DEPARTMENT OF HUMAN SERVICES

2026 Governor's Behavioral Health Policy Bill: Summary of Proposals

Mental Health Emergency Services Statute Clean-Up (Sec. 1, 26)

During the 2025 session, legislation was passed to clarify that individuals who are receiving emergency behavioral health services cannot be charged for those services. That revision unintentionally removed language that prohibited providers from delaying care based on a person's funding source. This proposal would amend Minn. Stat. 245.469 by reintroducing that language so it is clear that emergency service providers must provide care without regard to client funding.

Additionally, that legislation also clarified that MinnesotaCare enrollees are not subject to cost-sharing when mobile crisis services are provided. Mobile crisis services are delivered in three parts: crisis intervention, crisis stabilization, and crisis assessment. While the language specifically mentions crisis intervention and crisis assessment, crisis stabilization services were not included. This proposal would amend Minn. Stat. 256L.03 by clarifying that all parts of mobile crisis services are exempt from cost-sharing, co-pays and deductibles.

Alignment of Peer Recovery Support (PRS) Service Definitions (Sec. 2, 3, 4, 7)

Peer recovery support (PRS) was significantly revised during the 2024 session, resulting in a new statutory framework and enhanced program standards. One of the changes enacted was to expand supervision of recovery peers to include licensed mental health professionals. However, this update was not reflected across all relevant recovery peer statutes, specifically for licensed SUD treatment facilities and withdrawal management programs. This proposal would amend Minn. Stat. 245G.11 and Minn. Stat. 245F.15 by removing the language that limits supervision to alcohol and drug counselors only.

Additionally, several outdated citations related to PRS were missed when Minn. Stat. 254B.052 was created. This proposal would amend Minn. Stat. 245F.02 and Minn. Stat. 245F.08 by updating the statutory references to point to the correct peer recovery statute.

Tobacco Education (Sec. 5, 11)

While behavioral health programs are required to screen for mental health and substance use disorder (SUD) history, tobacco use is routinely underassessed. Commercial tobacco continues to be the leading cause of preventable deaths in Minnesota, and widespread misinformation exists about the negative impacts of commercial tobacco use for individuals in recovery.

This proposal would amend Minn. Stat. 245I.10 and Minn. Stat. 245G.04 by explicitly requiring: 1) licensed SUD treatment facilities and licensed mental health facilities to assess and document tobacco/nicotine use in diagnostic assessments; 2) mental health professionals to apply the Tobacco Use Disorder diagnosis when a client meets the DSM-5 criteria; and 3) licensed SUD treatment programs to provide tobacco education materials to all clients on the first day of service.

Treatment Coordinator Education Requirement (Sec. 6)

During the 2025 legislative session, the educational requirement to provide treatment coordination services was changed from requiring a bachelor's degree to requiring a high school diploma. However, the existing language that required a bachelor's degree was not removed, potentially leading to confusion.

This proposal would amend Minn. Stat. 245G.11, subd. 7 to remove the bachelor's degree requirement entirely so it is clear that the intended educational requirement is at the level of a high school diploma. It reflects the intent of the 2025 Legislature and compromise between interested parties.

Children's Therapeutic Services and Supports (CTSS) Technical Clean Up (Sec. 8, 21, 22)

Minn. Stat. 256B.043 Subd.6(a) requires CTSS providers to review policies and procedures every 3 years, whereas Minn. Stat. 245I.03 (Mental Health Uniform Service Standards Act) requires providers to complete and document a review of policies and procedures every 2 years.

This proposal will amend CTSS statute to align with 245I.03 and require reviews every 2 years. This proposal also cleans up section Minn. Stat. 256B.0943 Subd. 1 (k) and 245I.04 subd. 17 by removing outdated terminology of "individual behavior plan." Both changes clarify requirements for providers and increase alignment with core mental health standards as we prepare to transition CFSS to uniform service standards.

Mental Health Professional Affiliation and Supervision Limits (Sec. 9, 10)

Mental health professionals are responsible for training, supervising, and evaluating agency staff and the services they provide. Current statute requires a progress note and a signature each time a staff member delivers a mental health service, but it does not clearly specify who may sign the note. As a result, mental health professionals often review progress notes, but do not formally approve or sign them. This proposal would amend Minn. Stat. 245I.08 by requiring a physical, dated signature and credentials on all progress notes, ensuring clear accountability and documentation of clinical oversight.

Concerns have also arisen regarding the number of provider organizations a mental health professional may be affiliated with. Applications reveal a concerning pattern of mental health professionals who are linked to multiple agencies, in some cases over 50 organizations. To strengthen program integrity and ensure quality supervision, limits are needed. This proposal would amend Minn. Stat. 245I.08 by adding a new subdivision that would 1) limit a mental health professional's affiliation to no more than 10 provider organizations or service lines, and supervision to no more than 20 staff across all affiliated providers; and 2) establish an exception process for mental health professional seeking to affiliate with more than 10 providers or supervise more than 20 staff.

Substance Use Disorder Waiver Clean-Up (Sec. 11, 12, 15, 19, 20, 27)

In 2019, Minnesota received approval for a Section 1115 Substance Use Disorder (SUD) Medicaid waiver to improve access to high-quality, clinically appropriate treatment by implementing the American Society of Addiction Medicine (ASAM) criteria and ensure availability of critical levels of care. These policy changes have now been fully incorporated into statute and apply to most SUD providers. This proposal would amend Minn.

Stat. 256B.0759 by removing outdated language, updating statutory references, and consolidating the remaining SUD waiver provisions for clarity and consistency.

As part of the 1115 waiver, a utilization management (UM) program was also implemented to ensure individuals with SUD receive the right level of care at the right time. To maintain oversight of clinical standards and align with federal waiver requirements, updates to state law are also needed. This proposal would amend Minn. Stat. 254A.03 and Minn. Stat. 254B.0505 to designate up to ten percent of each SUD provider's clients to be randomly reviewed each month for UM.

Peer Recovery Support Services (PRS) Clarification for Tribally Licensed Programs (Sec. 14)

PRS helps individuals in substance use disorder (SUD) recovery by connecting them with experienced and trained peers to support them in the recovery process and improve outcomes. Current statute explicitly lists the types of programs that can deliver PRS, however, that list excludes tribally licensed programs. While tribally licensed programs can, and currently do, provide peer recovery services as permitted by the Medicaid State Plan, omitting it in the PRS statute has led to confusion.

This proposal would amend Minn. Stat. Minn. Stat. 254B.052, Subd 1(b) to align statutory authority with the Medicaid State Plan and explicitly recognize the authority of Tribally licensed programs to deliver PRS.

Adjusting Advance Care Directive Requirements in Mobile Crisis Response (Sec.16, 17)

Currently, mobile crisis teams are required to offer to develop an advance care directive while conducting crisis intervention services. Recent SAMHSA updates to best practices recommend that discussions about health care directives occur during follow-up contacts rather than during the initial crisis intervention, as these discussions often involve complex and stressful topics like future care planning or end-of-life decisions. Once the initial crisis has been addressed, mobile crisis team members then focus on stabilization services, such as connecting clients to medication management and case management, which is a more appropriate time to have that discussion.

This proposal would amend Minn. Stat. 256B.0624 to align state requirements with national best practices by moving the requirement to offer to develop a health care directive from the crisis intervention stage of service to the crisis stabilization stage.

Children's Intensive Behavioral Health Services (CIBHS) Administrative Changes (Sec. 18, 23)

CIBHS, formerly Intensive Treatment in Foster Care (ITFC), currently requires temporary service reductions to be documented in the child's treatment plan. Updating the treatment plan is a time-consuming and formal process that requires collaboration between the entire team and the family, which can make it difficult to respond quickly when a temporary reduction is needed.

This proposal would amend Minn. Stat. 256B.0947 and Minn. Stat. 256B.0625 to allow temporary service reductions to be documented in the case file. It also corrects a missed reference to Intensive Treatment in Foster Care.

Updating Requirements for Intensive Rehabilitative Mental Health Services (IRMHS) Psychiatric Care Providers (Sec. 24, 25)

IRMHS requires that a clinically qualified core team includes an advanced practice registered nurse (APRN) with certification in psychiatric or mental health care or a board-certified child and adolescent psychiatrist. In practice, the requirement for a psychiatrist to be board-certified with children and adolescents has contributed to workforce challenges, especially when qualified and experienced psychiatrists are available but cannot work on an IRMHS team due to not having that child and adolescent certification.

This proposal would amend Minn. Stat. 256B.0947 to align the requirements for APRNs and psychiatrists by implementing comparable standards for medication management and clinical experience.

Recovery Community Organization Certification Timeline (Sec. TBD)

MA Recovery Community Organizations (RCOs) are currently required to obtain certification from the Minnesota Alliance of Recovery Community Organizations (MARCO) by June 30, 2027. MARCO certification establishes consistent, statewide standards for RCOs. These standards strengthen program integrity for services that have been designated as high-risk by preventing bad actors from getting enrolled to provide MA PRS and ensuring the consistent delivery of high-quality peer recovery services, according to national best practices.

This proposal would amend Minn. Stat. 254B.0501 by advancing the certification deadline by one year, to June 30, 2026.