..... moves to amend H.F. No. 4354 as follows:

Page 1, after line 11, insert:

"ARTICLE 1

DIRECT CARE AND TREATMENT POLICY"

Page 16, after line 10, insert:

"ARTICLE 2

DEPARTMENT OF HUMAN SERVICES BEHAVIORAL HEALTH

Section 1. Minnesota Statutes 2025 Supplement, section 245.469, subdivision 1, is amended to read:

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

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

(2) minimize further deterioration of each client;

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

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

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

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

Sec. 2. Minnesota Statutes 2024, section 245F.02, subdivision 17, is amended to read:

Subd. 17. **Peer recovery support services.** "Peer recovery support services" means services provided according to ~~section 245F.08, subdivision 3~~ sections 245G.07, subdivision 2a, paragraph (b), clause (2), and 254B.052.

Sec. 3. Minnesota Statutes 2025 Supplement, section 245F.08, subdivision 3, is amended to read:

Subd. 3. **Peer recovery support services.** Peer recovery support services must meet the requirements in section ~~245G.07, subdivision 2a, paragraph (b), clause (2)~~ 254B.052, and must be provided by a person who is qualified according to the requirements in section ~~245F.15, subdivision 7~~ 245I.04, subdivisions 18 and 19.

Sec. 4. Minnesota Statutes 2024, section 245F.15, subdivision 7, is amended to read:

Subd. 7. **Recovery peer qualifications.** Recovery peers must:

(1) meet the qualifications in section 245I.04, subdivision 18; and

(2) provide services according to the scope of practice established in section 245I.04, subdivision 19~~, under the supervision of an alcohol and drug counselor~~.

Sec. 5. Minnesota Statutes 2024, section 245G.04, is amended by adding a subdivision to read:

Subd. 4. **Tobacco educational material.** A license holder must provide tobacco and nicotine educational material to a client on the day of service initiation. The license holder must use educational material approved by the commissioner that contains information on:

(1) risks associated with use of tobacco or nicotine products;

(2) types of tobacco or nicotine products, including differentiating between commercial versus traditional or sacred tobacco;

(3) treatment options, including the use of medication for tobacco use disorder; and

(4) benefits of receiving treatment for tobacco or nicotine use while attending substance use disorder treatment for another primary substance.

EFFECTIVE DATE. This section is effective January 1, 2027.

Sec. 6. Minnesota Statutes 2025 Supplement, section 245G.11, subdivision 7, is amended to read:

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

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

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

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

(4) meets one of the following criteria:

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

~~(ii)~~ (i) has a high school diploma or equivalent; or

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

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

(b) A treatment coordinator must receive the following levels of supervision from an alcohol and drug counselor or a mental health professional whose scope of practice includes substance use disorder treatment and assessments:

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

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

EFFECTIVE DATE. This section is effective August 1, 2026.

Sec. 7. Minnesota Statutes 2024, section 245G.11, subdivision 8, is amended to read:

Subd. 8. **Recovery peer qualifications.** A recovery peer must:

(1) meet the qualifications in section 245I.04, subdivision 18; and

(2) provide services according to the scope of practice established in section 245I.04, subdivision 19~~, under the supervision of an alcohol and drug counselor~~.

Sec. 8. Minnesota Statutes 2025 Supplement, section 245I.04, subdivision 17, is amended to read:

Subd. 17. **Mental health behavioral aide scope of practice.** While under the treatment supervision of a mental health professional, a mental health behavioral aide may practice psychosocial skills with a child client according to the child's treatment plan ~~and individual behavior plan~~ that a mental health professional, clinical trainee, or behavioral health practitioner has previously taught to the child.

Sec. 9. Minnesota Statutes 2024, section 245I.04, is amended by adding a subdivision to read:

Subd. 20. **Limitation on affiliation across service lines.** (a) A mental health professional, as defined in subdivision 3, may not simultaneously serve in a clinical, supervisory, or designated role for more than ten distinct licensed provider organizations or service lines delivering Medicaid-funded services. A mental health professional may not provide clinical or administrative supervision to more than 20 direct care or clinical staff across all affiliated provider organizations and service lines unless an exception is granted by the commissioner under paragraph (c).

(b) The commissioner shall establish criteria and a standardized process for evaluating exception requests under paragraph (a).

(c) Upon written request, the commissioner may grant an exception if the requester demonstrates that:

(1) the mental health professional can effectively meet all clinical, supervisory, and administrative responsibilities across affiliated programs;

(2) the oversight of client care will not be compromised; and

(3) the proposed arrangement complies with all applicable supervision, documentation, and service delivery requirements.

(d) In determining whether to grant an exception under paragraph (c), the commissioner shall consider:

(1) the geographic distribution of services;

(2) the complexity and acuity of client needs;

(3) the mental health professional's other responsibilities, including direct service provision; and

(4) whether adequate supervision can be maintained in compliance with program standards.

(e) The commissioner shall rescind approval of the exception granted under paragraph (c) if the requester fails to comply with applicable program standards or with the terms of the exception.

(f) The commissioner may adopt rules as necessary to implement and enforce this subdivision.

(g) A mental health professional determined to be in violation of this subdivision may be subject to corrective action, licensing sanctions, or administrative penalties in accordance with chapter 245A and other applicable law.

Sec. 10. Minnesota Statutes 2024, section 245I.08, subdivision 4, is amended to read:

Subd. 4. **Progress notes.** A license holder must use a progress note to document each occurrence of a mental health service that a staff person provides to a client. A progress note must include the following:

(1) the type of service;

(2) the date of service;

(3) the start and stop time of the service unless the license holder is licensed as a residential program;

(4) the location of the service;

(5) the scope of the service, including: (i) the targeted goal and objective; (ii) the intervention that the staff person provided to the client and the methods that the staff person

used; (iii) the client's response to the intervention; and (iv) the staff person's plan to take future actions, including changes in treatment that the staff person will implement if the intervention was ineffective;

(6) the signature and credentials of the staff person who provided the service to the client;

(7) the dated signature and credentials of the treatment supervisor;

~~(7)~~ (8) the mental health provider travel documentation required by section 256B.0625, if applicable; and

~~(8)~~ (9) significant observations by the staff person, if applicable, including: (i) the client's current risk factors; (ii) emergency interventions by staff persons; (iii) consultations with or referrals to other professionals, family, or significant others; and (iv) changes in the client's mental or physical symptoms.

Sec. 11. Minnesota Statutes 2024, section 245I.10, subdivision 6, is amended to read:

Subd. 6. **Standard diagnostic assessment; required elements.** (a) Only a mental health professional or a clinical trainee may complete a standard diagnostic assessment of a client. A standard diagnostic assessment of a client must include a face-to-face interview with a client and a written evaluation of the client. The assessor must complete a client's standard diagnostic assessment within the client's cultural context. An alcohol and drug counselor may gather and document the information in paragraphs (b) and (c) when completing a comprehensive assessment according to section 245G.05.

(b) When completing a standard diagnostic assessment of a client, the assessor must gather and document information about the client's current life situation, including the following information:

(1) the client's age;

(2) the client's current living situation, including the client's housing status and household members;

(3) the status of the client's basic needs;

(4) the client's education level and employment status;

(5) the client's current medications;

(6) any immediate risks to the client's health and safety, including withdrawal symptoms, medical conditions, and behavioral and emotional symptoms;

(7) the client's perceptions of the client's condition;

(8) the client's description of the client's symptoms, including the reason for the client's referral;

(9) the client's history of mental health and substance use disorder treatment, including treatment for tobacco or nicotine use;

(10) cultural influences on the client; and

(11) substance use history, if applicable, including:

(i) amounts and types of substances, including tobacco and nicotine products; frequency and duration~~,~~; route of administration~~,~~; periods of abstinence~~,~~; and circumstances of relapse; and

(ii) the impact to functioning when under the influence of substances, including legal interventions.

(c) If the assessor cannot obtain the information that this paragraph requires without retraumatizing the client or harming the client's willingness to engage in treatment, the assessor must identify which topics will require further assessment during the course of the client's treatment. The assessor must gather and document information related to the following topics:

(1) the client's relationship with the client's family and other significant personal relationships, including the client's evaluation of the quality of each relationship;

(2) the client's strengths and resources, including the extent and quality of the client's social networks;

(3) important developmental incidents in the client's life;

(4) maltreatment, trauma, potential brain injuries, and abuse that the client has suffered;

(5) the client's history of or exposure to alcohol and drug usage and treatment; and

(6) the client's health history and the client's family health history, including the client's physical, chemical, and mental health history.

(d) When completing a standard diagnostic assessment of a client, an assessor must use a recognized diagnostic framework.

(1) When completing a standard diagnostic assessment of a client who is five years of age or younger, the assessor must use the current edition of the DC: 0-5 Diagnostic

Classification of Mental Health and Development Disorders of Infancy and Early Childhood published by Zero to Three.

(2) When completing a standard diagnostic assessment of a client who is six years of age or older, the assessor must use the current edition of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association.

(3) When completing a standard diagnostic assessment of a client who is 18 years of age or older, an assessor must use either (i) the CAGE-AID Questionnaire or (ii) the criteria in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association to screen and assess the client for a substance use disorder, including tobacco use disorder.

(e) When completing a standard diagnostic assessment of a client, the assessor must include and document the following components of the assessment:

(1) the client's mental status examination;

(2) the client's baseline measurements; symptoms; behavior; skills; abilities; resources; vulnerabilities; safety needs, including client information that supports the assessor's findings after applying a recognized diagnostic framework from paragraph (d); and any differential diagnosis of the client; and

(3) an explanation of: (i) how the assessor diagnosed the client using the information from the client's interview, assessment, psychological testing, and collateral information about the client; (ii) the client's needs; (iii) the client's risk factors; (iv) the client's strengths; and (v) the client's responsivity factors.

(f) When completing a standard diagnostic assessment of a client, the assessor must consult the client and the client's family about which services that the client and the family prefer to treat the client. The assessor must make referrals for the client as to services required by law.

(g) Information from other providers and prior assessments may be used to complete the diagnostic assessment if the source of the information is documented in the diagnostic assessment.

EFFECTIVE DATE. This section is effective January 1, 2027.

Sec. 12. Minnesota Statutes 2025 Supplement, section 254A.03, subdivision 3, is amended to read:

Subd. 3. **Rules for substance use disorder care.** (a) An eligible vendor of comprehensive assessments under section 254B.0501 may determine 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)~~ (b) 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.0505. 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. A comprehensive assessment pursuant to section 245G.05 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)~~ (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 3. If the individual is enrolled in a prepaid health plan, the individual must comply with any provider network requirements or limitations.

Sec. 13. Minnesota Statutes 2025 Supplement, section 254B.0505, subdivision 8, is amended to read:

Subd. 8. **~~Peer recovery support services~~ Utilization review requirements.** (a) Eligible vendors of ~~peer recovery support~~ services in subdivision 1, clauses (1), (4) to (8), and (10), must~~:~~

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

~~(2)~~ (b) Entities billing for peer recovery support services individually and not receiving a daily rate must limit an individual client to 14 hours per week for peer recovery support services from an individual provider of peer recovery support services.

Sec. 14. Minnesota Statutes 2024, section 254B.052, subdivision 1, is amended to read:

Subdivision 1. **Peer recovery support services; service requirements.** (a) Peer recovery support services are face-to-face interactions between a recovery peer and a client, on a one-on-one basis, in which specific goals identified in an individual recovery plan, treatment plan, or stabilization plan are discussed and addressed. Peer recovery support services are provided to promote a client's recovery goals, self-sufficiency, self-advocacy, and development of natural supports and to support maintenance of a client's recovery.

(b) Peer recovery support services must be provided according to (1) an individual recovery plan if provided by a recovery community organization or county, a treatment plan if provided in either a substance use disorder treatment program under chapter 245G~~,~~ or a Tribally licensed substance use disorder treatment program, or (2) a stabilization plan if provided by a withdrawal management program under chapter 245F.

(c) A client receiving peer recovery support services must participate in the services voluntarily. Any program that incorporates peer recovery support services must provide written notice to the client that peer recovery support services will be provided.

(d) Peer recovery support services may not be provided to a client residing with or employed by a recovery peer from whom ~~they receive~~ the client receives services.

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

Sec. 15. Minnesota Statutes 2025 Supplement, section 254B.052, subdivision 6, is amended to read:

Subd. 6. **Monetary recovery.** ~~Peer recovery support~~ Services subject to section 254B.0505, subdivision 8, that are not provided in accordance with this section are subject to monetary recovery under section 256B.064 as money improperly paid.

Sec. 16. Minnesota Statutes 2024, section 256B.0624, subdivision 6b, is amended to read:

Subd. 6b. **Crisis intervention services.** (a) If the crisis assessment determines mobile crisis intervention services are needed, the crisis intervention services must be provided promptly. As opportunity presents during the intervention, at least two members of the mobile crisis intervention team must confer directly or by telephone about the crisis assessment, crisis treatment plan, and actions taken and needed. At least one of the team members must be providing face-to-face crisis intervention services. If providing crisis intervention services, a clinical trainee or mental health practitioner must seek treatment supervision as required in subdivision 9.

(b) If a provider delivers crisis intervention services while the recipient is absent, the provider must document the reason for delivering services while the recipient is absent.

(c) The mobile crisis intervention team must develop a crisis treatment plan according to subdivision 11.

(d) The mobile crisis intervention team must document which crisis treatment plan goals and objectives have been met and when no further crisis intervention services are required.

(e) If the recipient's mental health crisis is stabilized, but the recipient needs a referral to other services, the team must provide referrals to these services. If the recipient has a case manager, planning for other services must be coordinated with the case manager. If the recipient is unable to follow up on the referral, the team must link the recipient to the service and follow up to ensure the recipient is receiving the service.

~~(f) If the recipient's mental health crisis is stabilized and the recipient does not have an advance directive, the case manager or crisis team shall offer to work with the recipient to develop one.~~

EFFECTIVE DATE. This section is effective upon federal approval.

Sec. 17. Minnesota Statutes 2024, section 256B.0624, subdivision 7, is amended to read:

Subd. 7. **Crisis stabilization services.** (a) Crisis stabilization services must be provided by qualified staff of a crisis stabilization services provider entity and must meet the following standards:

(1) a crisis treatment plan must be developed that meets the criteria in subdivision 11;

(2) staff must be qualified as defined in subdivision 8;

(3) crisis stabilization services must be delivered according to the crisis treatment plan and include face-to-face contact with the recipient by qualified staff for further assessment,

help with referrals, updating of the crisis treatment plan, skills training, and collaboration with other service providers in the community; ~~and~~

(4) if a provider delivers crisis stabilization services while the recipient is absent, the provider must document the reason for delivering services while the recipient is absent~~.~~; and

(5) if the recipient is an adult and the recipient's mental health crisis is stabilized and the recipient does not have a health care directive as defined by section 145C.01, subdivision 5a, or psychiatric declaration as defined by section 253B.03, subdivision 6d, the case manager or crisis team must offer to work with the recipient to develop a directive or declaration.

(b) If crisis stabilization services are provided in a supervised, licensed residential setting that serves no more than four adult residents, and one or more individuals are present at the setting to receive residential crisis stabilization, the residential staff must include, for at least eight hours per day, at least one mental health professional, clinical trainee, certified rehabilitation specialist, or mental health practitioner. The commissioner shall establish a statewide per diem rate for crisis stabilization services provided under this paragraph to medical assistance enrollees. The rate for a provider shall not exceed the rate charged by that provider for the same service to other payers. Payment shall not be made to more than one entity for each individual for services provided under this paragraph on a given day. The commissioner shall set rates prospectively for the annual rate period. The commissioner shall require providers to submit annual cost reports on a uniform cost reporting form and shall use submitted cost reports to inform the rate-setting process. The commissioner shall recalculate the statewide per diem every year.

EFFECTIVE DATE. This section is effective upon federal approval.

Sec. 18. Minnesota Statutes 2024, section 256B.0625, subdivision 47, is amended to read:

Subd. 47. **Treatment foster care services.** ~~Effective July 1, 2011, and subject to federal approval,~~ Medical assistance covers ~~treatment foster care~~ children's intensive behavioral health services according to section 256B.0946.

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

Sec. 19. Minnesota Statutes 2024, section 256B.0759, subdivision 3, is amended to read:

Subd. 3. **Provider standards.** (a) The commissioner must establish requirements for ~~participating~~ providers that are consistent with the federal requirements of the demonstration project. The following programs licensed by the Department of Human Services that receive

payment for substance use disorder treatment services under section 256B.0625 must certify that the program meets the applicable American Society of Addiction Medicine (ASAM) levels of care according to section 254B.19:

(1) nonresidential substance use disorder treatment programs and residential treatment programs licensed under chapter 245G as licensed substance use disorder treatment facilities;

(2) withdrawal management programs licensed under chapter 245F; and

(3) out-of-state residential substance use disorder treatment programs.

Programs that do not meet the requirements of this paragraph are ineligible for payment for services provided under section 256B.0625.

~~(b) A participating residential provider must obtain applicable licensure under chapter 245F or 245G or other applicable standards for the services provided and must:~~

~~(1) deliver services in accordance with standards published by the commissioner pursuant to paragraph (d);~~

~~(2) maintain formal patient referral arrangements with providers delivering step-up or step-down levels of care in accordance with ASAM standards; and~~

~~(3) offer substance use disorder treatment services with medications for opioid use disorder on site or facilitate access to substance use disorder treatment services with medications for opioid use disorder off site.~~

~~(c) A participating outpatient provider must obtain applicable licensure under chapter 245G or other applicable standards for the services provided and must:~~

~~(1) deliver services in accordance with standards published by the commissioner pursuant to paragraph (d); and~~

~~(2) maintain formal patient referral arrangements with providers delivering step-up or step-down levels of care in accordance with ASAM standards.~~

~~(d) If the provider standards under chapter 245G or other applicable standards conflict or are duplicative, the commissioner may grant variances to the standards if the variances do not conflict with federal requirements. The commissioner must publish service components, service standards, and staffing requirements for participating providers that are consistent with ASAM standards and federal requirements by October 1, 2020.~~

(b) Programs licensed by the Department of Human Services as residential treatment programs according to section 245G.21 that (1) receive payment under this chapter, (2) are licensed as a hospital under sections 144.50 to 144.581, and (3) provide only ASAM level

3.7 medically monitored inpatient level of care are not required to enroll as demonstration project providers. Programs meeting the criteria in this paragraph must submit evidence of providing the required level of care to the commissioner to be exempt from enrolling in the demonstration.

(c) Tribally licensed programs that otherwise meet the requirements of subdivision 3 may elect to participate in the demonstration project. The Department of Human Services must consult with Tribal Nations to discuss participation in the substance use disorder demonstration project.

(d) Programs subject to this section must:

(1) deliver services in accordance with section 254B.19; and

(2) offer substance use disorder treatment services with medications for opioid use disorder on site or facilitate timely access to medications for opioid use disorder off site.

Sec. 20. Minnesota Statutes 2025 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.0505, subdivision 1. ~~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 outpatient individual and group substance use disorder services under section 254B.0505, subdivision 1, clause (1), 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.~~

~~(d)~~ (b) 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~~ requirements of section 254B.19 that 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 paragraph ~~(c)~~ (a). 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.

~~(e)~~ (c) Effective July 1, 2021, contracts between managed care plans and county-based purchasing plans and providers to whom paragraph ~~(d)~~ (b) applies must allow recovery of payments from those providers if, for any contract year, federal approval for the provisions of paragraph ~~(d)~~ (b) 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.

~~(f)~~ (d) For substance use disorder services with medications for opioid use disorder under section 254B.0505, subdivision 1, clause (7), provided on or after January 1, 2021, payment rates must be increased by 20 percent over the rates in effect on December 31, 2020. Upon implementation of new rates according to section 254B.121, the 20 percent increase will no longer apply.

Sec. 21. Minnesota Statutes 2025 Supplement, section 256B.0943, subdivision 1, is amended to read:

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

(b) "Children's therapeutic services and supports" means the flexible package of mental health services for children who require varying therapeutic and rehabilitative levels of intervention to treat a diagnosed mental illness, as defined in section 245.462, subdivision 20, or 245.4871, subdivision 15. The services are time-limited interventions that are delivered

using various treatment modalities and combinations of services designed to reach treatment outcomes identified in the individual treatment plan.

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

(d) "Crisis planning" has the meaning given in section 245.4871, subdivision 9a.

(e) "Culturally competent provider" means a provider who understands and can utilize to a client's benefit the client's culture when providing services to the client. A provider may be culturally competent because the provider is of the same cultural or ethnic group as the client or the provider has developed the knowledge and skills through training and experience to provide services to culturally diverse clients.

(f) "Day treatment program" for children means a site-based structured mental health program consisting of psychotherapy for three or more individuals and individual or group skills training provided by a team, under the treatment supervision of a mental health professional.

(g) "Direct service time" means the time that a mental health professional, clinical trainee, mental health practitioner, or mental health behavioral aide spends face-to-face with a client and the client's family or providing covered services through telehealth as defined under section 256B.0625, subdivision 3b. Direct service time includes time in which the provider obtains a client's history, develops a client's treatment plan, records individual treatment outcomes, or provides service components of children's therapeutic services and supports. Direct service time does not include time doing work before and after providing direct services, including scheduling or maintaining clinical records.

(h) "Direction of mental health behavioral aide" means the activities of a mental health professional, clinical trainee, or mental health practitioner in guiding the mental health behavioral aide in providing services to a client. The direction of a mental health behavioral aide must be based on the client's individual treatment plan and meet the requirements in subdivision 6, paragraph (b), clause (7).

(i) "Individual treatment plan" means the plan described in section 245I.10, subdivisions 7 and 8.

(j) "Mental health behavioral aide services" means medically necessary one-on-one activities performed by a mental health behavioral aide qualified according to section 245I.04, subdivision 16, to assist a child retain or generalize psychosocial skills as previously trained by a mental health professional, clinical trainee, or mental health practitioner and

as described in the child's individual treatment plan ~~and individual behavior plan~~. Activities involve working directly with the child or child's family as provided in subdivision 9, paragraph (b), clause (4).

(k) "Mental health certified family peer specialist" means a staff person who is qualified according to section 245I.04, subdivision 12.

(l) "Mental health practitioner" means a staff person who is qualified according to section 245I.04, subdivision 4.

(m) "Mental health professional" means a staff person who is qualified according to section 245I.04, subdivision 2.

(n) "Mental health service plan development" includes:

(1) development and revision of a child's individual treatment plan; and

(2) administering and reporting standardized outcome measurements approved by the commissioner, as periodically needed to evaluate the effectiveness of treatment.

(o) "Mental illness" has the meaning given in section 245.462, subdivision 20, paragraph (a), for persons at least 18 years of age but under 21 years of age, and has the meaning given in section 245.4871, subdivision 15, for children under 18 years of age.

(p) "Psychotherapy" means the treatment described in section 256B.0671, subdivision 11.

(q) "Rehabilitative services" or "psychiatric rehabilitation services" means interventions to: (1) restore a child or adolescent to an age-appropriate developmental trajectory that had been disrupted by a psychiatric illness; or (2) enable the child to self-monitor, compensate for, cope with, counteract, or replace psychosocial skills deficits or maladaptive skills acquired over the course of a psychiatric illness. Psychiatric rehabilitation services for children combine coordinated psychotherapy to address internal psychological, emotional, and intellectual processing deficits, and skills training to restore personal and social functioning. Psychiatric rehabilitation services establish a progressive series of goals with each achievement building upon a prior achievement.

(r) "Skills training" means individual, family, or group training, delivered by or under the supervision of a mental health professional, designed to facilitate the acquisition of psychosocial skills that are medically necessary to rehabilitate the child to an age-appropriate developmental trajectory heretofore disrupted by a psychiatric illness or to enable the child to self-monitor, compensate for, cope with, counteract, or replace skills deficits or

maladaptive skills acquired over the course of a psychiatric illness. Skills training is subject to the service delivery requirements under subdivision 9, paragraph (b), clause (2).

(s) "Standard diagnostic assessment" means the assessment described in section 245I.10, subdivision 6.

(t) "Treatment supervision" means the supervision described in section 245I.06.

Sec. 22. Minnesota Statutes 2024, section 256B.0943, subdivision 6, is amended to read:

Subd. 6. **Provider entity clinical infrastructure requirements.** (a) To be an eligible provider entity under this section, a provider entity must have a clinical infrastructure that utilizes diagnostic assessment, individual treatment plans, service delivery, and individual treatment plan review that are culturally competent, child-centered, and family-driven to achieve maximum benefit for the client. The provider entity must review, and update as necessary, the clinical policies and procedures every ~~three~~ two years, must distribute the policies and procedures to staff initially and upon each subsequent update, and must train staff accordingly.

(b) The clinical infrastructure written policies and procedures must include policies and procedures for meeting the requirements in this subdivision:

(1) providing or obtaining a client's standard diagnostic assessment, including a standard diagnostic assessment. When required components of the standard diagnostic assessment are not provided in an outside or independent assessment or cannot be attained immediately, the provider entity must determine the missing information within 30 days and amend the child's standard diagnostic assessment or incorporate the information into the child's individual treatment plan;

(2) developing an individual treatment plan;

(3) providing treatment supervision plans for staff according to section 245I.06. Treatment supervision does not include the authority to make or terminate court-ordered placements of the child. A treatment supervisor must be available for urgent consultation as required by the individual client's needs or the situation;

(4) requiring a mental health professional to determine the level of supervision for a behavioral health aide and to document and sign the supervision determination in the behavioral health aide's supervision plan;

(5) ensuring the immediate accessibility of a mental health professional, clinical trainee, or mental health practitioner to the behavioral aide during service delivery;

(6) providing service delivery that implements the individual treatment plan and meets the requirements under subdivision 9; and

(7) individual treatment plan review. The review must determine the extent to which the services have met each of the goals and objectives in the treatment plan. The review must assess the client's progress and ensure that services and treatment goals continue to be necessary and appropriate to the client and the client's family or foster family.

Sec. 23. Minnesota Statutes 2024, 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 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 180 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 180 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~~,~~ and documented~~, and included~~ in the treatment plan or case file. 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 child 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.

Sec. 24. Minnesota Statutes 2025 Supplement, section 256B.0947, subdivision 3a, is amended to read:

Subd. 3a. **Required service components.** (a) Intensive nonresidential rehabilitative mental health services, supports, and ancillary activities that are covered by a single daily rate per client must include the following, as needed by the individual client:

(1) individual, family, and group psychotherapy;

(2) individual, family, and group skills training, as defined in section 256B.0943, subdivision 1, paragraph (r);

(3) crisis planning as defined in section 245.4871, subdivision 9a;

(4) medication management provided by a ~~physician, an advanced practice registered nurse with certification in psychiatric and mental health care, or a physician assistant~~ qualified provider;

(5) mental health case management as provided in section 256B.0625, subdivision 20;

(6) medication education services as defined in this section;

(7) care coordination by a client-specific lead worker assigned by and responsible to the treatment team;

(8) psychoeducation of and consultation and coordination with the client's biological, adoptive, or foster family and, in the case of a youth living independently, the client's immediate nonfamilial support network;

(9) clinical consultation to a client's employer or school or to other service agencies or to the courts to assist in managing the mental illness or co-occurring disorder and to develop client support systems;

(10) coordination with, or performance of, crisis intervention and stabilization services as defined in section 256B.0624;

(11) transition services;

(12) co-occurring substance use disorder treatment as defined in section 245I.02, subdivision 11; and

(13) housing access support that assists clients to find, obtain, retain, and move to safe and adequate housing. Housing access support does not provide monetary assistance for rent, damage deposits, or application fees.

(b) The provider shall ensure and document the following by means of performing the required function or by contracting with a qualified person or entity: client access to crisis intervention services, as defined in section 256B.0624, and available 24 hours per day and seven days per week.

EFFECTIVE DATE. This section is effective July 1, 2027, or upon federal approval, whichever is later.

Sec. 25. Minnesota Statutes 2024, 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 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~~ a psychiatric care provider credentialed to prescribe medications who is either an advanced practice registered nurse with advanced education and training in psychiatric and mental health care or a board-certified psychiatrist. The psychiatric care provider must have demonstrated clinical experience and qualifications for working with children and adolescents with serious mental illness and co-occurring mental illness and substance use disorder;

(iii) 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; and

(iv) a co-occurring disorder specialist who meets the requirements under section 256B.0622, subdivision 7a, paragraph (a), clause (4), who will provide or facilitate the provision of co-occurring disorder treatment to clients.

(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.

EFFECTIVE DATE. This section is effective July 1, 2027, or upon federal approval, whichever is later.

Sec. 26. Minnesota Statutes 2025 Supplement, section 256L.03, subdivision 5, is amended to read:

Subd. 5. **Cost-sharing.** (a) Co-payments, coinsurance, and deductibles do not apply to children under the age of 21 and to American Indians as defined in Code of Federal Regulations, title 42, section 600.5.

(b) The commissioner must adjust co-payments, coinsurance, and deductibles for covered services in a manner sufficient to maintain the actuarial value of the benefit to 94 percent. The cost-sharing changes described in this paragraph do not apply to eligible recipients or services exempt from cost-sharing under state law. The cost-sharing changes described in this paragraph shall not be implemented prior to January 1, 2016.

(c) The cost-sharing changes authorized under paragraph (b) must satisfy the requirements for cost-sharing under the Basic Health Program as set forth in Code of Federal Regulations, title 42, sections 600.510 and 600.520.

(d) Cost-sharing for prescription drugs and related medical supplies to treat chronic disease must comply with the requirements of section 62Q.481.

(e) Co-payments, coinsurance, and deductibles do not apply to additional diagnostic services or testing that a health care provider determines an enrollee requires after a mammogram, as specified under section 62A.30, subdivision 5.

(f) Cost-sharing must not apply to drugs used for tobacco and nicotine cessation or to tobacco and nicotine cessation services covered under section 256B.0625, subdivision 68.

(g) Co-payments, coinsurance, and deductibles do not apply to pre-exposure prophylaxis (PrEP) and postexposure prophylaxis (PEP) medications when used for the prevention or treatment of the human immunodeficiency virus (HIV).

(h) Co-payments, coinsurance, and deductibles do not apply to mobile crisis intervention, crisis stabilization provided in a community setting, or crisis assessment as defined in section 256B.0624, subdivision 2.

Sec. 27. **REPEALER.**

Minnesota Statutes 2024, section 256B.0759, subdivisions 2 and 5, are repealed."

Amend the title accordingly