of emotional, behavioral, or cognitive problems that interfere with the client's participation in treatment activities.

(5) "4" The client has severe emotional or behavioral symptoms that place the client or others at acute risk of harm. The client also has intrusive thoughts of harming self or others. The client is unable to participate in treatment activities.

(e) Dimension 4: the vendor must use the criteria in Dimension 4 to determine a client's readiness for change.

(1) "0" The client admits to problems and is cooperative, motivated, ready to change, committed to change, and engaged in treatment as a responsible participant.

(2) "1" The client is motivated with active reinforcement to explore treatment and strategies for change but ambivalent about the client's illness or need for change.

(3) "2" The client displays verbal compliance but lacks consistent behaviors, has low motivation for change, and is passively involved in treatment.

(4) "3" The client displays inconsistent compliance, has minimal awareness of either the client's addiction or mental disorder, and is minimally cooperative.

(5) "4" The client is:

(i) noncompliant with treatment and has no awareness of addiction or mental disorder and does not want or is unwilling to explore change or is in total denial of the client's illness and its implications; or

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(ii) dangerously oppositional to the extent that the client is a threat of imminent harm to self and others.

(f) Dimension 5: the vendor must use the criteria in Dimension 5 to determine a client's relapse, continued substance use, and continued problem potential.

(1) "0" The client recognizes risk well and is able to manage potential problems.

(2) "1" The client recognizes relapse issues and prevention strategies, but displays some vulnerability for further substance use or mental health problems.

(3) "2" The client has minimal recognition and understanding of relapse and recidivism issues and displays moderate vulnerability for further substance use or mental health problems. The client has some coping skills inconsistently applied.

(4) "3" The client has poor recognition and understanding of relapse and recidivism issues and displays moderately high vulnerability for further substance use or mental health problems. The client has few coping skills and rarely applies coping skills.

(5) "4" The client has no coping skills to arrest mental health or addiction illnesses or to prevent relapse. The client has no recognition or understanding of relapse and recidivism issues and displays high vulnerability for further substance use or mental health problems.

(g) Dimension 6: the vendor must use the criteria in Dimension 6 to determine a client's recovery environment.

(1) "0" The client is engaged in structured, meaningful activity and has a supportive significant other, family, and living environment.

(2) "1" The client has passive social network support or the client's family and significant other are not interested in the client's recovery. The client is engaged in structured, meaningful activity.

(3) "2" The client is engaged in structured, meaningful activity, but the client's peers, family, significant other, and living environment are unsupportive, or there is criminal justice system involvement by the client or among the client's peers or significant other or in the client's living environment.

(4) "3" The client is not engaged in structured, meaningful activity and the client's peers, family, significant other, and living environment are unsupportive, or there is significant criminal justice system involvement.

(5) "4" The client has:

(i) a chronically antagonistic significant other, living environment, family, or peer group or long-term criminal justice system involvement that is harmful to the client's recovery or treatment progress; or

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(ii) dangerously oppositional to the extent that the client is a threat of imminent harm to self and others.

(f) Dimension 5: the vendor must use the criteria in Dimension 5 to determine a client's relapse, continued substance use, and continued problem potential.

(1) "0" The client recognizes risk well and is able to manage potential problems.

(2) "1" The client recognizes relapse issues and prevention strategies, but displays some vulnerability for further substance use or mental health problems.

(3) "2" The client has minimal recognition and understanding of relapse and recidivism issues and displays moderate vulnerability for further substance use or mental health problems. The client has some coping skills inconsistently applied.

(4) "3" The client has poor recognition and understanding of relapse and recidivism issues and displays moderately high vulnerability for further substance use or mental health problems. The client has few coping skills and rarely applies coping skills.

(5) "4" The client has no coping skills to arrest mental health or addiction illnesses or to prevent relapse. The client has no recognition or understanding of relapse and recidivism issues and displays high vulnerability for further substance use or mental health problems.

(g) Dimension 6: the vendor must use the criteria in Dimension 6 to determine a client's recovery environment.

(1) "0" The client is engaged in structured, meaningful activity and has a supportive significant other, family, and living environment.

(2) "1" The client has passive social network support or the client's family and significant other are not interested in the client's recovery. The client is engaged in structured, meaningful activity.

(3) "2" The client is engaged in structured, meaningful activity, but the client's peers, family, significant other, and living environment are unsupportive, or there is criminal justice system involvement by the client or among the client's peers or significant other or in the client's living environment.

(4) "3" The client is not engaged in structured, meaningful activity and the client's peers, family, significant other, and living environment are unsupportive, or there is significant criminal justice system involvement.

(5) "4" The client has:

(i) a chronically antagonistic significant other, living environment, family, or peer group or long-term criminal justice system involvement that is harmful to the client's recovery or treatment progress; or

(ii) an actively antagonistic significant other, family, work, or living environment, with an immediate threat to the client's safety and well-being.

EFFECTIVE DATE. This section is effective July 1, 2022.

Sec. 51. Minnesota Statutes 2020, section 254B.04, is amended by adding a subdivision to read:

Subd. 5. **Scope and applicability.** This section governs administration of the behavioral health fund, establishes the criteria to be applied by local agencies to determine a client's financial eligibility under the behavioral health fund, and determines a client's obligation to pay for substance use disorder treatment services.

EFFECTIVE DATE. This section is effective July 1, 2022.

Sec. 52. Minnesota Statutes 2020, section 254B.04, is amended by adding a subdivision to read:

Subd. 6. **Local agency responsibility to provide services.** The local agency may employ individuals to conduct administrative activities and facilitate access to substance use disorder treatment services.

EFFECTIVE DATE. This section is effective July 1, 2022.

Sec. 53. Minnesota Statutes 2020, section 254B.04, is amended by adding a subdivision to read:

Subd. 7. **Local agency to determine client financial eligibility.** (a) The local agency shall determine a client's financial eligibility for the behavioral health fund according to subdivision 1 with the income calculated prospectively for one year from the date of comprehensive assessment. The local agency shall pay for eligible clients according to chapter 256G. The local agency shall enter the financial eligibility span within ten calendar days of request. Client eligibility must be determined using forms prescribed by the commissioner. The local agency must determine a client's eligibility as follows:

(1) The local agency must determine the client's income. A client who is a minor child must not be deemed to have income available to pay for substance use disorder treatment, unless the minor child is responsible for payment under section 144.347 for substance use disorder treatment services sought under section 144.343, subdivision 1.

(2) The local agency must determine the client's household size according to the following:

(i) If the client is a minor child, the household size includes the following persons living in the same dwelling unit:

(A) the client;

(ii) an actively antagonistic significant other, family, work, or living environment, with an immediate threat to the client's safety and well-being.

EFFECTIVE DATE. This section is effective July 1, 2022.

Sec. 42. Minnesota Statutes 2020, section 254B.04, is amended by adding a subdivision to read:

Subd. 5. **Scope and applicability.** This section governs administration of the behavioral health fund, establishes the criteria to be applied by local agencies to determine a client's financial eligibility under the behavioral health fund, and determines a client's obligation to pay for substance use disorder treatment services.

EFFECTIVE DATE. This section is effective July 1, 2022.

Sec. 43. Minnesota Statutes 2020, section 254B.04, is amended by adding a subdivision to read:

Subd. 6. **Local agency responsibility to provide services.** The local agency may employ individuals to conduct administrative activities and facilitate access to substance use disorder treatment services.

EFFECTIVE DATE. This section is effective July 1, 2022.

Sec. 44. Minnesota Statutes 2020, section 254B.04, is amended by adding a subdivision to read:

Subd. 7. **Local agency to determine client financial eligibility.** (a) The local agency shall determine a client's financial eligibility for the behavioral health fund according to subdivision 1 with the income calculated prospectively for one year from the date of comprehensive assessment. The local agency shall pay for eligible clients according to chapter 256G. The local agency shall enter the financial eligibility span within ten calendar days of request. Client eligibility must be determined using forms prescribed by the commissioner. The local agency must determine a client's eligibility as follows:

(1) The local agency must determine the client's income. A client who is a minor child must not be deemed to have income available to pay for substance use disorder treatment, unless the minor child is responsible for payment under section 144.347 for substance use disorder treatment services sought under section 144.343, subdivision 1.

(2) The local agency must determine the client's household size according to the following:

(i) If the client is a minor child, the household size includes the following persons living in the same dwelling unit:

(A) the client;

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(B) the client's birth or adoptive parents; and

(C) the client's siblings who are minors.

(ii) If the client is an adult, the household size includes the following persons living in the same dwelling unit:

(A) the client;

(B) the client's spouse;

(C) the client's minor children; and

(D) the client's spouse's minor children.

(iii) Household size includes a person listed in items (i) and (ii) who is in out-of-home placement if a person listed in item (i) or (ii) is contributing to the cost of care of the person in out-of-home placement.

(3) The local agency must determine the client's current prepaid health plan enrollment and the availability of a third-party payment source, including the availability of total or partial payment and the amount of co-payment.

(4) The local agency must provide the required eligibility information to the commissioner in the manner specified by the commissioner.

(5) The local agency must require the client and policyholder to conditionally assign to the department the client's and policyholder's rights and the rights of minor children to benefits or services provided to the client if the commissioner is required to collect from a third-party payment source.

(b) The local agency must redetermine a client's eligibility for the behavioral health fund every 12 months.

(c) A client, responsible relative, and policyholder must provide income or wage verification and household size verification under paragraph (a), clause (3), and must make an assignment of third-party payment rights under paragraph (a), clause (5). If a client, responsible relative, or policyholder does not comply with this subdivision, the client is ineligible for behavioral health fund payment for substance use disorder treatment, and the client and responsible relative are obligated to pay the full cost of substance use disorder treatment services provided to the client.

EFFECTIVE DATE. This section is effective July 1, 2022.

Sec. 54. Minnesota Statutes 2020, section 254B.04, is amended by adding a subdivision to read:

Subd. 8. **Client fees.** A client whose household income is within current household size and income guidelines for entitled persons as defined in subdivision 1 must pay no fee.

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(B) the client's birth or adoptive parents; and

(C) the client's siblings who are minors.

(ii) If the client is an adult, the household size includes the following persons living in the same dwelling unit:

(A) the client;

(B) the client's spouse;

(C) the client's minor children; and

(D) the client's spouse's minor children.

(iii) Household size includes a person listed in items (i) and (ii) who is in out-of-home placement if a person listed in item (i) or (ii) is contributing to the cost of care of the person in out-of-home placement.

(3) The local agency must determine the client's current prepaid health plan enrollment and the availability of a third-party payment source, including the availability of total or partial payment and the amount of co-payment.

(4) The local agency must provide the required eligibility information to the commissioner in the manner specified by the commissioner.

(5) The local agency must require the client and policyholder to conditionally assign to the department the client's and policyholder's rights and the rights of minor children to benefits or services provided to the client if the commissioner is required to collect from a third-party payment source.

(b) The local agency must redetermine a client's eligibility for the behavioral health fund every 12 months.

(c) A client, responsible relative, and policyholder must provide income or wage verification and household size verification under paragraph (a), clause (3), and must make an assignment of third-party payment rights under paragraph (a), clause (5). If a client, responsible relative, or policyholder does not comply with this subdivision, the client is ineligible for behavioral health fund payment for substance use disorder treatment, and the client and responsible relative are obligated to pay the full cost of substance use disorder treatment services provided to the client.

EFFECTIVE DATE. This section is effective July 1, 2022.

Sec. 45. Minnesota Statutes 2020, section 254B.04, is amended by adding a subdivision to read:

Subd. 8. **Client fees.** A client whose household income is within current household size and income guidelines for entitled persons as defined in subdivision 1 must pay no fee.

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EFFECTIVE DATE. This section is effective July 1, 2022.

Sec. 55. Minnesota Statutes 2020, section 254B.04, is amended by adding a subdivision to read:

Subd. 9. **Vendor must participate in DAANES.** To be eligible for payment under the behavioral health fund, a vendor must participate in DAANES or submit to the commissioner the information required in DAANES in the format specified by the commissioner.

EFFECTIVE DATE. This section is effective July 1, 2022.

Sec. 56. Minnesota Statutes 2021 Supplement, section 254B.05, subdivision 1a, is amended to read:

Subd. 1a. **Room and board provider requirements.** (a) Effective January 1, 2000, vendors of room and board are eligible for behavioral health fund payment if the vendor:

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

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

(3) is not a jail or prison;

(4) is not concurrently receiving funds under chapter 256I for the recipient;

(5) admits individuals who are 18 years of age or older;

(6) is registered as a board and lodging or lodging establishment according to section 157.17;

(7) has awake staff on site 24 hours per day;

(8) has staff who are at least 18 years of age and meet the requirements of section 245G.11, subdivision 1, paragraph (b);

(9) has emergency behavioral procedures that meet the requirements of section 245G.16;

(10) meets the requirements of section 245G.08, subdivision 5, if administering medications to clients;

(11) meets the abuse prevention requirements of section 245A.65, including a policy on fraternization and the mandatory reporting requirements of section 626.557;

(12) documents coordination with the treatment provider to ensure compliance with section 254B.03, subdivision 2;

(13) protects client funds and ensures freedom from exploitation by meeting the provisions of section 245A.04, subdivision 13;

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EFFECTIVE DATE. This section is effective July 1, 2022.

Sec. 46. Minnesota Statutes 2020, section 254B.04, is amended by adding a subdivision to read:

Subd. 9. **Vendor must participate in DAANES.** To be eligible for payment under the behavioral health fund, a vendor must participate in DAANES or submit to the commissioner the information required in DAANES in the format specified by the commissioner.

EFFECTIVE DATE. This section is effective July 1, 2022.

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(14) has a grievance procedure that meets the requirements of section 245G.15, subdivision 2; and

(15) has sleeping and bathroom facilities for men and women separated by a door that is locked, has an alarm, or is supervised by awake staff.

(b) Programs licensed according to Minnesota Rules, chapter 2960, are exempt from paragraph (a), clauses (5) to (15).

(c) Programs providing children's mental health crisis admissions and stabilization under section 245.4882, subdivision 6, are eligible vendors of room and board.

~~(c)~~ (d) Licensed programs providing intensive residential treatment services or residential crisis stabilization services pursuant to section 256B.0622 or 256B.0624 are eligible vendors of room and board and are exempt from paragraph (a), clauses (6) to (15).

Sec. 57. Minnesota Statutes 2021 Supplement, section 254B.05, subdivision 4, is amended to read:

Subd. 4. **Regional treatment centers.** Regional treatment center chemical dependency treatment units are eligible vendors. The commissioner may expand the capacity of chemical dependency treatment units beyond the capacity funded by direct legislative appropriation to serve individuals who are referred for treatment by counties and whose treatment will be paid for by funding under this chapter or other funding sources. Notwithstanding the provisions of sections 254B.03 to ~~254B.041~~ 254B.04, payment for any person committed at county request to a regional treatment center under chapter 253B for chemical dependency treatment and determined to be ineligible under the behavioral health fund, shall become the responsibility of the county.

Sec. 58. Minnesota Statutes 2021 Supplement, section 254B.05, subdivision 5, is amended to read:

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

(b) Eligible substance use disorder treatment services include:

~~(1) outpatient treatment services that are licensed according to sections 245G.01 to 245G.17, or applicable tribal license;~~

(1) outpatient treatment services licensed according to sections 245G.01 to 245G.17, or applicable Tribal license, including:

(i) ASAM 1.0 Outpatient: zero to eight hours per week of skilled treatment services for adults and zero to five hours per week for adolescents. Peer recovery and treatment coordination may be provided beyond the skilled treatment service hours allowable per week; and

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Sec. 47. Minnesota Statutes 2021 Supplement, section 254B.05, subdivision 4, is amended to read:

Subd. 4. **Regional treatment centers.** Regional treatment center chemical dependency treatment units are eligible vendors. The commissioner may expand the capacity of chemical dependency treatment units beyond the capacity funded by direct legislative appropriation to serve individuals who are referred for treatment by counties and whose treatment will be paid for by funding under this chapter or other funding sources. Notwithstanding the provisions of sections 254B.03 to ~~254B.041~~ 254B.04, payment for any person committed at county request to a regional treatment center under chapter 253B for chemical dependency treatment and determined to be ineligible under the behavioral health fund, shall become the responsibility of the county.

Sec. 48. Minnesota Statutes 2021 Supplement, section 254B.05, subdivision 5, is amended to read:

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

(b) Eligible substance use disorder treatment services include:

~~(1) outpatient treatment services that are licensed according to sections 245G.01 to 245G.17, or applicable tribal license;~~

(1) outpatient treatment services licensed under sections 245G.01 to 245G.17, or applicable Tribal license, including:

(i) ASAM 1.0 outpatient: zero to eight hours per week of skilled treatment services for adults and zero to five hours per week for adolescents. Peer recovery and treatment coordination may be provided beyond the skilled treatment service hours allowable per week; and

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(ii) ASAM 2.1 Intensive Outpatient: nine or more hours per week of skilled treatment services for adults and six or more hours per week for adolescents in accordance with the limitations in paragraph (h). Peer recovery and treatment coordination may be provided beyond the skilled treatment service hours allowable per week;

(2) comprehensive assessments provided according to sections 245.4863, paragraph (a), and 245G.05;

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

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

(5) on July 1, 2019, or upon federal approval, whichever is later, withdrawal management services provided according to chapter 245F;

(6) ~~medication-assisted therapy services that are~~ substance use disorder treatment with medication for opioid use disorders provided in an opioid treatment program that is licensed according to sections 245G.01 to 245G.17 and 245G.22, or applicable tribal license;

~~(7) medication-assisted therapy plus enhanced treatment services that meet the requirements of clause (6) and provide nine hours of clinical services each week;~~

~~(8)~~ (7) high, medium, and low intensity residential treatment services that are licensed according to sections 245G.01 to 245G.17 and 245G.21 or applicable tribal license which provide, respectively, 30, 15, and five hours of clinical services each week;

~~(9)~~ (8) hospital-based treatment services that are licensed according to sections 245G.01 to 245G.17 or applicable tribal license and licensed as a hospital under sections 144.50 to 144.56;

~~(10)~~ (9) adolescent treatment programs that are licensed as outpatient treatment programs according to sections 245G.01 to 245G.18 or as residential treatment programs according to Minnesota Rules, parts 2960.0010 to 2960.0220, and 2960.0430 to 2960.0490, or applicable tribal license;

~~(11)~~ (10) high-intensity residential treatment services that are licensed according to sections 245G.01 to 245G.17 and 245G.21 or applicable tribal license, which provide 30 hours of clinical services each week provided by a state-operated vendor or to clients who have been civilly committed to the commissioner, present the most complex and difficult care needs, and are a potential threat to the community; and

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(ii) ASAM 2.1 intensive outpatient: nine or more hours per week of skilled treatment services for adults and six or more hours per week for adolescents in accordance with the limitations in paragraph (h). Peer recovery and treatment coordination may be provided beyond the skilled treatment service hours allowable per week;

(2) comprehensive assessments provided according to sections 245.4863, paragraph (a), and 245G.05;

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

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

(5) on July 1, 2019, or upon federal approval, whichever is later, withdrawal management services provided according to chapter 245F;

(6) medication-assisted therapy services that are licensed according to sections 245G.01 to 245G.17 and 245G.22, or applicable tribal license;

~~(7) medication-assisted therapy plus enhanced treatment services that meet the requirements of clause (6) and provide nine hours of clinical services each week;~~

~~(8)~~ (7) high, medium, and low intensity residential treatment services that are licensed according to sections 245G.01 to 245G.17 and 245G.21 or applicable tribal license ~~which~~that provide, respectively, 30, 15, and five hours of clinical services each treatment week. For purposes of this section, residential treatment services provided by a program that meets the American Society of Addiction Medicine (ASAM) level 3.3 standards for care, must be considered high intensity, including when the program makes and appropriately documents clinically supported modifications to, or reductions in, the hours of services provided to better meet the needs of individuals with cognitive deficits;

~~(9)~~ (8) hospital-based treatment services that are licensed according to sections 245G.01 to 245G.17 or applicable tribal license and licensed as a hospital under sections 144.50 to 144.56;

~~(10)~~ (9) adolescent treatment programs that are licensed as outpatient treatment programs according to sections 245G.01 to 245G.18 or as residential treatment programs according to Minnesota Rules, parts 2960.0010 to 2960.0220, and 2960.0430 to 2960.0490, or applicable tribal license;

~~(11)~~ (10) high-intensity residential treatment services that are licensed according to sections 245G.01 to 245G.17 and 245G.21 or applicable tribal license, ~~which~~that provide 30 hours of clinical services each week provided by a state-operated vendor or to clients who have been civilly committed to the commissioner, present the most complex and difficult care needs, and are a potential threat to the community; and

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~~(12)~~ (11) room and board facilities that meet the requirements of subdivision 1a.

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

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

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

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

(B) meets the licensure exclusion criteria of section 245A.03, subdivision 2, paragraph (a), clause (6), and meets the requirements under section 245G.19, subdivision 4; or

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

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

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

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

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

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

(5) programs that offer services to individuals with co-occurring mental health and chemical dependency problems if:

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

(ii) 25 percent of the counseling staff are licensed mental health professionals, as defined in section 245.462, subdivision 18, clauses (1) to (6), or are students or licensing candidates under the supervision of a licensed alcohol and drug counselor supervisor and licensed mental health professional, except that no more than 50 percent of the mental health staff may be students or licensing candidates with time documented to be directly related to provisions of co-occurring services;

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

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~~(12)~~ (11) room and board facilities that meet the requirements of subdivision 1a.

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

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

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

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

(B) meets the licensure exclusion criteria of section 245A.03, subdivision 2, paragraph (a), clause (6), and meets the requirements under section 245G.19, subdivision 4; or

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

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

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

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

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

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

(5) programs that offer services to individuals with co-occurring mental health and chemical dependency problems if:

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

(ii) ~~25 percent of~~ the program employs sufficient counseling staff, including at least one full-time equivalent staff member, who are licensed mental health professionals~~, as defined in section 245.462, subdivision 18, clauses (1) to (6)~~ under section 245I.04, subdivision 2, or are students or licensing candidates under the supervision of a licensed alcohol and drug counselor supervisor and ~~licensed~~ mental health professional under section 245I.04, subdivision 2~~, except that no more than 50 percent of the mental health staff may be students or licensing candidates with time documented to be directly related to provisions of co-occurring~~ to meet the need for client services;

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

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

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

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

(d) In order to be eligible for a higher rate under paragraph (c), clause (1), a program that provides arrangements for off-site child care must maintain current documentation at the chemical dependency facility of the child care provider's current licensure to provide child care services. Programs that provide child care according to paragraph (c), clause (1), must be deemed in compliance with the licensing requirements in section 245G.19.

(e) Adolescent residential programs that meet the requirements of Minnesota Rules, parts 2960.0430 to 2960.0490 and 2960.0580 to 2960.0690, are exempt from the requirements in paragraph (c), clause (4), items (i) to (iv).

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

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

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

EFFECTIVE DATE. This section is effective July 1, 2022, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

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

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

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

(d) ~~In order to~~To be eligible for a higher rate under paragraph (c), clause (1), a program that provides arrangements for off-site child care must maintain current documentation at the chemical dependency facility of the child care provider's current licensure to provide child care services. Programs that provide child care according to paragraph (c), clause (1), must be deemed in compliance with the licensing requirements in section 245G.19.

(e) Adolescent residential programs that meet the requirements of Minnesota Rules, parts 2960.0430 to 2960.0490 and 2960.0580 to 2960.0690, are exempt from the requirements in paragraph (c), clause (4), items (i) to (iv).

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

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

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

(i) Programs using a qualified guest speaker must maintain documentation of the person's qualifications to present to clients on a topic the program has determined to be of value to its clients. The guest speaker must present less than half of any treatment group. A qualified counselor must be present during the delivery of content and must be responsible for documentation of the group.

EFFECTIVE DATE. This section is effective July 1, 2022, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

House Language UES4410-2

Sec. 59. Minnesota Statutes 2020, section 256.042, subdivision 1, is amended to read:

Subdivision 1. **Establishment of the advisory council.** (a) The Opiate Epidemic Response Advisory Council is established to develop and implement a comprehensive and effective statewide effort to address the opioid addiction and overdose epidemic in Minnesota. The council shall focus on:

(1) prevention and education, including public education and awareness for adults and youth, prescriber education, the development and sustainability of opioid overdose prevention and education programs, the role of adult protective services in prevention and response, and providing financial support to local law enforcement agencies for opiate antagonist programs;

(2) training on the treatment of opioid addiction, including the use of all Food and Drug Administration approved opioid addiction medications, detoxification, relapse prevention, patient assessment, individual treatment planning, counseling, recovery supports, diversion control, and other best practices;

(3) the expansion and enhancement of a continuum of care for opioid-related substance use disorders, including primary prevention, early intervention, treatment, recovery, and aftercare services; and

(4) the development of measures to assess and protect the ability of cancer patients and survivors, persons battling life-threatening illnesses, persons suffering from severe chronic pain, and persons at the end stages of life, who legitimately need prescription pain medications, to maintain their quality of life by accessing these pain medications without facing unnecessary barriers. The measures must also address the needs of individuals described in this clause who are elderly or who reside in underserved or rural areas of the state.

(b) The council shall:

(1) review local, state, and federal initiatives and activities related to education, prevention, treatment, and services for individuals and families experiencing and affected by opioid use disorder;

(2) establish priorities to address the state's opioid epidemic, for the purpose of recommending initiatives to fund;

(3) recommend to the commissioner of human services specific projects and initiatives to be funded;

Senate Language S4025-3

THE BELOW SECTION IS FROM S4025-3, WHICH HAS PASSED IN BOTH CHAMBERS.

S4025-3

Sec. 4. Minnesota Statutes 2020, section 256.042, subdivision 1, is amended to read:

Subdivision 1. **Establishment of the advisory council.** (a) The Opiate Epidemic Response Advisory Council is established to develop and implement a comprehensive and effective statewide effort to address the opioid addiction and overdose epidemic in Minnesota. The council shall focus on:

(1) prevention and education, including public education and awareness for adults and youth, prescriber education, the development and sustainability of opioid overdose prevention and education programs, the role of adult protective services in prevention and response, and providing financial support to local law enforcement agencies for opiate antagonist programs;

(2) training on the treatment of opioid addiction, including the use of all Food and Drug Administration approved opioid addiction medications, detoxification, relapse prevention, patient assessment, individual treatment planning, counseling, recovery supports, diversion control, and other best practices;

(3) the expansion and enhancement of a continuum of care for opioid-related substance use disorders, including primary prevention, early intervention, treatment, recovery, and aftercare services; and

(4) the development of measures to assess and protect the ability of cancer patients and survivors, persons battling life-threatening illnesses, persons suffering from severe chronic pain, and persons at the end stages of life, who legitimately need prescription pain medications, to maintain their quality of life by accessing these pain medications without facing unnecessary barriers. The measures must also address the needs of individuals described in this clause who are elderly or who reside in underserved or rural areas of the state.

(b) The council shall:

(1) review local, state, and federal initiatives and activities related to education, prevention, treatment, and services for individuals and families experiencing and affected by opioid use disorder;

(2) establish priorities to address the state's opioid epidemic, for the purpose of recommending initiatives to fund;

(3) recommend to the commissioner of human services specific projects and initiatives to be funded;

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(4) ensure that available funding is allocated to align with other state and federal funding, to achieve the greatest impact and ensure a coordinated state effort;

(5) consult with the commissioners of human services, health, and management and budget to develop measurable outcomes to determine the effectiveness of funds allocated; ~~and~~

(6) develop recommendations for an administrative and organizational framework for the allocation, on a sustainable and ongoing basis, of any money deposited into the separate account under section 16A.151, subdivision 2, paragraph (f), in order to address the opioid abuse and overdose epidemic in Minnesota and the areas of focus specified in paragraph (a)~~.~~;

(7) review reports, data, and performance measures submitted by municipalities, as defined in section 466.01, subdivision 1, in receipt of direct payments from settlement agreements, as described in section 256.043, subdivision 4; and

(8) consult with relevant stakeholders, including lead agencies and municipalities, to review and provide recommendations for necessary revisions to required reporting to ensure the reporting reflects measures of progress in addressing the harms of the opioid epidemic.

(c) The council, in consultation with the commissioner of management and budget, and within available appropriations, shall select from the awarded grants projects or may select municipality projects funded by settlement monies as described in section 256.043, subdivision 4, that include promising practices or theory-based activities for which the commissioner of management and budget shall conduct evaluations using experimental or quasi-experimental design. Grants awarded to proposals or municipality projects funded by settlement monies that include promising practices or theory-based activities and that are selected for an evaluation shall be administered to support the experimental or quasi-experimental evaluation and require grantees and municipality projects to collect and report information that is needed to complete the evaluation. The commissioner of management and budget, under section 15.08, may obtain additional relevant data to support the experimental or quasi-experimental evaluation studies. For the purposes of this paragraph, "municipality" has the meaning given in section 466.01, subdivision 1.

(d) The council, in consultation with the commissioners of human services, health, public safety, and management and budget, shall establish goals related to addressing the opioid epidemic and determine a baseline against which progress shall be monitored and set measurable outcomes, including benchmarks. The goals established must include goals for prevention and public health, access to treatment, and multigenerational impacts. The council shall use existing measures and data collection systems to determine baseline data against which progress shall be measured. The council shall include the proposed goals, the measurable outcomes, and proposed benchmarks to meet these goals in its initial report to the legislature under subdivision 5, paragraph (a), due January 31, 2021.

Senate Language S4025-3

(4) ensure that available funding is allocated to align with other state and federal funding, to achieve the greatest impact and ensure a coordinated state effort;

(5) consult with the commissioners of human services, health, and management and budget to develop measurable outcomes to determine the effectiveness of funds allocated; ~~and~~

(6) develop recommendations for an administrative and organizational framework for the allocation, on a sustainable and ongoing basis, of any money deposited into the separate account under section 16A.151, subdivision 2, paragraph (f), in order to address the opioid abuse and overdose epidemic in Minnesota and the areas of focus specified in paragraph (a);

(7) review reports, data, and performance measures submitted by municipalities under subdivision 5; and

(8) consult with relevant stakeholders, including lead agencies and municipalities, to review and provide recommendations for necessary revisions to the reporting requirements under subdivision 5 to ensure that the required reporting accurately measures progress in addressing the harms of the opioid epidemic.

(c) The council, in consultation with the commissioner of management and budget, and within available appropriations, shall select from ~~the~~ projects awarded grants ~~projects~~ under section 256.043, subdivisions 3 and 3a, and municipality projects funded by direct payments received as part of a statewide opioid settlement agreement, that include promising practices or theory-based activities for which the commissioner of management and budget shall conduct evaluations using experimental or quasi-experimental design. ~~Grants awarded to~~ Grant proposals and municipality projects that include promising practices or theory-based activities and ~~that~~ are selected for an evaluation shall be administered to support the experimental or quasi-experimental evaluation ~~and require~~. Grantees ~~to~~ and municipalities shall collect and report information that is needed to complete the evaluation. The commissioner of management and budget, under section 15.08, may obtain additional relevant data to support the experimental or quasi-experimental evaluation studies.

(d) The council, in consultation with the commissioners of human services, health, public safety, and management and budget, shall establish goals related to addressing the opioid epidemic and determine a baseline against which progress shall be monitored and set measurable outcomes, including benchmarks. The goals established must include goals for prevention and public health, access to treatment, and multigenerational impacts. The council shall use existing measures and data collection systems to determine baseline data against which progress shall be measured. The council shall include the proposed goals, the measurable outcomes, and proposed benchmarks to meet these goals in its initial report to the legislature under subdivision 5, paragraph (a), due January 31, 2021.

Sec. 60. Minnesota Statutes 2020, section 256.042, subdivision 2, is amended to read:

Subd. 2. **Membership.** (a) The council shall consist of the following ~~19~~ 30 voting members, appointed by the commissioner of human services except as otherwise specified, and three nonvoting members:

(1) two members of the house of representatives, appointed in the following sequence: the first from the majority party appointed by the speaker of the house and the second from the minority party appointed by the minority leader. Of these two members, one member must represent a district outside of the seven-county metropolitan area, and one member must represent a district that includes the seven-county metropolitan area. The appointment by the minority leader must ensure that this requirement for geographic diversity in appointments is met;

(2) two members of the senate, appointed in the following sequence: the first from the majority party appointed by the senate majority leader and the second from the minority party appointed by the senate minority leader. Of these two members, one member must represent a district outside of the seven-county metropolitan area and one member must represent a district that includes the seven-county metropolitan area. The appointment by the minority leader must ensure that this requirement for geographic diversity in appointments is met;

(3) one member appointed by the Board of Pharmacy;

(4) one member who is a physician appointed by the Minnesota Medical Association;

(5) one member representing opioid treatment programs, sober living programs, or substance use disorder programs licensed under chapter 245G;

(6) one member appointed by the Minnesota Society of Addiction Medicine who is an addiction psychiatrist;

(7) one member representing professionals providing alternative pain management therapies, including, but not limited to, acupuncture, chiropractic, or massage therapy;

(8) one member representing nonprofit organizations conducting initiatives to address the opioid epidemic, with the commissioner's initial appointment being a member representing the Steve Rummler Hope Network, and subsequent appointments representing this or other organizations;

(9) one member appointed by the Minnesota Ambulance Association who is serving with an ambulance service as an emergency medical technician, advanced emergency medical technician, or paramedic;

(10) one member representing the Minnesota courts who is a judge or law enforcement officer;

(11) one public member who is a Minnesota resident and who is in opioid addiction recovery;

(12) ~~two~~ 11 members representing Indian tribes, one representing ~~the Ojibwe tribes and one representing the Dakota tribes~~ each of Minnesota's Tribal Nations;

(13) two members representing the urban American Indian population;

~~(13)~~ (14) one public member who is a Minnesota resident and who is suffering from chronic pain, intractable pain, or a rare disease or condition;

~~(14)~~ (15) one mental health advocate representing persons with mental illness;

~~(15)~~ (16) one member appointed by the Minnesota Hospital Association;

~~(16)~~ (17) one member representing a local health department; and

~~(17)~~ (18) the commissioners of human services, health, and corrections, or their designees, who shall be ex officio nonvoting members of the council.

(b) The commissioner of human services shall coordinate the commissioner's appointments to provide geographic, racial, and gender diversity, and shall ensure that at least one-half of council members appointed by the commissioner reside outside of the seven-county metropolitan area and that at least one-half of the members have lived experience with opiate addiction. Of the members appointed by the commissioner, to the extent practicable, at least one member must represent a community of color disproportionately affected by the opioid epidemic.

(c) The council is governed by section 15.059, except that members of the council shall serve three-year terms and shall receive no compensation other than reimbursement for expenses. Notwithstanding section 15.059, subdivision 6, the council shall not expire.

(d) The chair shall convene the council at least quarterly, and may convene other meetings as necessary. The chair shall convene meetings at different locations in the state to provide geographic access, and shall ensure that at least one-half of the meetings are held at locations outside of the seven-county metropolitan area.

(e) The commissioner of human services shall provide staff and administrative services for the advisory council.

(f) The council is subject to chapter 13D.

Sec. 61. Minnesota Statutes 2021 Supplement, section 256.042, subdivision 4, is amended to read:

Subd. 4. **Grants.** (a) The commissioner of human services shall submit a report of the grants proposed by the advisory council to be awarded for the upcoming calendar year to the chairs and ranking minority members of the legislative committees with jurisdiction

SECTION 256.042, SUBD. 4 IS ALSO AMENDED BY S4025-3, SECTION 5 WHICH HAS PASSED IN BOTH CHAMBERS, BUT THAT SECTION MATCHES WITH HOUSE ARTICLE 20. SENATE ARTICLE 16, SECTION 17 AMENDS THE SAME STATUTE AS WELL BUT IS NOT SUBSTANTIVELY SIMILAR.

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over health and human services policy and finance, by December 1 of each year, beginning March 1, 2020.

(b) The grants shall be awarded to proposals selected by the advisory council that address the priorities in subdivision 1, paragraph (a), clauses (1) to (4), unless otherwise appropriated by the legislature. The advisory council shall determine grant awards and funding amounts based on the funds appropriated to the commissioner under section 256.043, subdivision 3, paragraph (e). The commissioner shall award the grants from the opiate epidemic response fund and administer the grants in compliance with section 16B.97. No more than ten percent of the grant amount may be used by a grantee for administration. The commissioner must award at least 40 percent of grants to projects that include a focus on addressing the opiate crisis in Black and Indigenous communities and communities of color.

Sec. 62. Minnesota Statutes 2020, section 256.042, subdivision 5, is amended to read:

Subd. 5. **Reports.** (a) The advisory council shall report annually to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services policy and finance by January 31 of each year~~, beginning January 31, 2021~~. The report shall include information about the individual projects that receive grants, the municipality projects funded by settlement monies as described in section 256.043, subdivision 4, and the overall role of the ~~project~~ projects in addressing the opioid addiction and overdose epidemic in Minnesota. The report must describe the grantees and the activities implemented, along with measurable outcomes as determined by the council in consultation with the commissioner of human services and the commissioner of management and budget. At a minimum, the report must include information about the number of individuals who received information or treatment, the outcomes the individuals achieved, and demographic information about the individuals participating in the project; an assessment of the progress toward achieving statewide access to qualified providers and comprehensive treatment and recovery services; and an update on the evaluations implemented by the commissioner of management and budget for the promising practices and theory-based projects that receive funding.

(b) The commissioner of management and budget, in consultation with the Opiate Epidemic Response Advisory Council, shall report to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services policy and finance when an evaluation study described in subdivision 1, paragraph (c), is complete on the promising practices or theory-based projects that are selected for evaluation activities. The report shall include demographic information; outcome information for the individuals in the program; the results for the program in promoting recovery, employment, family reunification, and reducing involvement with the criminal justice system; and other relevant outcomes determined by the commissioner of management and budget that are

Senate Language S4410-3

THE BELOW SECTION IS FROM S4025-3, WHICH HAS PASSED IN BOTH CHAMBERS. SENATE ARTICLE 16, SECTION 18 AMENDS THE SAME STATUTE AS BELOW BUT IS NOT SUBSTANTIVELY SIMILAR.

Sec. 6. Minnesota Statutes 2020, section 256.042, subdivision 5, is amended to read:

Subd. 5. **Reports.** (a) The advisory council shall report annually to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services policy and finance by January 31 of each year~~, beginning January 31, 2021~~. The report shall include information about the individual projects that receive grants, the municipality projects funded by direct payments received as part of a statewide opioid settlement agreement, and the overall role of the project in addressing the opioid addiction and overdose epidemic in Minnesota. The report must describe the grantees and municipalities and the activities implemented, along with measurable outcomes as determined by the council in consultation with the commissioner of human services and the commissioner of management and budget. At a minimum, the report must include information about the number of individuals who received information or treatment, the outcomes the individuals achieved, and demographic information about the individuals participating in the project; an assessment of the progress toward achieving statewide access to qualified providers and comprehensive treatment and recovery services; and an update on the evaluations implemented by the commissioner of management and budget for the promising practices and theory-based projects that receive funding.

(b) The commissioner of management and budget, in consultation with the Opiate Epidemic Response Advisory Council, shall report to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services policy and finance when an evaluation study described in subdivision 1, paragraph (c), is complete on the promising practices or theory-based projects that are selected for evaluation activities. The report shall include demographic information; outcome information for the individuals in the program; the results for the program in promoting recovery, employment, family reunification, and reducing involvement with the criminal justice system; and other relevant outcomes determined by the commissioner of management and budget that are

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specific to the projects that are evaluated. The report shall include information about the ability of grant programs to be scaled to achieve the statewide results that the grant project demonstrated.

(c) The advisory council, in its annual report to the legislature under paragraph (a) due by January 31, 2024, shall include recommendations on whether the appropriations to the specified entities under Laws 2019, chapter 63, should be continued, adjusted, or discontinued; whether funding should be appropriated for other purposes related to opioid abuse prevention, education, and treatment; and on the appropriate level of funding for existing and new uses.

(d) Municipalities receiving direct payments for settlement agreements as described in section 256.043, subdivision 4, must annually report to the commissioner on how the funds were used on opioid remediation. The report must be submitted in a format prescribed by the commissioner. The report must include data and measurable outcomes on expenditures funded with opioid settlement funds, as identified by the commissioner, including details on services drawn from the categories of approved uses, as identified in agreements between the state of Minnesota, the Association of Minnesota Counties, and the League of Minnesota Cities. Minimum reporting requirements must include:

(1) contact information;

(2) information on funded services and programs; and

(3) target populations for each funded service and program.

(e) In reporting data and outcomes under paragraph (d), municipalities should include information on the use of evidence-based and culturally relevant services, to the extent feasible.

(f) Reporting requirements for municipal projects using $25,000 or more of settlement funds in a calendar year must also include:

(1) a brief qualitative description of successes or challenges; and

(2) results using process and quality measures.

(g) For the purposes of this subdivision, "municipality" or "municipalities" has the meaning given in section 466.01, subdivision 1.

Senate Language S4025-3

specific to the projects that are evaluated. The report shall include information about the ability of grant programs to be scaled to achieve the statewide results that the grant project demonstrated.

(c) The advisory council, in its annual report to the legislature under paragraph (a) due by January 31, 2024, shall include recommendations on whether the appropriations to the specified entities under Laws 2019, chapter 63, should be continued, adjusted, or discontinued; whether funding should be appropriated for other purposes related to opioid abuse prevention, education, and treatment; and on the appropriate level of funding for existing and new uses.

(d) Municipalities receiving direct payments from a statewide opioid settlement agreement must report annually to the commissioner of human services on how the payments were used on opioid remediation. The report must be submitted in a format prescribed by the commissioner. The report must include data and measurable outcomes on expenditures funded with direct payments from a statewide opioid settlement agreement, including details on services listed in the categories of approved uses, as identified in agreements between the state of Minnesota, the Association of Minnesota Counties, and the League of Minnesota Cities. Reporting requirements must include, at a minimum:

(1) contact information;

(2) information on funded services and programs; and

(3) target populations for each funded service and program.

(e) In reporting data and outcomes under paragraph (d), municipalities must include, to the extent feasible, information on the use of evidence-based and culturally relevant services.

(f) For municipal projects using $25,000 or more of statewide opioid settlement agreement payments in a calendar year, municipalities must also include in the report required under paragraph (d):

(1) a brief qualitative description of successes or challenges; and

(2) results using process and quality measures.

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

Sec. 63. Minnesota Statutes 2021 Supplement, section 256B.0625, subdivision 5m, is amended to read:

Subd. 5m. **Certified community behavioral health clinic services.** (a) Medical assistance covers services provided by a not-for-profit certified community behavioral health clinic (CCBHC) ~~services~~ that ~~meet~~ meets the requirements of section 245.735, subdivision 3.

(b) The commissioner shall reimburse CCBHCs on a ~~per-visit~~ per-day basis ~~under the prospective payment~~ for each day that an eligible service is delivered using the CCBHC daily bundled rate system for medical assistance payments as described in paragraph (c). The commissioner shall include a quality incentive payment in the ~~prospective payment~~ CCBHC daily bundled rate system as described in paragraph (e). There is no county share for medical assistance services when reimbursed through the CCBHC ~~prospective payment~~ daily bundled rate system.

(c) The commissioner shall ensure that the ~~prospective payment~~ CCBHC daily bundled rate system for CCBHC payments under medical assistance meets the following requirements:

(1) the ~~prospective payment~~ CCBHC daily bundled rate shall be a provider-specific rate calculated for each CCBHC, based on the daily cost of providing CCBHC services and the total annual allowable CCBHC costs ~~for CCBHCs~~ divided by the total annual number of CCBHC visits. For calculating the payment rate, total annual visits include visits covered by medical assistance and visits not covered by medical assistance. Allowable costs include but are not limited to the salaries and benefits of medical assistance providers; the cost of CCBHC services provided under section 245.735, subdivision 3, paragraph (a), clauses (6) and (7); and other costs such as insurance or supplies needed to provide CCBHC services;

(2) payment shall be limited to one payment per day per medical assistance enrollee ~~for each~~ when an eligible CCBHC ~~visit eligible for reimbursement~~ service is provided. A CCBHC visit is eligible for reimbursement if at least one of the CCBHC services listed under section 245.735, subdivision 3, paragraph (a), clause (6), is furnished to a medical assistance enrollee by a health care practitioner or licensed agency employed by or under contract with a CCBHC;

(3) ~~new payment~~ initial CCBHC daily bundled rates ~~set by the commissioner~~ for newly certified CCBHCs under section 245.735, subdivision 3, shall be ~~based on rates for established CCBHCs with a similar scope of services. If no comparable CCBHC exists, the commissioner shall establish a clinic-specific rate using audited historical cost report data adjusted for the estimated cost of delivering CCBHC services, including the estimated cost of providing the full scope of services and the projected change in visits resulting from the change in scope~~ established by the commissioner using a provider-specific rate based on the newly certified CCBHC's audited historical cost report data adjusted for the expected cost of delivering CCBHC services. Estimates are subject to review by the commissioner and must include the expected cost of providing the full scope of CCBHC services and the expected number of visits for the rate period;

(4) the commissioner shall rebase CCBHC rates once every three years following the last rebasing and no less than 12 months following an initial rate or a rate change due to a change in the scope of services;

(5) the commissioner shall provide for a 60-day appeals process after notice of the results of the rebasing;

(6) the ~~prospective payment~~ CCBHC daily bundled rate under this section does not apply to services rendered by CCBHCs to individuals who are dually eligible for Medicare and medical assistance when Medicare is the primary payer for the service. An entity that receives a ~~prospective payment~~ CCBHC daily bundled rate system ~~rate~~ that overlaps with the CCBHC rate is not eligible for the CCBHC rate;

(7) payments for CCBHC services to individuals enrolled in managed care shall be coordinated with the state's phase-out of CCBHC wrap payments. The commissioner shall complete the phase-out of CCBHC wrap payments within 60 days of the implementation of the ~~prospective payment~~ CCBHC daily bundled rate system in the Medicaid Management Information System (MMIS), for CCBHCs reimbursed under this chapter, with a final settlement of payments due made payable to CCBHCs no later than 18 months thereafter;

(8) the ~~prospective payment~~ CCBHC daily bundled rate for each CCBHC shall be updated by trending each provider-specific rate by the Medicare Economic Index for primary care services. This update shall occur each year in between rebasing periods determined by the commissioner in accordance with clause (4). CCBHCs must provide data on costs and visits to the state annually using the CCBHC cost report established by the commissioner; and

(9) a CCBHC may request a rate adjustment for changes in the CCBHC's scope of services when such changes are expected to result in an adjustment to the CCBHC payment rate by 2.5 percent or more. The CCBHC must provide the commissioner with information regarding the changes in the scope of services, including the estimated cost of providing the new or modified services and any projected increase or decrease in the number of visits resulting from the change. Estimated costs are subject to review by the commissioner. Rate adjustments for changes in scope shall occur no more than once per year in between rebasing periods per CCBHC and are effective on the date of the annual CCBHC rate update.

(d) Managed care plans and county-based purchasing plans shall reimburse CCBHC providers at the ~~prospective payment~~ CCBHC daily bundled rate. The commissioner shall monitor the effect of this requirement on the rate of access to the services delivered by CCBHC providers. If, for any contract year, federal approval is not received for this paragraph, the commissioner must adjust the capitation rates paid to managed care plans and county-based purchasing plans for that contract year to reflect the removal of this provision. Contracts between managed care plans and county-based purchasing plans and providers to whom this paragraph applies must allow recovery of payments from those providers if capitation rates are adjusted in accordance with this paragraph. Payment recoveries must not exceed the amount equal to any increase in rates that results from this

provision. This paragraph expires if federal approval is not received for this paragraph at any time.

(e) The commissioner shall implement a quality incentive payment program for CCBHCs that meets the following requirements:

(1) a CCBHC shall receive a quality incentive payment upon meeting specific numeric thresholds for performance metrics established by the commissioner, in addition to payments for which the CCBHC is eligible under the ~~prospective payment~~ CCBHC daily bundled rate system described in paragraph (c);

(2) a CCBHC must be certified and enrolled as a CCBHC for the entire measurement year to be eligible for incentive payments;

(3) each CCBHC shall receive written notice of the criteria that must be met in order to receive quality incentive payments at least 90 days prior to the measurement year; and

(4) a CCBHC must provide the commissioner with data needed to determine incentive payment eligibility within six months following the measurement year. The commissioner shall notify CCBHC providers of their performance on the required measures and the incentive payment amount within 12 months following the measurement year.

(f) All claims to managed care plans for CCBHC services as provided under this section shall be submitted directly to, and paid by, the commissioner on the dates specified no later than January 1 of the following calendar year, if:

(1) one or more managed care plans does not comply with the federal requirement for payment of clean claims to CCBHCs, as defined in Code of Federal Regulations, title 42, section 447.45(b), and the managed care plan does not resolve the payment issue within 30 days of noncompliance; and

(2) the total amount of clean claims not paid in accordance with federal requirements by one or more managed care plans is 50 percent of, or greater than, the total CCBHC claims eligible for payment by managed care plans.

If the conditions in this paragraph are met between January 1 and June 30 of a calendar year, claims shall be submitted to and paid by the commissioner beginning on January 1 of the following year. If the conditions in this paragraph are met between July 1 and December 31 of a calendar year, claims shall be submitted to and paid by the commissioner beginning on July 1 of the following year.

Sec. 64. Minnesota Statutes 2020, section 256B.0757, subdivision 5, is amended to read:

Subd. 5. **Payments.** The commissioner shall ~~make payments to each designated provider for the provision of~~ establish a single statewide reimbursement rate for health home services ~~described in subdivision 3 to each eligible individual under subdivision 2 that selects the~~

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Sec. 49. Minnesota Statutes 2020, section 256B.0757, subdivision 5, is amended to read:

Subd. 5. **Payments.** The commissioner shall make payments to each designated provider for the provision of behavioral health home services described in subdivision 3 to each eligible individual under subdivision 2 that selects the behavioral health home as a provider.

~~health home as a provider~~ under this section. In setting this rate, the commissioner must include input from stakeholders, including providers of the services. The statewide reimbursement rate shall be adjusted annually to match the growth in the Medicare Economic Index.

EFFECTIVE DATE. This section is effective July 1, 2022.

Sec. 65. Minnesota Statutes 2021 Supplement, section 256B.0759, subdivision 4, is amended to read:

Subd. 4. **Provider payment rates.** (a) Payment rates for participating providers must be increased for services provided to medical assistance enrollees. To receive a rate increase, participating providers must meet demonstration project requirements and provide evidence of formal referral arrangements with providers delivering step-up or step-down levels of care. Providers that have enrolled in the demonstration project but have not met the provider standards under subdivision 3 as of July 1, 2022, are not eligible for a rate increase under this subdivision until the date that the provider meets the provider standards in subdivision 3. Services provided from July 1, 2022, to the date that the provider meets the provider standards under subdivision 3 shall be reimbursed at rates according to section 254B.05, subdivision 5, paragraph (b). Rate increases paid under this subdivision to a provider for services provided between July 1, 2021, and July 1, 2022, are not subject to recoupment when the provider is taking meaningful steps to meet demonstration project requirements that are not otherwise required by law, and the provider provides documentation to the commissioner, upon request, of the steps being taken.

(b) The commissioner may temporarily suspend payments to the provider according to section 256B.04, subdivision 21, paragraph (d), if the provider does not meet the requirements in paragraph (a). Payments withheld from the provider must be made once the commissioner determines that the requirements in paragraph (a) are met.

(c) For substance use disorder services under section 254B.05, subdivision 5, paragraph (b), clause ~~(8)~~ (7), provided on or after July 1, 2020, payment rates must be increased by 25 percent over the rates in effect on December 31, 2019.

(d) For substance use disorder services under section 254B.05, subdivision 5, paragraph (b), clauses (1)~~;~~ and (6), ~~and (7),~~ and adolescent treatment programs that are licensed as outpatient treatment programs according to sections 245G.01 to 245G.18, provided on or after January 1, 2021, payment rates must be increased by 20 percent over the rates in effect on December 31, 2020.

(e) Effective January 1, 2021, and contingent on annual federal approval, managed care plans and county-based purchasing plans must reimburse providers of the substance use disorder services meeting the criteria described in paragraph (a) who are employed by or under contract with the plan an amount that is at least equal to the fee-for-service base rate payment for the substance use disorder services described in paragraphs (c) and (d). The commissioner must monitor the effect of this requirement on the rate of access to substance

use disorder services and residential substance use disorder rates. Capitation rates paid to managed care organizations and county-based purchasing plans must reflect the impact of this requirement. This paragraph expires if federal approval is not received at any time as required under this paragraph.

(f) Effective July 1, 2021, contracts between managed care plans and county-based purchasing plans and providers to whom paragraph (e) applies must allow recovery of payments from those providers if, for any contract year, federal approval for the provisions of paragraph (e) is not received, and capitation rates are adjusted as a result. Payment recoveries must not exceed the amount equal to any decrease in rates that results from this provision.

Sec. 66. Minnesota Statutes 2020, section 256B.0941, is amended by adding a subdivision to read:

Subd. 2a. **Sleeping hours.** During normal sleeping hours, a psychiatric residential treatment facility provider must provide at least one staff person for every six residents present within a living unit. A provider must adjust sleeping-hour staffing levels based on the clinical needs of the residents in the facility.

Sec. 67. Minnesota Statutes 2020, section 256B.0941, subdivision 3, is amended to read:

Subd. 3. **Per diem rate.** (a) The commissioner must establish one per diem rate per provider for psychiatric residential treatment facility services for individuals 21 years of age or younger. The rate for a provider must not exceed the rate charged by that provider for the same service to other payers. Payment must not be made to more than one entity for each individual for services provided under this section on a given day. The commissioner must set rates prospectively for the annual rate period. The commissioner must require providers to submit annual cost reports on a uniform cost reporting form and must use submitted cost reports to inform the rate-setting process. The cost reporting must be done according to federal requirements for Medicare cost reports.

(b) The following are included in the rate:

(1) costs necessary for licensure and accreditation, meeting all staffing standards for participation, meeting all service standards for participation, meeting all requirements for active treatment, maintaining medical records, conducting utilization review, meeting inspection of care, and discharge planning. The direct services costs must be determined using the actual cost of salaries, benefits, payroll taxes, and training of direct services staff and service-related transportation; and

(2) payment for room and board provided by facilities meeting all accreditation and licensing requirements for participation.

(c) A facility may submit a claim for payment outside of the per diem for professional services arranged by and provided at the facility by an appropriately licensed professional who is enrolled as a provider with Minnesota health care programs. Arranged services may

be billed by either the facility or the licensed professional. These services must be included in the individual plan of care and are subject to prior authorization.

(d) Medicaid must reimburse for concurrent services as approved by the commissioner to support continuity of care and successful discharge from the facility. "Concurrent services" means services provided by another entity or provider while the individual is admitted to a psychiatric residential treatment facility. Payment for concurrent services may be limited and these services are subject to prior authorization by the state's medical review agent. Concurrent services may include targeted case management, assertive community treatment, clinical care consultation, team consultation, and treatment planning.

(e) Payment rates under this subdivision must not include the costs of providing the following services:

(1) educational services;

(2) acute medical care or specialty services for other medical conditions;

(3) dental services; and

(4) pharmacy drug costs.

(f) For purposes of this section, "actual cost" means costs that are allowable, allocable, reasonable, and consistent with federal reimbursement requirements in Code of Federal Regulations, title 48, chapter 1, part 31, relating to for-profit entities, and the Office of Management and Budget Circular Number A-122, relating to nonprofit entities.

(g) The commissioner shall consult with providers and stakeholders to develop an assessment tool that identifies when a child with a medical necessity for psychiatric residential treatment facility level of care will require specialized care planning, including but not limited to a one-on-one staffing ratio in a living environment. The commissioner must develop the tool based on clinical and safety review and recommend best uses of the protocols to align with reimbursement structures.

Sec. 68. Minnesota Statutes 2020, section 256B.0941, is amended by adding a subdivision to read:

Subd. 5. **Start-up grants.** Start-up grants to prospective psychiatric residential treatment facility sites may be used for:

(1) administrative expenses;

(2) consulting services;

(3) Health Insurance Portability and Accountability Act of 1996 compliance;

(4) therapeutic resources including evidence-based, culturally appropriate curriculums, and training programs for staff and clients;

(5) allowable physical renovations to the property; and

(6) emergency workforce shortage uses, as determined by the commissioner.

Sec. 69. Minnesota Statutes 2021 Supplement, section 256B.0946, subdivision 1, is amended to read:

Subdivision 1. **Required covered service components.** (a) Subject to federal approval, medical assistance covers medically necessary intensive behavioral health treatment services when the services are provided by a provider entity certified under and meeting the standards in this section. The provider entity must make reasonable and good faith efforts to report individual client outcomes to the commissioner, using instruments and protocols approved by the commissioner.

(b) Intensive behavioral health treatment services to children with mental illness residing in foster family settings or with legal guardians that comprise specific required service components provided in clauses (1) to (6) are reimbursed by medical assistance when they meet the following standards:

(1) psychotherapy provided by a mental health professional or a clinical trainee;

(2) crisis planning;

(3) individual, family, and group psychoeducation services provided by a mental health professional or a clinical trainee;

(4) clinical care consultation provided by a mental health professional or a clinical trainee;

(5) individual treatment plan development as defined in Minnesota Rules, part 9505.0371, subpart 7; and

(6) service delivery payment requirements as provided under subdivision 4.

EFFECTIVE DATE. This section is effective January 1, 2023, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 70. Minnesota Statutes 2021 Supplement, section 256B.0946, subdivision 1a, is amended to read:

Subd. 1a. **Definitions.** For the purposes of this section, the following terms have the meanings given them.

(a) "At risk of out-of-home placement" means the child has participated in community-based therapeutic or behavioral services including psychotherapy within the past 30 days and has experienced severe difficulty in managing mental health and behavior in multiple settings and has one of the following:

(1) has previously been in out-of-home placement for mental health issues within the past six months;

(2) has a history of threatening harm to self or others and has actively engaged in self-harming or threatening behavior in the past 30 days;

(3) demonstrates extremely inappropriate or dangerous social behavior in home, community, and school settings;

(4) has a history of repeated intervention from mental health programs, social services, mobile crisis programs, or law enforcement to maintain safety in the home, community, or school within the past 60 days; or

(5) whose parent is unable to safely manage the child's mental health, behavioral, or emotional problems in the home and has been actively seeking placement for at least two weeks.

~~(a)~~ (b) "Clinical care consultation" means communication from a treating clinician to other providers working with the same client to inform, inquire, and instruct regarding the client's symptoms, strategies for effective engagement, care and intervention needs, and treatment expectations across service settings, including but not limited to the client's school, social services, day care, probation, home, primary care, medication prescribers, disabilities services, and other mental health providers and to direct and coordinate clinical service components provided to the client and family.

~~(b)~~ (c) "Clinical trainee" means a staff person who is qualified according to section 245I.04, subdivision 6.

~~(c)~~ (d) "Crisis planning" has the meaning given in section 245.4871, subdivision 9a.

~~(d)~~ (e) "Culturally appropriate" means providing mental health services in a manner that incorporates the child's cultural influences into interventions as a way to maximize resiliency factors and utilize cultural strengths and resources to promote overall wellness.

~~(e)~~ (f) "Culture" means the distinct ways of living and understanding the world that are used by a group of people and are transmitted from one generation to another or adopted by an individual.

~~(f)~~ (g) "Standard diagnostic assessment" means the assessment described in section 245I.10, subdivision 6.

~~(g)~~ (h) "Family" means a person who is identified by the client or the client's parent or guardian as being important to the client's mental health treatment. Family may include, but is not limited to, parents, foster parents, children, spouse, committed partners, former spouses, persons related by blood or adoption, persons who are a part of the client's permanency plan, or persons who are presently residing together as a family unit.

~~(h)~~ (i) "Foster care" has the meaning given in section 260C.007, subdivision 18.

~~(i)~~ (j) "Foster family setting" means the foster home in which the license holder resides.

~~(j)~~ (k) "Individual treatment plan" means the plan described in section 245I.10, subdivisions 7 and 8.

~~(k)~~ (l) "Mental health certified family peer specialist" means a staff person who is qualified according to section 245I.04, subdivision 12.

~~(l)~~ (m) "Mental health professional" means a staff person who is qualified according to section 245I.04, subdivision 2.

~~(m)~~ (n) "Mental illness" has the meaning given in section 245I.02, subdivision 29.

~~(n)~~ (o) "Parent" has the meaning given in section 260C.007, subdivision 25.

~~(o)~~ (p) "Psychoeducation services" means information or demonstration provided to an individual, family, or group to explain, educate, and support the individual, family, or group in understanding a child's symptoms of mental illness, the impact on the child's development, and needed components of treatment and skill development so that the individual, family, or group can help the child to prevent relapse, prevent the acquisition of comorbid disorders, and achieve optimal mental health and long-term resilience.

~~(p)~~ (q) "Psychotherapy" means the treatment described in section 256B.0671, subdivision 11.

~~(q)~~ (r) "Team consultation and treatment planning" means the coordination of treatment plans and consultation among providers in a group concerning the treatment needs of the child, including disseminating the child's treatment service schedule to all members of the service team. Team members must include all mental health professionals working with the child, a parent, the child unless the team lead or parent deem it clinically inappropriate, and at least two of the following: an individualized education program case manager; probation agent; children's mental health case manager; child welfare worker, including adoption or guardianship worker; primary care provider; foster parent; and any other member of the child's service team.

~~(r)~~ (s) "Trauma" has the meaning given in section 245I.02, subdivision 38.

~~(s)~~ (t) "Treatment supervision" means the supervision described under section 245I.06.

EFFECTIVE DATE. This section is effective January 1, 2023, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 71. Minnesota Statutes 2021 Supplement, section 256B.0946, subdivision 2, is amended to read:

Subd. 2. **Determination of client eligibility.** An eligible recipient is an individual, from birth through age 20, who is currently placed in a foster home licensed under Minnesota Rules, parts 2960.3000 to 2960.3340, or placed in a foster home licensed under the

regulations established by a federally recognized Minnesota Tribe, or who is residing in the legal guardian's home and is at risk of out-of-home placement, and has received: (1) a standard diagnostic assessment within 180 days before the start of service that documents that intensive behavioral health treatment services are medically necessary ~~within a foster family setting~~ to ameliorate identified symptoms and functional impairments; and (2) a level of care assessment as defined in section 245I.02, subdivision 19, that demonstrates that the individual requires intensive intervention without 24-hour medical monitoring, and a functional assessment as defined in section 245I.02, subdivision 17. The level of care assessment and the functional assessment must include information gathered from the placing county, Tribe, or case manager.

EFFECTIVE DATE. This section is effective January 1, 2023, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 72. Minnesota Statutes 2021 Supplement, section 256B.0946, subdivision 3, is amended to read:

Subd. 3. **Eligible mental health services providers.** (a) Eligible providers for children's intensive ~~children's mental health~~ behavioral health services ~~in a foster family setting~~ must be certified by the state ~~and have a service provision contract with a county board or a reservation tribal council~~ and must be able to demonstrate the ability to provide all of the services required in this section and meet the standards in chapter 245I, as required in section 245I.011, subdivision 5.

(b) For purposes of this section, a provider agency must be:

(1) a county-operated entity certified by the state;

(2) an Indian Health Services facility operated by a Tribe or Tribal organization under funding authorized by United States Code, title 25, sections 450f to 450n, or title 3 of the Indian Self-Determination Act, Public Law 93-638, section 638 (facilities or providers); or

(3) a noncounty entity.

(c) Certified providers that do not meet the service delivery standards required in this section shall be subject to a decertification process.

(d) For the purposes of this section, all services delivered to a client must be provided by a mental health professional or a clinical trainee.

EFFECTIVE DATE. This section is effective January 1, 2023, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 73. Minnesota Statutes 2021 Supplement, section 256B.0946, subdivision 4, is amended to read:

Subd. 4. **Service delivery payment requirements.** (a) To be eligible for payment under this section, a provider must develop and practice written policies and procedures for children's intensive ~~treatment in foster care~~ behavioral health services, consistent with subdivision 1, paragraph (b), and comply with the following requirements in paragraphs (b) to (n).

(b) Each previous and current mental health, school, and physical health treatment provider must be contacted to request documentation of treatment and assessments that the eligible client has received. This information must be reviewed and incorporated into the standard diagnostic assessment and team consultation and treatment planning review process.

(c) Each client receiving treatment must be assessed for a trauma history, and the client's treatment plan must document how the results of the assessment will be incorporated into treatment.

(d) The level of care assessment as defined in section 245I.02, subdivision 19, and functional assessment as defined in section 245I.02, subdivision 17, must be updated at least every 90 days or prior to discharge from the service, whichever comes first.

(e) Each client receiving treatment services must have an individual treatment plan that is reviewed, evaluated, and approved every 90 days using the team consultation and treatment planning process.

(f) Clinical care consultation must be provided in accordance with the client's individual treatment plan.

(g) Each client must have a crisis plan within ten days of initiating services and must have access to clinical phone support 24 hours per day, seven days per week, during the course of treatment. The crisis plan must demonstrate coordination with the local or regional mobile crisis intervention team.

(h) Services must be delivered and documented at least three days per week, equaling at least six hours of treatment per week. If the mental health professional, client, and family agree, service units may be temporarily reduced for a period of no more than 60 days in order to meet the needs of the client and family, or as part of transition or on a discharge plan to another service or level of care. The reasons for service reduction must be identified, documented, and included in the treatment plan. Billing and payment are prohibited for days on which no services are delivered and documented.

(i) Location of service delivery must be in the client's home, day care setting, school, or other community-based setting that is specified on the client's individualized treatment plan.

(j) Treatment must be developmentally and culturally appropriate for the client.

(k) Services must be delivered in continual collaboration and consultation with the client's medical providers and, in particular, with prescribers of psychotropic medications, including those prescribed on an off-label basis. Members of the service team must be aware of the medication regimen and potential side effects.

(l) Parents, siblings, foster parents, legal guardians, and members of the child's permanency plan must be involved in treatment and service delivery unless otherwise noted in the treatment plan.

(m) Transition planning for ~~the~~ a child in foster care must be conducted starting with the first treatment plan and must be addressed throughout treatment to support the child's permanency plan and postdischarge mental health service needs.

(n) In order for a provider to receive the daily per-client encounter rate, at least one of the services listed in subdivision 1, paragraph (b), clauses (1) to (3), must be provided. The services listed in subdivision 1, paragraph (b), clauses (4) and (5), may be included as part of the daily per-client encounter rate.

EFFECTIVE DATE. This section is effective January 1, 2023, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 74. Minnesota Statutes 2021 Supplement, section 256B.0946, subdivision 6, is amended to read:

Subd. 6. **Excluded services.** (a) Services in clauses (1) to (7) are not covered under this section and are not eligible for medical assistance payment as components of children's intensive ~~treatment in foster care~~ behavioral health services, but may be billed separately:

(1) inpatient psychiatric hospital treatment;

(2) mental health targeted case management;

(3) partial hospitalization;

(4) medication management;

(5) children's mental health day treatment services;

(6) crisis response services under section 256B.0624;

(7) transportation; and

(8) mental health certified family peer specialist services under section 256B.0616.

(b) Children receiving intensive ~~treatment in foster care~~ behavioral health services are not eligible for medical assistance reimbursement for the following services while receiving children's intensive ~~treatment in foster care~~ behavioral health services:

(1) psychotherapy and skills training components of children's therapeutic services and supports under section 256B.0943;

(2) mental health behavioral aide services as defined in section 256B.0943, subdivision 1, paragraph (l);

(3) home and community-based waiver services;

(4) mental health residential treatment; and

(5) room and board costs as defined in section 256I.03, subdivision 6.

EFFECTIVE DATE. This section is effective January 1, 2023, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 75. Minnesota Statutes 2020, section 256B.0946, subdivision 7, is amended to read:

Subd. 7. **Medical assistance payment and rate setting.** The commissioner shall establish a single daily per-client encounter rate for children's intensive ~~treatment in foster care~~ behavioral health services. The rate must be constructed to cover only eligible services delivered to an eligible recipient by an eligible provider, as prescribed in subdivision 1, paragraph (b).

EFFECTIVE DATE. This section is effective January 1, 2023, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 76. Minnesota Statutes 2021 Supplement, section 256B.0947, subdivision 2, is amended to read:

Subd. 2. **Definitions.** For purposes of this section, the following terms have the meanings given them.

(a) "Intensive nonresidential rehabilitative mental health services" means child rehabilitative mental health services as defined in section 256B.0943, except that these services are provided by a multidisciplinary staff using a total team approach consistent with assertive community treatment, as adapted for youth, and are directed to recipients who are eight years of age or older and under ~~26~~ 21 years of age who require intensive services to prevent admission to an inpatient psychiatric hospital or placement in a residential treatment facility or who require intensive services to step down from inpatient or residential care to community-based care.

(b) "Co-occurring mental illness and substance use disorder" means a dual diagnosis of at least one form of mental illness and at least one substance use disorder. Substance use disorders include alcohol or drug abuse or dependence, excluding nicotine use.

(c) "Standard diagnostic assessment" means the assessment described in section 245I.10, subdivision 6.

(d) "Medication education services" means services provided individually or in groups, which focus on:

(1) educating the client and client's family or significant nonfamilial supporters about mental illness and symptoms;

(2) the role and effects of medications in treating symptoms of mental illness; and

(3) the side effects of medications.

Medication education is coordinated with medication management services and does not duplicate it. Medication education services are provided by physicians, pharmacists, or registered nurses with certification in psychiatric and mental health care.

(e) "Mental health professional" means a staff person who is qualified according to section 245I.04, subdivision 2.

(f) "Provider agency" means a for-profit or nonprofit organization established to administer an assertive community treatment for youth team.

(g) "Substance use disorders" means one or more of the disorders defined in the diagnostic and statistical manual of mental disorders, current edition.

(h) "Transition services" means:

(1) activities, materials, consultation, and coordination that ensures continuity of the client's care in advance of and in preparation for the client's move from one stage of care or life to another by maintaining contact with the client and assisting the client to establish provider relationships;

(2) providing the client with knowledge and skills needed posttransition;

(3) establishing communication between sending and receiving entities;

(4) supporting a client's request for service authorization and enrollment; and

(5) establishing and enforcing procedures and schedules.

A youth's transition from the children's mental health system and services to the adult mental health system and services and return to the client's home and entry or re-entry into community-based mental health services following discharge from an out-of-home placement or inpatient hospital stay.

(i) "Treatment team" means all staff who provide services to recipients under this section.

(j) "Family peer specialist" means a staff person who is qualified under section 256B.0616.

Sec. 77. Minnesota Statutes 2021 Supplement, section 256B.0947, subdivision 3, is amended to read:

Subd. 3. **Client eligibility.** An eligible recipient is an individual who:

(1) is eight years of age or older and under ~~26~~ 21 years of age;

(2) is diagnosed with a serious mental illness or co-occurring mental illness and substance use disorder, for which intensive nonresidential rehabilitative mental health services are needed;

(3) has received a level of care assessment as defined in section 245I.02, subdivision 19, that indicates a need for intensive integrated intervention without 24-hour medical monitoring and a need for extensive collaboration among multiple providers;

(4) has received a functional assessment as defined in section 245I.02, subdivision 17, that indicates functional impairment and a history of difficulty in functioning safely and successfully in the community, school, home, or job; or who is likely to need services from the adult mental health system during adulthood; and

(5) has had a recent standard diagnostic assessment that documents that intensive nonresidential rehabilitative mental health services are medically necessary to ameliorate identified symptoms and functional impairments and to achieve individual transition goals.

Sec. 78. Minnesota Statutes 2021 Supplement, section 256B.0947, subdivision 5, is amended to read:

Subd. 5. **Standards for intensive nonresidential rehabilitative providers.** (a) Services must meet the standards in this section and chapter 245I as required in section 245I.011, subdivision 5.

(b) The treatment team must have specialized training in providing services to the specific age group of youth that the team serves. An individual treatment team must serve youth who are: (1) at least eight years of age or older and under 16 years of age, or (2) at least 14 years of age or older and under ~~26~~ 21 years of age.

(c) The treatment team for intensive nonresidential rehabilitative mental health services comprises both permanently employed core team members and client-specific team members as follows:

(1) Based on professional qualifications and client needs, clinically qualified core team members are assigned on a rotating basis as the client's lead worker to coordinate a client's care. The core team must comprise at least four full-time equivalent direct care staff and must minimally include:

(i) a mental health professional who serves as team leader to provide administrative direction and treatment supervision to the team;

(ii) an advanced-practice registered nurse with certification in psychiatric or mental health care or a board-certified child and adolescent psychiatrist, either of which must be credentialed to prescribe medications;

(iii) a licensed alcohol and drug counselor who is also trained in mental health interventions; and

(iv) a mental health certified peer specialist who is qualified according to section 245I.04, subdivision 10, and is also a former children's mental health consumer.

(2) The core team may also include any of the following:

(i) additional mental health professionals;

(ii) a vocational specialist;

(iii) an educational specialist with knowledge and experience working with youth regarding special education requirements and goals, special education plans, and coordination of educational activities with health care activities;

(iv) a child and adolescent psychiatrist who may be retained on a consultant basis;

(v) a clinical trainee qualified according to section 245I.04, subdivision 6;

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

(vii) a case management service provider, as defined in section 245.4871, subdivision 4;

(viii) a housing access specialist; and

(ix) a family peer specialist as defined in subdivision 2, paragraph (j).

(3) A treatment team may include, in addition to those in clause (1) or (2), ad hoc members not employed by the team who consult on a specific client and who must accept overall clinical direction from the treatment team for the duration of the client's placement with the treatment team and must be paid by the provider agency at the rate for a typical session by that provider with that client or at a rate negotiated with the client-specific member. Client-specific treatment team members may include:

(i) the mental health professional treating the client prior to placement with the treatment team;

(ii) the client's current substance use counselor, if applicable;

(iii) a lead member of the client's individualized education program team or school-based mental health provider, if applicable;

(iv) a representative from the client's health care home or primary care clinic, as needed to ensure integration of medical and behavioral health care;

(v) the client's probation officer or other juvenile justice representative, if applicable; and

(vi) the client's current vocational or employment counselor, if applicable.

(d) The treatment supervisor shall be an active member of the treatment team and shall function as a practicing clinician at least on a part-time basis. The treatment team shall meet with the treatment supervisor at least weekly to discuss recipients' progress and make rapid adjustments to meet recipients' needs. The team meeting must include client-specific case reviews and general treatment discussions among team members. Client-specific case reviews and planning must be documented in the individual client's treatment record.

(e) The staffing ratio must not exceed ten clients to one full-time equivalent treatment team position.

(f) The treatment team shall serve no more than 80 clients at any one time. Should local demand exceed the team's capacity, an additional team must be established rather than exceed this limit.

(g) Nonclinical staff shall have prompt access in person or by telephone to a mental health practitioner, clinical trainee, or mental health professional. The provider shall have the capacity to promptly and appropriately respond to emergent needs and make any necessary staffing adjustments to ensure the health and safety of clients.

(h) The intensive nonresidential rehabilitative mental health services provider shall participate in evaluation of the assertive community treatment for youth (Youth ACT) model as conducted by the commissioner, including the collection and reporting of data and the reporting of performance measures as specified by contract with the commissioner.

(i) A regional treatment team may serve multiple counties.

Sec. 79. Minnesota Statutes 2020, section 256B.0949, subdivision 15, is amended to read:

Subd. 15. **EIDBI provider qualifications.** (a) A QSP must be employed by an agency and be:

(1) a licensed mental health professional who has at least 2,000 hours of supervised clinical experience or training in examining or treating people with ASD or a related condition or equivalent documented coursework at the graduate level by an accredited university in ASD diagnostics, ASD developmental and behavioral treatment strategies, and typical child development; or

(2) a developmental or behavioral pediatrician who has at least 2,000 hours of supervised clinical experience or training in examining or treating people with ASD or a related condition or equivalent documented coursework at the graduate level by an accredited university in the areas of ASD diagnostics, ASD developmental and behavioral treatment strategies, and typical child development.

(b) A level I treatment provider must be employed by an agency and:

(1) have at least 2,000 hours of supervised clinical experience or training in examining or treating people with ASD or a related condition or equivalent documented coursework at the graduate level by an accredited university in ASD diagnostics, ASD developmental and behavioral treatment strategies, and typical child development or an equivalent combination of documented coursework or hours of experience; and

(2) have or be at least one of the following:

(i) a master's degree in behavioral health or child development or related fields including, but not limited to, mental health, special education, social work, psychology, speech pathology, or occupational therapy from an accredited college or university;

(ii) a bachelor's degree in a behavioral health, child development, or related field including, but not limited to, mental health, special education, social work, psychology, speech pathology, or occupational therapy, from an accredited college or university, and advanced certification in a treatment modality recognized by the department;

(iii) a board-certified behavior analyst; or

(iv) a board-certified assistant behavior analyst with 4,000 hours of supervised clinical experience that meets all registration, supervision, and continuing education requirements of the certification.

(c) A level II treatment provider must be employed by an agency and must be:

(1) a person who has a bachelor's degree from an accredited college or university in a behavioral or child development science or related field including, but not limited to, mental health, special education, social work, psychology, speech pathology, or occupational therapy; and meets at least one of the following:

(i) has at least 1,000 hours of supervised clinical experience or training in examining or treating people with ASD or a related condition or equivalent documented coursework at the graduate level by an accredited university in ASD diagnostics, ASD developmental and behavioral treatment strategies, and typical child development or a combination of coursework or hours of experience;

(ii) has certification as a board-certified assistant behavior analyst from the Behavior Analyst Certification Board;

(iii) is a registered behavior technician as defined by the Behavior Analyst Certification Board; or

(iv) is certified in one of the other treatment modalities recognized by the department; or

(2) a person who has:

(i) an associate's degree in a behavioral or child development science or related field including, but not limited to, mental health, special education, social work, psychology, speech pathology, or occupational therapy from an accredited college or university; and

(ii) at least 2,000 hours of supervised clinical experience in delivering treatment to people with ASD or a related condition. Hours worked as a mental health behavioral aide or level III treatment provider may be included in the required hours of experience; or

(3) a person who has at least 4,000 hours of supervised clinical experience in delivering treatment to people with ASD or a related condition. Hours worked as a mental health behavioral aide or level III treatment provider may be included in the required hours of experience; or

(4) a person who is a graduate student in a behavioral science, child development science, or related field and is receiving clinical supervision by a QSP affiliated with an agency to meet the clinical training requirements for experience and training with people with ASD or a related condition; or

(5) a person who is at least 18 years of age and who:

(i) is fluent in a non-English language or an individual certified by a Tribal Nation;

(ii) completed the level III EIDBI training requirements; and

(iii) receives observation and direction from a QSP or level I treatment provider at least once a week until the person meets 1,000 hours of supervised clinical experience.

(d) A level III treatment provider must be employed by an agency, have completed the level III training requirement, be at least 18 years of age, and have at least one of the following:

(1) a high school diploma or commissioner of education-selected high school equivalency certification;

(2) fluency in a non-English language or certification by a Tribal Nation;

(3) one year of experience as a primary personal care assistant, community health worker, waiver service provider, or special education assistant to a person with ASD or a related condition within the previous five years; or

(4) completion of all required EIDBI training within six months of employment.

EFFECTIVE DATE. This section is effective January 1, 2023, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

SENATE ARTICLE 4, SECTION 50 HAS BEEN REMOVED TO MATCH WITH HOUSE ARTICLE 8, SECTION 29.

House Language UES4410-2

Sec. 80. Minnesota Statutes 2020, section 256D.09, subdivision 2a, is amended to read:

Subd. 2a. **Vendor payments for drug dependent persons.** If, at the time of application or at any other time, there is a reasonable basis for questioning whether a person applying for or receiving financial assistance is drug dependent, as defined in section 254A.02, subdivision 5, the person shall be referred for a chemical health assessment, and only emergency assistance payments or general assistance vendor payments may be provided until the assessment is complete and the results of the assessment made available to the county agency. A reasonable basis for referring an individual for an assessment exists when:

(1) the person has required detoxification two or more times in the past 12 months;

(2) the person appears intoxicated at the county agency as indicated by two or more of the following:

(i) the odor of alcohol;

(ii) slurred speech;

(iii) disconjugate gaze;

(iv) impaired balance;

(v) difficulty remaining awake;

(vi) consumption of alcohol;

(vii) responding to sights or sounds that are not actually present;

(viii) extreme restlessness, fast speech, or unusual belligerence;

(3) the person has been involuntarily committed for drug dependency at least once in the past 12 months; or

(4) the person has received treatment, including domiciliary care, for drug abuse or dependency at least twice in the past 12 months.

The assessment and determination of drug dependency, if any, must be made by an assessor qualified under ~~Minnesota Rules, part 9530.6615, subpart 2~~ section 245G.11, subdivisions 1 and 5, to perform an assessment of chemical use. The county shall only provide emergency general assistance or vendor payments to an otherwise eligible applicant or recipient who is determined to be drug dependent, except up to 15 percent of the grant amount the person would otherwise receive may be paid in cash. Notwithstanding subdivision 1, the commissioner of human services shall also require county agencies to provide assistance only in the form of vendor payments to all eligible recipients who assert chemical dependency as a basis for eligibility under section 256D.05, subdivision 1, paragraph (a), clauses (1) and (5).

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Sec. 51. Minnesota Statutes 2020, section 256D.09, subdivision 2a, is amended to read:

Subd. 2a. **Vendor payments for drug dependent persons.** If, at the time of application or at any other time, there is a reasonable basis for questioning whether a person applying for or receiving financial assistance is drug dependent, as defined in section 254A.02, subdivision 5, the person shall be referred for a chemical health assessment, and only emergency assistance payments or general assistance vendor payments may be provided until the assessment is complete and the results of the assessment made available to the county agency. A reasonable basis for referring an individual for an assessment exists when:

(1) the person has required detoxification two or more times in the past 12 months;

(2) the person appears intoxicated at the county agency as indicated by two or more of the following:

(i) the odor of alcohol;

(ii) slurred speech;

(iii) disconjugate gaze;

(iv) impaired balance;

(v) difficulty remaining awake;

(vi) consumption of alcohol;

(vii) responding to sights or sounds that are not actually present;

(viii) extreme restlessness, fast speech, or unusual belligerence;

(3) the person has been involuntarily committed for drug dependency at least once in the past 12 months; or

(4) the person has received treatment, including domiciliary care, for drug abuse or dependency at least twice in the past 12 months.

The assessment and determination of drug dependency, if any, must be made by an assessor qualified under ~~Minnesota Rules, part 9530.6615, subpart 2~~ section 245G.11, subdivisions 1 and 5, to perform an assessment of chemical use. The county shall only provide emergency general assistance or vendor payments to an otherwise eligible applicant or recipient who is determined to be drug dependent, except up to 15 percent of the grant amount the person would otherwise receive may be paid in cash. Notwithstanding subdivision 1, the commissioner of human services shall also require county agencies to provide assistance only in the form of vendor payments to all eligible recipients who assert chemical dependency as a basis for eligibility under section 256D.05, subdivision 1, paragraph (a), clauses (1) and (5).

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The determination of drug dependency shall be reviewed at least every 12 months. If the county determines a recipient is no longer drug dependent, the county may cease vendor payments and provide the recipient payments in cash.

Sec. 81. Minnesota Statutes 2021 Supplement, section 256L.03, subdivision 2, is amended to read:

Subd. 2. **Alcohol and drug dependency.** Beginning July 1, 1993, covered health services shall include individual outpatient treatment of alcohol or drug dependency by a qualified health professional or outpatient program.

Persons who may need chemical dependency services under the provisions of this chapter ~~shall be assessed by a local agency~~ must be offered access by a local agency to a comprehensive assessment as defined under section ~~254B.01~~ 245G.05, and under the assessment provisions of section 254A.03, subdivision 3. A local agency or managed care plan under contract with the Department of Human Services must ~~place~~ offer services to a person in need of chemical dependency services ~~as provided in Minnesota Rules, parts 9530.6600 to 9530.6655~~ based on the recommendations of section 245G.05. Persons who are recipients of medical benefits under the provisions of this chapter and who are financially eligible for behavioral health fund services provided under the provisions of chapter 254B shall receive chemical dependency treatment services under the provisions of chapter 254B only if:

(1) they have exhausted the chemical dependency benefits offered under this chapter; or

(2) an assessment indicates that they need a level of care not provided under the provisions of this chapter.

Recipients of covered health services under the children's health plan, as provided in Minnesota Statutes 1990, section 256.936, and as amended by Laws 1991, chapter 292, article 4, section 17, and recipients of covered health services enrolled in the children's health plan or the MinnesotaCare program after October 1, 1992, pursuant to Laws 1992, chapter 549, article 4, sections 5 and 17, are eligible to receive alcohol and drug dependency benefits under this subdivision.

Sec. 82. Minnesota Statutes 2020, section 256L.12, subdivision 8, is amended to read:

Subd. 8. **Chemical dependency assessments.** The managed care plan shall be responsible for assessing the need and ~~placement for~~ provision of chemical dependency services according to criteria set forth in ~~Minnesota Rules, parts 9530.6600 to 9530.6655~~ section 245G.05.

Sec. 83. Minnesota Statutes 2020, section 260B.157, subdivision 1, is amended to read:

Subdivision 1. **Investigation.** Upon request of the court the local social services agency or probation officer shall investigate the personal and family history and environment of any minor coming within the jurisdiction of the court under section 260B.101 and shall

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The determination of drug dependency shall be reviewed at least every 12 months. If the county determines a recipient is no longer drug dependent, the county may cease vendor payments and provide the recipient payments in cash.

Sec. 52. Minnesota Statutes 2021 Supplement, section 256L.03, subdivision 2, is amended to read:

Subd. 2. **Alcohol and drug dependency.** Beginning July 1, 1993, covered health services shall include individual outpatient treatment of alcohol or drug dependency by a qualified health professional or outpatient program.

Persons who may need chemical dependency services under the provisions of this chapter ~~shall be assessed by a local agency~~ must be offered access by a local agency to a comprehensive assessment as defined under section ~~254B.01~~ 245G.05, and under the assessment provisions of section 254A.03, subdivision 3. A local agency or managed care plan under contract with the Department of Human Services must ~~place~~ offer services to a person in need of chemical dependency services ~~as provided in Minnesota Rules, parts 9530.6600 to 9530.6655~~ based on the recommendations of section 245G.05. Persons who are recipients of medical benefits under the provisions of this chapter and who are financially eligible for behavioral health fund services provided under the provisions of chapter 254B shall receive chemical dependency treatment services under the provisions of chapter 254B only if:

(1) they have exhausted the chemical dependency benefits offered under this chapter; or

(2) an assessment indicates that they need a level of care not provided under the provisions of this chapter.

Recipients of covered health services under the children's health plan, as provided in Minnesota Statutes 1990, section 256.936, and as amended by Laws 1991, chapter 292, article 4, section 17, and recipients of covered health services enrolled in the children's health plan or the MinnesotaCare program after October 1, 1992, pursuant to Laws 1992, chapter 549, article 4, sections 5 and 17, are eligible to receive alcohol and drug dependency benefits under this subdivision.

Sec. 53. Minnesota Statutes 2020, section 256L.12, subdivision 8, is amended to read:

Subd. 8. **Chemical dependency assessments.** The managed care plan shall be responsible for assessing the need and ~~placement for~~ provision of chemical dependency services according to criteria set forth in ~~Minnesota Rules, parts 9530.6600 to 9530.6655~~ section 245G.05.

Sec. 54. Minnesota Statutes 2020, section 260B.157, subdivision 1, is amended to read:

Subdivision 1. **Investigation.** Upon request of the court the local social services agency or probation officer shall investigate the personal and family history and environment of any minor coming within the jurisdiction of the court under section 260B.101 and shall

report its findings to the court. The court may order any minor coming within its jurisdiction to be examined by a duly qualified physician, psychiatrist, or psychologist appointed by the court.

The court shall order a chemical use assessment conducted when a child is (1) found to be delinquent for violating a provision of chapter 152, or for committing a felony-level violation of a provision of chapter 609 if the probation officer determines that alcohol or drug use was a contributing factor in the commission of the offense, or (2) alleged to be delinquent for violating a provision of chapter 152, if the child is being held in custody under a detention order. The assessor's qualifications must comply with section 245G.11, subdivisions 1 and 5, and the assessment criteria ~~shall~~ must comply with ~~Minnesota Rules, parts 9530.6600 to 9530.6655~~ section 245G.05. If funds under chapter 254B are to be used to pay for the recommended treatment, the assessment ~~and placement~~ must comply with all provisions of ~~Minnesota Rules, parts 9530.6600 to 9530.6655 and 9530.7000 to 9530.7030~~ sections 245G.05 and 254B.04. The commissioner of human services shall reimburse the court for the cost of the chemical use assessment, up to a maximum of $100.

The court shall order a children's mental health screening conducted when a child is found to be delinquent. The screening shall be conducted with a screening instrument approved by the commissioner of human services and shall be conducted by a mental health practitioner as defined in section 245.4871, subdivision 26, or a probation officer who is trained in the use of the screening instrument. If the screening indicates a need for assessment, the local social services agency, in consultation with the child's family, shall have a diagnostic assessment conducted, including a functional assessment, as defined in section 245.4871.

With the consent of the commissioner of corrections and agreement of the county to pay the costs thereof, the court may, by order, place a minor coming within its jurisdiction in an institution maintained by the commissioner for the detention, diagnosis, custody and treatment of persons adjudicated to be delinquent, in order that the condition of the minor be given due consideration in the disposition of the case. Any funds received under the provisions of this subdivision shall not cancel until the end of the fiscal year immediately following the fiscal year in which the funds were received. The funds are available for use by the commissioner of corrections during that period and are hereby appropriated annually to the commissioner of corrections as reimbursement of the costs of providing these services to the juvenile courts.

Sec. 84. Minnesota Statutes 2020, section 260B.157, subdivision 3, is amended to read:

Subd. 3. **Juvenile treatment screening team.** (a) The local social services agency shall establish a juvenile treatment screening team to conduct screenings and prepare case plans under this subdivision. The team, which may be the team constituted under section 245.4885 or 256B.092 or ~~Minnesota Rules, parts 9530.6600 to 9530.6655~~ chapter 254B, shall consist of social workers, juvenile justice professionals, and persons with expertise in the treatment of juveniles who are emotionally disabled, chemically dependent, or have a developmental disability. The team shall involve parents or guardians in the screening process as appropriate. The team may be the same team as defined in section 260C.157, subdivision 3.

report its findings to the court. The court may order any minor coming within its jurisdiction to be examined by a duly qualified physician, psychiatrist, or psychologist appointed by the court.

The court shall order a chemical use assessment conducted when a child is (1) found to be delinquent for violating a provision of chapter 152, or for committing a felony-level violation of a provision of chapter 609 if the probation officer determines that alcohol or drug use was a contributing factor in the commission of the offense, or (2) alleged to be delinquent for violating a provision of chapter 152, if the child is being held in custody under a detention order. The assessor's qualifications must comply with section 245G.11, subdivisions 1 and 5, and the assessment criteria ~~shall~~ must comply with ~~Minnesota Rules, parts 9530.6600 to 9530.6655~~ section 245G.05. If funds under chapter 254B are to be used to pay for the recommended treatment, the assessment ~~and placement~~ must comply with all provisions of ~~Minnesota Rules, parts 9530.6600 to 9530.6655 and 9530.7000 to 9530.7030~~ sections 245G.05 and 254B.04. The commissioner of human services shall reimburse the court for the cost of the chemical use assessment, up to a maximum of $100.

The court shall order a children's mental health screening conducted when a child is found to be delinquent. The screening shall be conducted with a screening instrument approved by the commissioner of human services and shall be conducted by a mental health practitioner as defined in section 245.4871, subdivision 26, or a probation officer who is trained in the use of the screening instrument. If the screening indicates a need for assessment, the local social services agency, in consultation with the child's family, shall have a diagnostic assessment conducted, including a functional assessment, as defined in section 245.4871.

With the consent of the commissioner of corrections and agreement of the county to pay the costs thereof, the court may, by order, place a minor coming within its jurisdiction in an institution maintained by the commissioner for the detention, diagnosis, custody and treatment of persons adjudicated to be delinquent, in order that the condition of the minor be given due consideration in the disposition of the case. Any funds received under the provisions of this subdivision shall not cancel until the end of the fiscal year immediately following the fiscal year in which the funds were received. The funds are available for use by the commissioner of corrections during that period and are hereby appropriated annually to the commissioner of corrections as reimbursement of the costs of providing these services to the juvenile courts.

Sec. 55. Minnesota Statutes 2020, section 260B.157, subdivision 3, is amended to read:

Subd. 3. **Juvenile treatment screening team.** (a) The local social services agency shall establish a juvenile treatment screening team to conduct screenings and prepare case plans under this subdivision. The team, which may be the team constituted under section 245.4885 or 256B.092 or ~~Minnesota Rules, parts 9530.6600 to 9530.6655~~ chapter 254B, shall consist of social workers, juvenile justice professionals, and persons with expertise in the treatment of juveniles who are emotionally disabled, chemically dependent, or have a developmental disability. The team shall involve parents or guardians in the screening process as appropriate. The team may be the same team as defined in section 260C.157, subdivision 3.

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(b) If the court, prior to, or as part of, a final disposition, proposes to place a child:

(1) for the primary purpose of treatment for an emotional disturbance, and residential placement is consistent with section 260.012, a developmental disability, or chemical dependency in a residential treatment facility out of state or in one which is within the state and licensed by the commissioner of human services under chapter 245A; or

(2) in any out-of-home setting potentially exceeding 30 days in duration, including a post-dispositional placement in a facility licensed by the commissioner of corrections or human services, the court shall notify the county welfare agency. The county's juvenile treatment screening team must either:

(i) screen and evaluate the child and file its recommendations with the court within 14 days of receipt of the notice; or

(ii) elect not to screen a given case, and notify the court of that decision within three working days.

(c) If the screening team has elected to screen and evaluate the child, the child may not be placed for the primary purpose of treatment for an emotional disturbance, a developmental disability, or chemical dependency, in a residential treatment facility out of state nor in a residential treatment facility within the state that is licensed under chapter 245A, unless one of the following conditions applies:

(1) a treatment professional certifies that an emergency requires the placement of the child in a facility within the state;

(2) the screening team has evaluated the child and recommended that a residential placement is necessary to meet the child's treatment needs and the safety needs of the community, that it is a cost-effective means of meeting the treatment needs, and that it will be of therapeutic value to the child; or

(3) the court, having reviewed a screening team recommendation against placement, determines to the contrary that a residential placement is necessary. The court shall state the reasons for its determination in writing, on the record, and shall respond specifically to the findings and recommendation of the screening team in explaining why the recommendation was rejected. The attorney representing the child and the prosecuting attorney shall be afforded an opportunity to be heard on the matter.

Sec. 85. Minnesota Statutes 2021 Supplement, section 260C.157, subdivision 3, is amended to read:

Subd. 3. **Juvenile treatment screening team.** (a) The responsible social services agency shall establish a juvenile treatment screening team to conduct screenings under this chapter and chapter 260D, for a child to receive treatment for an emotional disturbance, a developmental disability, or related condition in a residential treatment facility licensed by the commissioner of human services under chapter 245A, or licensed or approved by a Tribe. A screening team is not required for a child to be in: (1) a residential facility

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(b) If the court, prior to, or as part of, a final disposition, proposes to place a child:

(1) for the primary purpose of treatment for an emotional disturbance, and residential placement is consistent with section 260.012, a developmental disability, or chemical dependency in a residential treatment facility out of state or in one which is within the state and licensed by the commissioner of human services under chapter 245A; or

(2) in any out-of-home setting potentially exceeding 30 days in duration, including a post-dispositional placement in a facility licensed by the commissioner of corrections or human services, the court shall notify the county welfare agency. The county's juvenile treatment screening team must either:

(i) screen and evaluate the child and file its recommendations with the court within 14 days of receipt of the notice; or

(ii) elect not to screen a given case, and notify the court of that decision within three working days.

(c) If the screening team has elected to screen and evaluate the child, the child may not be placed for the primary purpose of treatment for an emotional disturbance, a developmental disability, or chemical dependency, in a residential treatment facility out of state nor in a residential treatment facility within the state that is licensed under chapter 245A, unless one of the following conditions applies:

(1) a treatment professional certifies that an emergency requires the placement of the child in a facility within the state;

(2) the screening team has evaluated the child and recommended that a residential placement is necessary to meet the child's treatment needs and the safety needs of the community, that it is a cost-effective means of meeting the treatment needs, and that it will be of therapeutic value to the child; or

(3) the court, having reviewed a screening team recommendation against placement, determines to the contrary that a residential placement is necessary. The court shall state the reasons for its determination in writing, on the record, and shall respond specifically to the findings and recommendation of the screening team in explaining why the recommendation was rejected. The attorney representing the child and the prosecuting attorney shall be afforded an opportunity to be heard on the matter.

Sec. 56. Minnesota Statutes 2021 Supplement, section 260C.157, subdivision 3, is amended to read:

Subd. 3. **Juvenile treatment screening team.** (a) The responsible social services agency shall establish a juvenile treatment screening team to conduct screenings under this chapter and chapter 260D, for a child to receive treatment for an emotional disturbance, a developmental disability, or related condition in a residential treatment facility licensed by the commissioner of human services under chapter 245A, or licensed or approved by a Tribe. A screening team is not required for a child to be in: (1) a residential facility

specializing in prenatal, postpartum, or parenting support; (2) a facility specializing in high-quality residential care and supportive services to children and youth who have been or are at risk of becoming victims of sex trafficking or commercial sexual exploitation; (3) supervised settings for youth who are 18 years of age or older and living independently; or (4) a licensed residential family-based treatment facility for substance abuse consistent with section 260C.190. Screenings are also not required when a child must be placed in a facility due to an emotional crisis or other mental health emergency.

(b) The responsible social services agency shall conduct screenings within 15 days of a request for a screening, unless the screening is for the purpose of residential treatment and the child is enrolled in a prepaid health program under section 256B.69, in which case the agency shall conduct the screening within ten working days of a request. The responsible social services agency shall convene the juvenile treatment screening team, which may be constituted under section 245.4885 ~~or~~, 254B.05, or 256B.092 ~~or Minnesota Rules, parts 9530.6600 to 9530.6655~~. The team shall consist of social workers; persons with expertise in the treatment of juveniles who are emotionally disturbed, chemically dependent, or have a developmental disability; and the child's parent, guardian, or permanent legal custodian. The team may include the child's relatives as defined in section 260C.007, subdivisions 26b and 27, the child's foster care provider, and professionals who are a resource to the child's family such as teachers, medical or mental health providers, and clergy, as appropriate, consistent with the family and permanency team as defined in section 260C.007, subdivision 16a. Prior to forming the team, the responsible social services agency must consult with the child's parents, the child if the child is age 14 or older, and, if applicable, the child's Tribe to obtain recommendations regarding which individuals to include on the team and to ensure that the team is family-centered and will act in the child's best interests. If the child, child's parents, or legal guardians raise concerns about specific relatives or professionals, the team should not include those individuals. This provision does not apply to paragraph (c).

(c) If the agency provides notice to Tribes under section 260.761, and the child screened is an Indian child, the responsible social services agency must make a rigorous and concerted effort to include a designated representative of the Indian child's Tribe on the juvenile treatment screening team, unless the child's Tribal authority declines to appoint a representative. The Indian child's Tribe may delegate its authority to represent the child to any other federally recognized Indian Tribe, as defined in section 260.755, subdivision 12. The provisions of the Indian Child Welfare Act of 1978, United States Code, title 25, sections 1901 to 1963, and the Minnesota Indian Family Preservation Act, sections 260.751 to 260.835, apply to this section.

(d) If the court, prior to, or as part of, a final disposition or other court order, proposes to place a child with an emotional disturbance or developmental disability or related condition in residential treatment, the responsible social services agency must conduct a screening. If the team recommends treating the child in a qualified residential treatment program, the agency must follow the requirements of sections 260C.70 to 260C.714.

specializing in prenatal, postpartum, or parenting support; (2) a facility specializing in high-quality residential care and supportive services to children and youth who have been or are at risk of becoming victims of sex trafficking or commercial sexual exploitation; (3) supervised settings for youth who are 18 years of age or older and living independently; or (4) a licensed residential family-based treatment facility for substance abuse consistent with section 260C.190. Screenings are also not required when a child must be placed in a facility due to an emotional crisis or other mental health emergency.

(b) The responsible social services agency shall conduct screenings within 15 days of a request for a screening, unless the screening is for the purpose of residential treatment and the child is enrolled in a prepaid health program under section 256B.69, in which case the agency shall conduct the screening within ten working days of a request. The responsible social services agency shall convene the juvenile treatment screening team, which may be constituted under section 245.4885 ~~or~~, 254B.05, or 256B.092 ~~or Minnesota Rules, parts 9530.6600 to 9530.6655~~. The team shall consist of social workers; persons with expertise in the treatment of juveniles who are emotionally disturbed, chemically dependent, or have a developmental disability; and the child's parent, guardian, or permanent legal custodian. The team may include the child's relatives as defined in section 260C.007, subdivisions 26b and 27, the child's foster care provider, and professionals who are a resource to the child's family such as teachers, medical or mental health providers, and clergy, as appropriate, consistent with the family and permanency team as defined in section 260C.007, subdivision 16a. Prior to forming the team, the responsible social services agency must consult with the child's parents, the child if the child is age 14 or older, and, if applicable, the child's Tribe to obtain recommendations regarding which individuals to include on the team and to ensure that the team is family-centered and will act in the child's best interests. If the child, child's parents, or legal guardians raise concerns about specific relatives or professionals, the team should not include those individuals. This provision does not apply to paragraph (c).

(c) If the agency provides notice to Tribes under section 260.761, and the child screened is an Indian child, the responsible social services agency must make a rigorous and concerted effort to include a designated representative of the Indian child's Tribe on the juvenile treatment screening team, unless the child's Tribal authority declines to appoint a representative. The Indian child's Tribe may delegate its authority to represent the child to any other federally recognized Indian Tribe, as defined in section 260.755, subdivision 12. The provisions of the Indian Child Welfare Act of 1978, United States Code, title 25, sections 1901 to 1963, and the Minnesota Indian Family Preservation Act, sections 260.751 to 260.835, apply to this section.

(d) If the court, prior to, or as part of, a final disposition or other court order, proposes to place a child with an emotional disturbance or developmental disability or related condition in residential treatment, the responsible social services agency must conduct a screening. If the team recommends treating the child in a qualified residential treatment program, the agency must follow the requirements of sections 260C.70 to 260C.714.

The court shall ascertain whether the child is an Indian child and shall notify the responsible social services agency and, if the child is an Indian child, shall notify the Indian child's Tribe as paragraph (c) requires.

(e) When the responsible social services agency is responsible for placing and caring for the child and the screening team recommends placing a child in a qualified residential treatment program as defined in section 260C.007, subdivision 26d, the agency must: (1) begin the assessment and processes required in section 260C.704 without delay; and (2) conduct a relative search according to section 260C.221 to assemble the child's family and permanency team under section 260C.706. Prior to notifying relatives regarding the family and permanency team, the responsible social services agency must consult with the child's parent or legal guardian, the child if the child is age 14 or older, and, if applicable, the child's Tribe to ensure that the agency is providing notice to individuals who will act in the child's best interests. The child and the child's parents may identify a culturally competent qualified individual to complete the child's assessment. The agency shall make efforts to refer the assessment to the identified qualified individual. The assessment may not be delayed for the purpose of having the assessment completed by a specific qualified individual.

(f) When a screening team determines that a child does not need treatment in a qualified residential treatment program, the screening team must:

(1) document the services and supports that will prevent the child's foster care placement and will support the child remaining at home;

(2) document the services and supports that the agency will arrange to place the child in a family foster home; or

(3) document the services and supports that the agency has provided in any other setting.

(g) When the Indian child's Tribe or Tribal health care services provider or Indian Health Services provider proposes to place a child for the primary purpose of treatment for an emotional disturbance, a developmental disability, or co-occurring emotional disturbance and chemical dependency, the Indian child's Tribe or the Tribe delegated by the child's Tribe shall submit necessary documentation to the county juvenile treatment screening team, which must invite the Indian child's Tribe to designate a representative to the screening team.

(h) The responsible social services agency must conduct and document the screening in a format approved by the commissioner of human services.

Sec. 86. Minnesota Statutes 2020, section 260E.20, subdivision 1, is amended to read:

Subdivision 1. **General duties.** (a) The local welfare agency shall offer services to prevent future maltreatment, safeguarding and enhancing the welfare of the maltreated child, and supporting and preserving family life whenever possible.

(b) If the report alleges a violation of a criminal statute involving maltreatment or child endangerment under section 609.378, the local law enforcement agency and local welfare

The court shall ascertain whether the child is an Indian child and shall notify the responsible social services agency and, if the child is an Indian child, shall notify the Indian child's Tribe as paragraph (c) requires.

(e) When the responsible social services agency is responsible for placing and caring for the child and the screening team recommends placing a child in a qualified residential treatment program as defined in section 260C.007, subdivision 26d, the agency must: (1) begin the assessment and processes required in section 260C.704 without delay; and (2) conduct a relative search according to section 260C.221 to assemble the child's family and permanency team under section 260C.706. Prior to notifying relatives regarding the family and permanency team, the responsible social services agency must consult with the child's parent or legal guardian, the child if the child is age 14 or older, and, if applicable, the child's Tribe to ensure that the agency is providing notice to individuals who will act in the child's best interests. The child and the child's parents may identify a culturally competent qualified individual to complete the child's assessment. The agency shall make efforts to refer the assessment to the identified qualified individual. The assessment may not be delayed for the purpose of having the assessment completed by a specific qualified individual.

(f) When a screening team determines that a child does not need treatment in a qualified residential treatment program, the screening team must:

(1) document the services and supports that will prevent the child's foster care placement and will support the child remaining at home;

(2) document the services and supports that the agency will arrange to place the child in a family foster home; or

(3) document the services and supports that the agency has provided in any other setting.

(g) When the Indian child's Tribe or Tribal health care services provider or Indian Health Services provider proposes to place a child for the primary purpose of treatment for an emotional disturbance, a developmental disability, or co-occurring emotional disturbance and chemical dependency, the Indian child's Tribe or the Tribe delegated by the child's Tribe shall submit necessary documentation to the county juvenile treatment screening team, which must invite the Indian child's Tribe to designate a representative to the screening team.

(h) The responsible social services agency must conduct and document the screening in a format approved by the commissioner of human services.

Sec. 57. Minnesota Statutes 2020, section 260E.20, subdivision 1, is amended to read:

Subdivision 1. **General duties.** (a) The local welfare agency shall offer services to prevent future maltreatment, safeguarding and enhancing the welfare of the maltreated child, and supporting and preserving family life whenever possible.

(b) If the report alleges a violation of a criminal statute involving maltreatment or child endangerment under section 609.378, the local law enforcement agency and local welfare

agency shall coordinate the planning and execution of their respective investigation and assessment efforts to avoid a duplication of fact-finding efforts and multiple interviews. Each agency shall prepare a separate report of the results of the agency's investigation or assessment.

(c) In cases of alleged child maltreatment resulting in death, the local agency may rely on the fact-finding efforts of a law enforcement investigation to make a determination of whether or not maltreatment occurred.

(d) When necessary, the local welfare agency shall seek authority to remove the child from the custody of a parent, guardian, or adult with whom the child is living.

(e) In performing any of these duties, the local welfare agency shall maintain an appropriate record.

(f) In conducting a family assessment or investigation, the local welfare agency shall gather information on the existence of substance abuse and domestic violence.

(g) If the family assessment or investigation indicates there is a potential for abuse of alcohol or other drugs by the parent, guardian, or person responsible for the child's care, the local welfare agency ~~shall conduct a chemical use~~ must coordinate a comprehensive assessment pursuant to ~~Minnesota Rules, part 9530.6615~~ section 245G.05.

(h) The agency may use either a family assessment or investigation to determine whether the child is safe when responding to a report resulting from birth match data under section 260E.03, subdivision 23, paragraph (c). If the child subject of birth match data is determined to be safe, the agency shall consult with the county attorney to determine the appropriateness of filing a petition alleging the child is in need of protection or services under section 260C.007, subdivision 6, clause (16), in order to deliver needed services. If the child is determined not to be safe, the agency and the county attorney shall take appropriate action as required under section 260C.503, subdivision 2.

agency shall coordinate the planning and execution of their respective investigation and assessment efforts to avoid a duplication of fact-finding efforts and multiple interviews. Each agency shall prepare a separate report of the results of the agency's investigation or assessment.

(c) In cases of alleged child maltreatment resulting in death, the local agency may rely on the fact-finding efforts of a law enforcement investigation to make a determination of whether or not maltreatment occurred.

(d) When necessary, the local welfare agency shall seek authority to remove the child from the custody of a parent, guardian, or adult with whom the child is living.

(e) In performing any of these duties, the local welfare agency shall maintain an appropriate record.

(f) In conducting a family assessment or investigation, the local welfare agency shall gather information on the existence of substance abuse and domestic violence.

(g) If the family assessment or investigation indicates there is a potential for abuse of alcohol or other drugs by the parent, guardian, or person responsible for the child's care, the local welfare agency ~~shall conduct a chemical use~~ must coordinate a comprehensive assessment pursuant to ~~Minnesota Rules, part 9530.6615~~ section 245G.05.

(h) The agency may use either a family assessment or investigation to determine whether the child is safe when responding to a report resulting from birth match data under section 260E.03, subdivision 23, paragraph (c). If the child subject of birth match data is determined to be safe, the agency shall consult with the county attorney to determine the appropriateness of filing a petition alleging the child is in need of protection or services under section 260C.007, subdivision 6, clause (16), in order to deliver needed services. If the child is determined not to be safe, the agency and the county attorney shall take appropriate action as required under section 260C.503, subdivision 2.

Sec. 58. Minnesota Statutes 2021 Supplement, section 297E.02, subdivision 3, is amended to read:

Subd. 3. **Collection; disposition.** (a) Taxes imposed by this section are due and payable to the commissioner when the gambling tax return is required to be filed. Distributors must file their monthly sales figures with the commissioner on a form prescribed by the commissioner. Returns covering the taxes imposed under this section must be filed with the commissioner on or before the 20th day of the month following the close of the previous calendar month. The commissioner shall prescribe the content, format, and manner of returns or other documents pursuant to section 270C.30. The proceeds, along with the revenue received from all license fees and other fees under sections 349.11 to 349.191, 349.211, and 349.213, must be paid to the commissioner of management and budget for deposit in the general fund.

(b) The sales tax imposed by chapter 297A on the sale of pull-tabs and tipboards by the distributor is imposed on the retail sales price. The retail sale of pull-tabs or tipboards by the organization is exempt from taxes imposed by chapter 297A and is exempt from all local taxes and license fees except a fee authorized under section 349.16, subdivision 8.

(c) One-half of one percent of the revenue deposited in the general fund under paragraph (a), is appropriated to the commissioner of human services for the compulsive gambling treatment program established under section 245.98. Money appropriated under this paragraph must not replace existing state funding for these programs.

(d) One-half of one percent of the revenue deposited in the general fund under paragraph (a), is appropriated to the commissioner of human services ~~for a grant~~. By June 30 of each fiscal year, the commissioner of human services must transfer the amount deposited in the general fund under this paragraph to the special revenue fund. By October 15 of each fiscal year, the commissioner of human services must award a grant in an amount equal to the entire amount transferred to the special revenue fund under this paragraph for the prior fiscal year to the state affiliate recognized by the National Council on Problem Gambling to increase public awareness of problem gambling, education and training for individuals and organizations providing effective treatment services to problem gamblers and their families, and research relating to problem gambling. Money appropriated by this paragraph must supplement and must not replace existing state funding for these programs.

~~(d)~~ (e) The commissioner of human services must provide to the state affiliate recognized by the National Council on Problem Gambling a monthly statement of the amounts deposited under ~~paragraph~~ paragraphs (c) and (d). Beginning January 1, 2022, the commissioner of human services must provide to the chairs and ranking minority members of the legislative committees with jurisdiction over treatment for problem gambling and to the state affiliate recognized by the National Council on Problem Gambling an annual reconciliation of the amounts deposited under paragraph (c). The annual reconciliation under this paragraph must include the amount allocated to the commissioner of human services for the compulsive gambling treatment program established under section 245.98, and the amount allocated to the state affiliate recognized by the National Council on Problem Gambling.

Sec. 59. Minnesota Statutes 2020, section 297E.021, subdivision 3, is amended to read:

Subd. 3. **Available revenues.** For purposes of this section, "available revenues" equals the amount determined under subdivision 2, plus up to $20,000,000 each fiscal year from the taxes imposed under section 290.06, subdivision 1:

(1) reduced by the following amounts paid for the fiscal year under:

(i) the appropriation to principal and interest on appropriation bonds under section 16A.965, subdivision 8;

(ii) the appropriation from the general fund to make operating expense payments under section 473J.13, subdivision 2, paragraph (b);

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Sec. 87. Minnesota Statutes 2020, section 299A.299, subdivision 1, is amended to read:

Subdivision 1. **Establishment of team.** A county, a multicounty organization of counties formed by an agreement under section 471.59, or a city with a population of no more than 50,000, may establish a multidisciplinary chemical abuse prevention team. The chemical abuse prevention team may include, but not be limited to, representatives of health, mental health, public health, law enforcement, educational, social service, court service, community education, religious, and other appropriate agencies, and parent and youth groups. For purposes of this section, "chemical abuse" has the meaning given in ~~Minnesota Rules, part 9530.6605, subpart 6~~ section 254A.02, subdivision 6a. When possible the team must coordinate its activities with existing local groups, organizations, and teams dealing with the same issues the team is addressing.

HOUSE ARTICLE 13, SECTION 38 AMENDS THE SAME STATUTE SIMILARLY TO SENATE ARTICLE 4, SECTION 61.

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(iii) the appropriation for contributions to the capital reserve fund under section 473J.13, subdivision 4, paragraph (c);

(iv) the appropriations under Laws 2012, chapter 299, article 4, for administration and any successor appropriation;

(v) the reduction in revenues resulting from the sales tax exemptions under section 297A.71, subdivision 43;

(vi) reimbursements authorized by section 473J.15, subdivision 2, paragraph (d);

(vii) the compulsive gambling appropriations under section 297E.02, subdivision 3, ~~paragraph~~ paragraphs (c) and (d), and any successor appropriation; and

(viii) the appropriation for the city of St. Paul under section 16A.726, paragraph (c); and

(2) increased by the revenue deposited in the general fund under section 297A.994, subdivision 4, clauses (1) to (3), for the fiscal year.

Sec. 60. Minnesota Statutes 2020, section 299A.299, subdivision 1, is amended to read:

Subdivision 1. **Establishment of team.** A county, a multicounty organization of counties formed by an agreement under section 471.59, or a city with a population of no more than 50,000, may establish a multidisciplinary chemical abuse prevention team. The chemical abuse prevention team may include, but not be limited to, representatives of health, mental health, public health, law enforcement, educational, social service, court service, community education, religious, and other appropriate agencies, and parent and youth groups. For purposes of this section, "chemical abuse" has the meaning given in ~~Minnesota Rules, part 9530.6605, subpart 6~~ section 254A.02, subdivision 6a. When possible the team must coordinate its activities with existing local groups, organizations, and teams dealing with the same issues the team is addressing.

Sec. 61. Minnesota Statutes 2020, section 626.5571, subdivision 1, is amended to read:

Subdivision 1. **Establishment of team.** A county may establish a multidisciplinary adult protection team comprised of the director of the local welfare agency or designees, the county attorney or designees, the county sheriff or designees, and representatives of health care. In addition, representatives of mental health or other appropriate human service agencies, community corrections agencies, representatives from local tribal governments, local law enforcement agencies or designees thereof, and adult advocate groups may be added to the adult protection team.

Sec. 62. **[626.8477] MENTAL HEALTH AND HEALTH RECORDS; WRITTEN POLICY REQUIRED.**

The chief officer of every state and local law enforcement agency that seeks or uses mental health data under section 13.46, subdivision 7, paragraph (c), or health records under section 144.294, subdivision 2, must establish and enforce a written policy governing its

Sec. 88. Laws 2021, First Special Session chapter 7, article 17, section 1, subdivision 2, is amended to read:

Subd. 2. **Eligibility.** An individual is eligible for the transition to community initiative if the individual does not meet eligibility criteria for the medical assistance program under section 256B.056 or 256B.057, but who meets at least one of the following criteria:

(1) the person otherwise meets the criteria under section 256B.092, subdivision 13, or 256B.49, subdivision 24;

(2) the person has met treatment objectives and no longer requires a hospital-level care or a secure treatment setting, but the person's discharge from the Anoka Metro Regional Treatment Center, the Minnesota Security Hospital, or a community behavioral health hospital would be substantially delayed without additional resources available through the transitions to community initiative;

(3) the person is in a community hospital ~~and on the waiting list for the Anoka Metro Regional Treatment Center~~, but alternative community living options would be appropriate for the person~~, and the person has received approval from the commissioner~~; or

(4)(i) the person is receiving customized living services reimbursed under section 256B.4914, 24-hour customized living services reimbursed under section 256B.4914, or community residential services reimbursed under section 256B.4914; (ii) the person expresses a desire to move; and (iii) the person has received approval from the commissioner.

Sec. 89. Laws 2021, First Special Session chapter 7, article 17, section 11, is amended to read:

Sec. 11. **EXPAND MOBILE CRISIS.**

~~(a)~~ This act includes $8,000,000 in fiscal year 2022 and $8,000,000 in fiscal year 2023 for additional funding for grants for adult mobile crisis services under Minnesota Statutes, section 245.4661, subdivision 9, paragraph (b), clause (15) and children's mobile crisis services under Minnesota Statutes, section 256B.0944. The general fund base in this act for this purpose is ~~$4,000,000~~ $8,000,000 in fiscal year 2024 and ~~$0~~ $8,000,000 in fiscal year 2025.

use. At a minimum, the written policy must incorporate the requirements of sections 13.46, subdivision 7, paragraph (c), and 144.294, subdivision 2, and access procedures, retention policies, and data security safeguards that, at a minimum, meet the requirements of chapter 13 and any other applicable law.

Sec. 63. **OLMSTED COUNTY RECOVERY COMMUNITY ORGANIZATION.**

The commissioner of human services shall establish a grant to a recovery community organization in Olmsted County, located in the city of Rochester, Minnesota, that provides services in an 11-county region, to provide services to individuals in substance use recovery.

~~(b) Beginning April 1, 2024, counties may fund and continue conducting activities funded under this section.~~

~~(c) All grant activities must be completed by March 31, 2024.~~

~~(d) This section expires June 30, 2024.~~

Sec. 90. Laws 2021, First Special Session chapter 7, article 17, section 12, is amended to read:

Sec. 12. **~~PSYCHIATRIC RESIDENTIAL TREATMENT FACILITY AND CHILD AND ADOLESCENT~~ ADULT AND CHILDREN'S MOBILE TRANSITION ~~UNIT~~ UNITS.**

(a) This act includes $2,500,000 in fiscal year 2022 and $2,500,000 in fiscal year 2023 for the commissioner of human services to create adult and children's mental health transition and support teams to facilitate transition back to the community ~~of children~~ or to the least restrictive level of care from inpatient psychiatric settings, emergency departments, residential treatment facilities, and child and adolescent behavioral health hospitals. The general fund base included in this act for this purpose is $1,875,000 in fiscal year 2024 and $0 in fiscal year 2025.

(b) Beginning April 1, 2024, counties may fund and continue conducting activities funded under this section.

(c) This section expires March 31, 2024.

Sec. 91. **RATE INCREASE FOR MENTAL HEALTH ADULT DAY TREATMENT.**

The commissioner of human services must increase the reimbursement rate for adult day treatment by 50 percent over the reimbursement rate in effect as of June 30, 2022.

EFFECTIVE DATE. This section is effective January 1, 2023, or 60 days following federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 92. **DIRECTION TO COMMISSIONER.**

The commissioner must update the behavioral health fund room and board rate schedule to include programs providing children's mental health crisis admissions and stabilization under Minnesota Statutes, section 245.4882, subdivision 6. The commissioner must establish room and board rates commensurate with current room and board rates for adolescent programs licensed under Minnesota Statutes, section 245G.18.

Sec. 64. **RATE INCREASE FOR ADULT DAY TREATMENT SERVICES.**

Effective January 1, 2023, or 60 days following federal approval, whichever is later, the commissioner of human services shall increase the reimbursement rate under Minnesota Rules, part 9505.0372, subpart 8, for adult day treatment services covered under Minnesota Statutes, section 256B.0671, subdivision 3, by 50 percent from the rates in effect on December 31, 2022.

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Sec. 93. **DIRECTION TO COMMISSIONER; BEHAVIORAL HEALTH FUND ALLOCATION.**

The commissioner of human services, in consultation with counties and Tribal Nations, must make recommendations on an updated allocation to local agencies from funds allocated under Minnesota Statutes, section 254B.02, subdivision 5. The commissioner must submit the recommendations to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services finance and policy by January 1, 2024.

Sec. 94. **DIRECTION TO COMMISSIONER; MEDICATION-ASSISTED THERAPY SERVICES PAYMENT METHODOLOGY.**

The commissioner of human services shall revise the payment methodology for medication-assisted therapy services under Minnesota Statutes, section 254B.05, subdivision 5, paragraph (b), clause (6). The revised payment methodology must only allow payment if the provider renders the service or services billed on the specified date of service or, in the case of drugs and drug-related services, within a week of the specified date of service, as defined by the commissioner. The revised payment methodology must include a weekly bundled rate, based on the Medicare rate, that includes the costs of drugs; drug administration and observation; drug packaging and preparation; and nursing time. The commissioner shall seek all necessary waivers, state plan amendments, and federal authorizations required to implement the revised payment methodology.

Sec. 95. **REVISOR INSTRUCTION.**

(a) The revisor of statutes shall change the terms "medication-assisted treatment" and "medication-assisted therapy" or similar terms to "substance use disorder treatment with medications for opioid use disorder" whenever the terms appear in Minnesota Statutes and Minnesota Rules. The revisor may make technical and other necessary grammatical changes related to the term change.

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Sec. 65. **ROCHESTER NONPROFIT RECOVERY COMMUNITY ORGANIZATION.**

The commissioner shall establish a grant to a nonprofit recovery community organization located in the city of Rochester, Minnesota, that provides pretreatment housing, post-treatment recovery housing, treatment coordination, and peer recovery support to individuals pursuing a life of recovery from substance use disorders, and that also offers a recovery coaching academy to individuals interested in becoming peer recovery specialists.

Sec. 66. **WELLNESS IN THE WOODS.**

The commissioner shall establish a grant to Wellness in the Woods to provide daily peer support and special sessions for individuals who are in substance use recovery, are transitioning out of incarceration, or have experienced trauma.

Sec. 67. **DIRECTION TO THE COMMISSIONER OF HUMAN SERVICES; BEHAVIORAL HEALTH FUND ALLOCATION.**

The commissioner of human services, in consultation with counties and Tribal Nations, must make recommendations on an updated allocation to local agencies from funds allocated under Minnesota Statutes, section 254B.02, subdivision 5. The commissioner must submit the recommendations to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services finance and policy by January 1, 2024.

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(b) The revisor of statutes shall change the term "intensive treatment in foster care" or similar terms to "children's intensive behavioral health services" wherever they appear in Minnesota Statutes and Minnesota Rules when referring to those providers and services regulated under Minnesota Statutes, section 256B.0946. The revisor shall make technical and grammatical changes related to the changes in terms.

Sec. 96. **REPEALER.**

(a) Minnesota Statutes 2020, sections 169A.70, subdivision 6; 245G.22, subdivision 19; 254A.02, subdivision 8a; 254A.16, subdivision 6; 254A.19, subdivisions 1a and 2; 254B.04, subdivisions 2b and 2c; and 254B.041, subdivision 2, are repealed.

(b) Minnesota Statutes 2021 Supplement, section 254A.19, subdivision 5, is repealed.

(c) Minnesota Rules, parts 9530.7000, subparts 1, 2, 5, 6, 7, 8, 9, 10, 11, 13, 14, 15, 17a, 19, 20, and 21; 9530.7005; 9530.7010; 9530.7012; 9530.7015, subparts 1, 2a, 4, 5, and 6; 9530.7020, subparts 1, 1a, and 2; 9530.7021; 9530.7022, subpart 1; 9530.7025; and 9530.7030, subpart 1, are repealed.

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Sec. 68. **REPEALER.**

(a) Minnesota Statutes 2020, sections 169A.70, subdivision 6; 245G.22, subdivision 19; 254A.02, subdivision 8a; 254A.16, subdivision 6; 254A.19, subdivisions 1a and 2; 254B.04, subdivisions 2b and 2c; and 254B.041, subdivision 2, are repealed.

(b) Minnesota Statutes 2021 Supplement, section 254A.19, subdivision 5, is repealed.

(c) Minnesota Rules, parts 9530.7000, subparts 1, 2, 5, 6, 7, 8, 9, 10, 11, 13, 14, 15, 17a, 19, 20, and 21; 9530.7005; 9530.7010; 9530.7012; 9530.7015, subparts 1, 2a, 4, 5, and 6; 9530.7020, subparts 1, 1a, and 2; 9530.7021; 9530.7022, subpart 1; 9530.7025; and 9530.7030, subpart 1, are repealed.