467.14 **ARTICLE 12**

467.15 **BEHAVIORAL HEALTH**

468.23 Sec. 2. Minnesota Statutes 2020, section 245.462, subdivision 17, is amended to read:

468.24 Subd. 17. **Mental health practitioner.** (a) "Mental health practitioner" means a person
468.25 providing services to adults with mental illness or children with emotional disturbance who
468.26 is qualified in at least one of the ways described in paragraphs (b) to (g). A mental health
468.27 practitioner for a child client must have training working with children. A mental health
468.28 practitioner for an adult client must have training working with adults.

468.29 (b) For purposes of this subdivision, a practitioner is qualified through relevant
468.30 coursework if the practitioner completes at least 30 semester hours or 45 quarter hours in
468.31 behavioral sciences or related fields and:

468.32 (1) has at least 2,000 hours of supervised experience in the delivery of services to adults
468.33 or children with:

469.1 (i) mental illness, substance use disorder, or emotional disturbance; or

469.2 (ii) traumatic brain injury or developmental disabilities and completes training on mental
469.3 illness, recovery from mental illness, mental health de-escalation techniques, co-occurring
469.4 mental illness and substance abuse, and psychotropic medications and side effects;

469.5 (2) is fluent in the non-English language of the ethnic group to which at least 50 percent
469.6 of the practitioner's clients belong, completes 40 hours of training in the delivery of services
469.7 to adults with mental illness or children with emotional disturbance, and receives clinical
469.8 supervision from a mental health professional at least once a week until the requirement of
469.9 2,000 hours of supervised experience is met;

469.10 (3) is working in a day treatment program under section 245.4712, subdivision 2; ~~or~~

469.11 (4) has completed a practicum or internship that (i) requires direct interaction with adults
469.12 or children served, and (ii) is focused on behavioral sciences or related fields~~.~~; or

469.13 (5) is in the process of completing a practicum or internship as part of a formal
469.14 undergraduate or graduate training program in social work, psychology, or counseling.

469.15 (c) For purposes of this subdivision, a practitioner is qualified through work experience
469.16 if the person:

469.17 (1) has at least 4,000 hours of supervised experience in the delivery of services to adults
469.18 or children with:

469.19 (i) mental illness, substance use disorder, or emotional disturbance; or

469.20 (ii) traumatic brain injury or developmental disabilities and completes training on mental
469.21 illness, recovery from mental illness, mental health de-escalation techniques, co-occurring
469.22 mental illness and substance abuse, and psychotropic medications and side effects; or

397.14 **ARTICLE 13**

397.15 **BEHAVIORAL HEALTH**

469.23 (2) has at least 2,000 hours of supervised experience in the delivery of services to adults
469.24 or children with:

469.25 (i) mental illness, emotional disturbance, or substance use disorder, and receives clinical
469.26 supervision as required by applicable statutes and rules from a mental health professional
469.27 at least once a week until the requirement of 4,000 hours of supervised experience is met;
469.28 or

469.29 (ii) traumatic brain injury or developmental disabilities; completes training on mental
469.30 illness, recovery from mental illness, mental health de-escalation techniques, co-occurring
469.31 mental illness and substance abuse, and psychotropic medications and side effects; and
469.32 receives clinical supervision as required by applicable statutes and rules at least once a week
470.1 from a mental health professional until the requirement of 4,000 hours of supervised
470.2 experience is met.

470.3 (d) For purposes of this subdivision, a practitioner is qualified through a graduate student
470.4 internship if the practitioner is a graduate student in behavioral sciences or related fields
470.5 and is formally assigned by an accredited college or university to an agency or facility for
470.6 clinical training.

470.7 (e) For purposes of this subdivision, a practitioner is qualified by a bachelor's or master's
470.8 degree if the practitioner:

470.9 (1) holds a master's or other graduate degree in behavioral sciences or related fields; or

470.10 (2) holds a bachelor's degree in behavioral sciences or related fields and completes a
470.11 practicum or internship that (i) requires direct interaction with adults or children served,
470.12 and (ii) is focused on behavioral sciences or related fields.

470.13 (f) For purposes of this subdivision, a practitioner is qualified as a vendor of medical
470.14 care if the practitioner meets the definition of vendor of medical care in section 256B.02,
470.15 subdivision 7, paragraphs (b) and (c), and is serving a federally recognized tribe.

470.16 (g) For purposes of medical assistance coverage of diagnostic assessments, explanations
470.17 of findings, and psychotherapy under section 256B.0625, subdivision 65, a mental health
470.18 practitioner working as a clinical trainee means that the practitioner's clinical supervision
470.19 experience is helping the practitioner gain knowledge and skills necessary to practice
470.20 effectively and independently. This may include supervision of direct practice, treatment
470.21 team collaboration, continued professional learning, and job management. The practitioner
470.22 must also:

470.23 (1) comply with requirements for licensure or board certification as a mental health
470.24 professional, according to the qualifications under Minnesota Rules, part 9505.0371, subpart
470.25 5, item A, including supervised practice in the delivery of mental health services for the
470.26 treatment of mental illness; or

470.27 (2) be a student in a bona fide field placement or internship under a program leading to
470.28 completion of the requirements for licensure as a mental health professional according to
470.29 the qualifications under Minnesota Rules, part 9505.0371, subpart 5, item A.

470.30 (h) For purposes of this subdivision, "behavioral sciences or related fields" has the
470.31 meaning given in section 256B.0623, subdivision 5, paragraph (d).

471.1 (i) Notwithstanding the licensing requirements established by a health-related licensing
471.2 board, as defined in section 214.01, subdivision 2, this subdivision supersedes any other
471.3 statute or rule.

471.4 Sec. 3. Minnesota Statutes 2020, section 245.4876, subdivision 3, is amended to read:

471.5 Subd. 3. **Individual treatment plans.** All providers of outpatient services, day treatment
471.6 services, professional home-based family treatment, residential treatment, and acute care
471.7 hospital inpatient treatment, and all regional treatment centers that provide mental health
471.8 services for children must develop an individual treatment plan for each child client. The
471.9 individual treatment plan must be based on a diagnostic assessment. To the extent appropriate,
471.10 the child and the child's family shall be involved in all phases of developing and
471.11 implementing the individual treatment plan. Providers of residential treatment, professional
471.12 home-based family treatment, and acute care hospital inpatient treatment, and regional
471.13 treatment centers must develop the individual treatment plan within ten working days of
471.14 client intake or admission and must review the individual treatment plan every 90 days after
471.15 intake~~, except that the administrative review of the treatment plan of a child placed in a~~
471.16 ~~residential facility shall be as specified in sections 260C.203 and 260C.212, subdivision 9~~.
471.17 Providers of day treatment services must develop the individual treatment plan before the
471.18 completion of five working days in which service is provided or within 30 days after the
471.19 diagnostic assessment is completed or obtained, whichever occurs first. Providers of
471.20 outpatient services must develop the individual treatment plan within 30 days after the
471.21 diagnostic assessment is completed or obtained or by the end of the second session of an
471.22 outpatient service, not including the session in which the diagnostic assessment was provided,
471.23 whichever occurs first. Providers of outpatient and day treatment services must review the
471.24 individual treatment plan every 90 days after intake.

471.25 Sec. 4. Minnesota Statutes 2020, section 245.4882, subdivision 1, is amended to read:

471.26 Subdivision 1. **Availability of residential treatment services.** County boards must
471.27 provide or contract for enough residential treatment services to meet the needs of each child
471.28 with severe emotional disturbance residing in the county and needing this level of care.
471.29 Length of stay is based on the child's residential treatment need and shall be ~~subject to the~~
471.30 ~~six-month review process established in section 260C.203, and for children in voluntary~~
471.31 ~~placement for treatment, the court review process in section 260D.06~~ reviewed every 90
471.32 days. Services must be appropriate to the child's age and treatment needs and must be made
471.33 available as close to the county as possible. Residential treatment must be designed to:

312.5 Section 1. Minnesota Statutes 2020, section 245.4876, subdivision 3, is amended to read:

312.6 Subd. 3. **Individual treatment plans.** All providers of outpatient services, day treatment
312.7 services, professional home-based family treatment, residential treatment, and acute care
312.8 hospital inpatient treatment, and all regional treatment centers that provide mental health
312.9 services for children must develop an individual treatment plan for each child client. The
312.10 individual treatment plan must be based on a diagnostic assessment. To the extent appropriate,
312.11 the child and the child's family shall be involved in all phases of developing and
312.12 implementing the individual treatment plan. Providers of residential treatment, professional
312.13 home-based family treatment, and acute care hospital inpatient treatment, and regional
312.14 treatment centers must develop the individual treatment plan within ten working days of
312.15 client intake or admission and must review the individual treatment plan every 90 days after
312.16 intake~~, except that the administrative review of the treatment plan of a child placed in a~~
312.17 ~~residential facility shall be as specified in sections 260C.203 and 260C.212, subdivision 9~~.
312.18 Providers of day treatment services must develop the individual treatment plan before the
312.19 completion of five working days in which service is provided or within 30 days after the
312.20 diagnostic assessment is completed or obtained, whichever occurs first. Providers of
312.21 outpatient services must develop the individual treatment plan within 30 days after the
312.22 diagnostic assessment is completed or obtained or by the end of the second session of an
312.23 outpatient service, not including the session in which the diagnostic assessment was provided,
312.24 whichever occurs first. Providers of outpatient and day treatment services must review the
312.25 individual treatment plan every 90 days after intake.

312.26 **EFFECTIVE DATE.** This section is effective September 30, 2021.

312.27 Sec. 2. Minnesota Statutes 2020, section 245.4882, subdivision 1, is amended to read:

312.28 Subdivision 1. **Availability of residential treatment services.** County boards must
312.29 provide or contract for enough residential treatment services to meet the needs of each child
312.30 with severe emotional disturbance residing in the county and needing this level of care.
312.31 Length of stay is based on the child's residential treatment need and shall be ~~subject to the~~
312.32 ~~six-month review process established in section 260C.203, and for children in voluntary~~
312.33 ~~placement for treatment, the court review process in section 260D.06~~ reviewed every 90
313.1 days. Services must be appropriate to the child's age and treatment needs and must be made
313.2 available as close to the county as possible. Residential treatment must be designed to:

472.1 (1) help the child improve family living and social interaction skills;

472.2 (2) help the child gain the necessary skills to return to the community;

472.3 (3) stabilize crisis admissions; and

472.4 (4) work with families throughout the placement to improve the ability of the families
472.5 to care for children with severe emotional disturbance in the home.

472.6 Sec. 5. Minnesota Statutes 2020, section 245.4882, subdivision 3, is amended to read:

472.7 Subd. 3. **Transition to community.** Residential treatment facilities and regional treatment
472.8 centers serving children must plan for and assist those children and their families in making
472.9 a transition to less restrictive community-based services. Discharge planning for the child
472.10 to return to the community must include identification of and referrals to appropriate home
472.11 and community supports that meet the needs of the child and family. Discharge planning
472.12 must begin within 30 days after the child enters residential treatment and be updated every
472.13 60 days. Residential treatment facilities must also arrange for appropriate follow-up care
472.14 in the community. Before a child is discharged, the residential treatment facility or regional
472.15 treatment center shall provide notification to the child's case manager, if any, so that the
472.16 case manager can monitor and coordinate the transition and make timely arrangements for
472.17 the child's appropriate follow-up care in the community.

472.18 Sec. 6. Minnesota Statutes 2020, section 245.4885, subdivision 1, is amended to read:

472.19 Subdivision 1. **Admission criteria.** (a) Prior to admission or placement, except in the
472.20 case of an emergency, all children referred for treatment of severe emotional disturbance
472.21 in a treatment foster care setting, residential treatment facility, or informally admitted to a
472.22 regional treatment center shall undergo an assessment to determine the appropriate level of
472.23 care if ~~public~~ county funds are used to pay for the child's services.

472.24 (b) The ~~responsible social services agency~~ county board shall determine the appropriate
472.25 level of care for a child when county-controlled funds are used to pay for the child's ~~services~~
472.26 ~~or placement in a qualified residential treatment facility under chapter 260C and licensed~~
472.27 ~~by the commissioner under chapter 245A. In accordance with section 260C.157, a juvenile~~
472.28 ~~treatment screening team shall conduct a screening before the team may recommend whether~~
472.29 ~~to place a child~~ residential treatment under this chapter, including residential treatment
472.30 provided in a qualified residential treatment program as defined in section 260C.007,
472.31 subdivision 26d. When a ~~social services agency~~ county board does not have responsibility
472.32 for a child's placement and the child is enrolled in a prepaid health program under section
473.1 256B.69, the enrolled child's contracted health plan must determine the appropriate level
473.2 of care for the child. When Indian Health Services funds or funds of a tribally owned facility
473.3 funded under the Indian Self-Determination and Education Assistance Act, Public Law
473.4 93-638, are ~~to be~~ used for the child, the Indian Health Services or 638 tribal health facility
473.5 must determine the appropriate level of care for the child. When more than one entity bears

313.3 (1) help the child improve family living and social interaction skills;

313.4 (2) help the child gain the necessary skills to return to the community;

313.5 (3) stabilize crisis admissions; and

313.6 (4) work with families throughout the placement to improve the ability of the families
313.7 to care for children with severe emotional disturbance in the home.

313.8 **EFFECTIVE DATE.** This section is effective September 30, 2021.

SEE PAGE R6, SENATE LINES 315.10-315.13

313.9 Sec. 3. Minnesota Statutes 2020, section 245.4885, subdivision 1, is amended to read:

313.10 Subdivision 1. **Admission criteria.** (a) Prior to admission or placement, except in the
313.11 case of an emergency, all children referred for treatment of severe emotional disturbance
313.12 in a ~~treatment foster care setting,~~ residential treatment facility~~,~~ or informally admitted to a
313.13 regional treatment center shall undergo an assessment to determine the appropriate level of
313.14 care if ~~public~~ county funds are used to pay for the child's services.

313.15 (b) The ~~responsible social services agency~~ county board shall determine the appropriate
313.16 level of care for a child when county-controlled funds are used to pay for the child's ~~services~~
313.17 ~~or placement~~ residential treatment under this chapter, including residential treatment provided
313.18 in a qualified residential treatment ~~facility under chapter 260C and licensed by the~~
313.19 ~~commissioner under chapter 245A. In accordance with section 260C.157, a juvenile treatment~~
313.20 ~~screening team shall conduct a screening before the team may recommend whether to place~~
313.21 ~~a child in a qualified residential treatment~~ program as defined in section 260C.007,
313.22 subdivision 26d. When a ~~social services agency~~ county board does not have responsibility
313.23 for a child's placement and the child is enrolled in a prepaid health program under section
313.24 256B.69, the enrolled child's contracted health plan must determine the appropriate level
313.25 of care for the child. When Indian Health Services funds or funds of a tribally owned facility
313.26 funded under the Indian Self-Determination and Education Assistance Act, Public Law
313.27 93-638, are to be used for a child, the Indian Health Services or 638 tribal health facility
313.28 must determine the appropriate level of care for the child. When more than one entity bears

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

473.8 (c) The responsible social services agency must make the level of care determination
473.9 available to the juvenile treatment screening team, as permitted under chapter 13. The level
473.10 of care determination shall inform the juvenile treatment screening team process and the
473.11 assessment in section 260C.704 when considering whether to place the child in a qualified
473.12 residential treatment program. When the responsible social services agency is not involved
473.13 in determining a child's placement, the child's level of care determination shall determine
473.14 whether the proposed treatment:

473.15 (1) is necessary;

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

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

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

473.20 (d) When a level of care determination is conducted, the responsible social services
473.21 agency county board or other entity may not determine that a screening under section
473.22 260C.157 or, referral, or admission to a treatment foster care setting or residential treatment
473.23 facility is not appropriate solely because services were not first provided to the child in a
473.24 less restrictive setting and the child failed to make progress toward or meet treatment goals
473.25 in the less restrictive setting. The level of care determination must be based on a diagnostic
473.26 assessment of a child that includes a functional assessment which evaluates family, school,
473.27 and community living situations; and an assessment of the child's need for care out of the
473.28 home using a validated tool which assesses a child's functional status and assigns an
473.29 appropriate level of care to the child. The validated tool must be approved by the
473.30 commissioner of human services. If a diagnostic assessment including a functional assessment
473.31 has been completed by a mental health professional within the past 180 days, a new diagnostic
473.32 assessment need not be completed unless in the opinion of the current treating mental health
473.33 professional the child's mental health status has changed markedly since the assessment
473.34 was completed. The child's parent shall be notified if an assessment will not be completed
474.1 and of the reasons. A copy of the notice shall be placed in the child's file. Recommendations
474.2 developed as part of the level of care determination process shall include specific community
474.3 services needed by the child and, if appropriate, the child's family, and shall indicate whether
474.4 or not these services are available and accessible to the child and the child's family. The
474.5 child and the child's family must be invited to any meeting where the level of care
474.6 determination is discussed and decisions regarding residential treatment are made. The child
474.7 and the child's family may invite other relatives, friends, or advocates to attend these
474.8 meetings.

474.9 (e) During the level of care determination process, the child, child's family, or child's
474.10 legal representative, as appropriate, must be informed of the child's eligibility for case

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

313.31 (c) The responsible social services agency must make the level of care determination
313.32 available to the juvenile treatment screening team, as permitted under chapter 13. The level
313.33 of care determination shall inform the juvenile treatment screening team process and the
314.1 assessment in section 260C.704 when considering whether to place the child in a qualified
314.2 residential treatment program. When the responsible social services agency is not involved
314.3 in determining a child's placement, the child's level of care determination shall determine
314.4 whether the proposed treatment:

314.5 (1) is necessary;

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

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

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

314.10 (d) When a level of care determination is conducted, the responsible social services
314.11 agency county board or other entity may not determine that a screening under section
314.12 260C.157 or, referral, or admission to a treatment foster care setting or residential treatment
314.13 facility is not appropriate solely because services were not first provided to the child in a
314.14 less restrictive setting and the child failed to make progress toward or meet treatment goals
314.15 in the less restrictive setting. The level of care determination must be based on a diagnostic
314.16 assessment that includes a functional assessment of a child which evaluates the child's
314.17 family, school, and community living situations; and an assessment of the child's need for
314.18 care out of the home using a validated tool which assesses a child's functional status and
314.19 assigns an appropriate level of care to the child. The validated tool must be approved by
314.20 the commissioner of human services. If a diagnostic assessment including a functional
314.21 assessment has been completed by a mental health professional within the past 180 days, a
314.22 new diagnostic assessment need not be completed unless in the opinion of the current treating
314.23 mental health professional the child's mental health status has changed markedly since the
314.24 assessment was completed. The child's parent shall be notified if an assessment will not be
314.25 completed and of the reasons. A copy of the notice shall be placed in the child's file.
314.26 Recommendations developed as part of the level of care determination process shall include
314.27 specific community services needed by the child and, if appropriate, the child's family, and
314.28 shall indicate whether or not these services are available and accessible to the child and the
314.29 child's family. The child and the child's family must be invited to any meeting at which the
314.30 level of care determination is discussed and decisions regarding residential treatment are
314.31 made. The child and the child's family may invite other relatives, friends, or advocates to
314.32 attend these meetings.

314.33 (e) During the level of care determination process, the child, child's family, or child's
314.34 legal representative, as appropriate, must be informed of the child's eligibility for case

474.11 management services and family community support services and that an individual family
474.12 community support plan is being developed by the case manager, if assigned.

474.13 ~~(f) When the responsible social services agency has authority, the agency must engage~~
474.14 ~~the child's parents in case planning under sections 260C.212 and 260C.708 unless a court~~
474.15 ~~terminates the parent's rights or court orders restrict the parent from participating in case~~
474.16 ~~planning, visitation, or parental responsibilities.~~

474.17 ~~(g)~~ (f) The level of care determination, and placement decision, and recommendations
474.18 for mental health services must be documented in the child's record~~, as required in chapter~~
474.19 ~~260C~~ and made available to the child's family, as appropriate.

474.20 **EFFECTIVE DATE.** This section is effective September 30, 2021.

474.21 Sec. 7. Minnesota Statutes 2020, section 245.4889, subdivision 1, is amended to read:

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

474.24 (1) counties;

474.25 (2) Indian tribes;

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

474.27 (4) mental health service providers.

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

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

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

475.3 (3) respite care services for children with emotional disturbances or severe emotional
475.4 disturbances who are at risk of out-of-home placement. A child is not required to have case
475.5 management services to receive respite care services;

475.6 (4) children's mental health crisis services;

475.7 (5) mental health services for people from cultural and ethnic minorities, including
475.8 supervision of clinical trainees who are Black, indigenous, or people of color, providing
475.9 services in clinics that serve clients enrolled in medical assistance;

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

315.1 management services and family community support services and that an individual family
315.2 community support plan is being developed by the case manager, if assigned.

315.3 (f) ~~When the responsible social services agency has authority, the agency must engage~~
315.4 ~~the child's parents in case planning under sections 260C.212 and 260C.708 unless a court~~
315.5 ~~terminates the parent's rights or court orders restrict the parent from participating in case~~
315.6 ~~planning, visitation, or parental responsibilities.~~

315.7 ~~(g)~~ The level of care determination, and placement decision, and recommendations for
315.8 mental health services must be documented in the child's record, as required in ~~chapter~~
315.9 chapters 260C and 260D.

315.10 (g) Discharge planning for the child to return to the community must include identification
315.11 of and referrals to appropriate home and community supports to meet the needs of the child
315.12 and family. Discharge planning must begin within 30 days after the child enters residential
315.13 treatment and be updated every 60 days.

315.14 **EFFECTIVE DATE.** This section is effective September 30, 2021.

397.16 Section 1. Minnesota Statutes 2020, section 245.4889, subdivision 1, is amended to read:

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

397.19 (1) counties;

397.20 (2) Indian tribes;

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

397.22 (4) mental health service providers.

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

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

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

397.28 (3) respite care services for children with emotional disturbances or severe emotional
397.29 disturbances who are at risk of out-of-home placement. A child is not required to have case
397.30 management services to receive respite care services;

398.1 (4) children's mental health crisis services;

398.2 (5) mental health services for people from cultural and ethnic minorities;

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

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

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

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

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

475.17 (11) mental health first aid training;

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

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

475.23 (14) early childhood mental health consultation;

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

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

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

476.1 (18) mental health services based on traditional, spiritual, and holistic healing practices,
476.2 provided by cultural healers from African American, American Indian, Asian American,
476.3 Latinx, Pacific Islander, and Pan-African communities.

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

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

476.10 Sec. 8. **[245.4902] CULTURALLY INFORMED AND CULTURALLY RESPONSIVE**
476.11 **MENTAL HEALTH TASK FORCE.**

476.12 Subdivision 1. **Establishment; duties.** The Culturally Informed and Culturally
476.13 Responsive Mental Health Task Force is established to evaluate and make recommendations

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

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

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

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

398.10 (11) mental health first aid training;

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

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

398.16 (14) early childhood mental health consultation;

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

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

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

398.23 (18) evidence-informed interventions for youth and young adults who are at risk of
398.24 developing a mood disorder or are experiencing an emerging mood disorder, including
398.25 major depression and bipolar disorders, and a public awareness campaign on the signs and
398.26 symptoms of mood disorders in youth and young adults.

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

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

476.14 on improving the provision of culturally informed and culturally responsive mental health
476.15 services throughout Minnesota. The task force must make recommendations on:

476.16 (1) recruiting mental health providers from diverse racial and ethnic communities;

476.17 (2) training all mental health providers on cultural competency and cultural humility;

476.18 (3) assessing the extent to which mental health provider organizations embrace diversity
476.19 and demonstrate proficiency in culturally competent mental health treatment and services;
476.20 and

476.21 (4) increasing the number of mental health organizations owned, managed, or led by
476.22 individuals who are Black, indigenous, or people of color.

476.23 Subd. 2. **Membership.** (a) The task force must consist of the following 16 members:

476.24 (1) the commissioner of human services or the commissioner's designee;

476.25 (2) one representative from the Board of Psychology;

476.26 (3) one representative from the Board of Marriage and Family Therapy;

476.27 (4) one representative from the Board of Behavioral Health and Therapy;

476.28 (5) one representative from the Board of Social Work;

476.29 (6) three members representing undergraduate and graduate-level mental health
476.30 professional education programs, appointed by the governor;

477.1 (7) three mental health providers who are members of communities of color or
477.2 underrepresented communities, as defined in section 148E.010, subdivision 20, appointed
477.3 by the governor;

477.4 (8) two members representing mental health advocacy organizations, appointed by the
477.5 governor;

477.6 (9) two mental health providers, appointed by the governor; and

477.7 (10) one expert in providing training and education in cultural competency and cultural
477.8 responsiveness, appointed by the governor.

477.9 (b) Appointments to the task force must be made no later than June 1, 2022.

477.10 (c) Member compensation and reimbursement for expenses are governed by section
477.11 15.059, subdivision 3.

477.12 Subd. 3. **Chairs; meetings.** The members of the task force must elect two cochairs of
477.13 the task force no earlier than July 1, 2022, and the cochairs must convene the first meeting
477.14 of the task force no later than August 15, 2022. The task force must meet upon the call of

H2128-4		UEH2128-1	
477.15	the cochairs, sufficiently often to accomplish the duties identified in this section. The task		
477.16	force is subject to the open meeting law under chapter 13D.		
477.17	Subd. 4. **Administrative support.** The Department of Human Services must provide		
477.18	administrative support and meeting space for the task force.		
477.19	Subd. 5. **Reports.** No later than January 1, 2023, and by January 1 of each year thereafter,		
477.20	the task force must submit a written report to the members of the legislative committees		
477.21	with jurisdiction over health and human services on the recommendations developed under		
477.22	subdivision 1.		
477.23	Subd. 6. **Expiration.** The task force expires on January 1, 2025.		
477.24	Sec. 9. Minnesota Statutes 2020, section 245.735, subdivision 3, is amended to read:	399.3	Sec. 2. Minnesota Statutes 2020, section 245.735, subdivision 3, is amended to read:
477.25	Subd. 3. **Certified community behavioral health clinics.** (a) The commissioner shall	399.4	Subd. 3. **Certified community behavioral health clinics.** (a) The commissioner shall
477.26	establish a state certification process for certified community behavioral health clinics	399.5	establish a state certification process for certified community behavioral health clinics
477.27	(CCBHCs) that satisfy all federal requirements necessary for CCBHCs certified under this	399.6	(CCBHCs) that satisfy all federal requirements necessary for CCBHCs certified under this
477.28	section to be eligible for reimbursement under medical assistance, without service area	399.7	section to be eligible for reimbursement under medical assistance, without service area
477.29	limits based on geographic area or region. The commissioner shall consult with CCBHC	399.8	limits based on geographic area or region. The commissioner shall consult with CCBHC
477.30	stakeholders before establishing and implementing changes in the certification process and	399.9	stakeholders before establishing and implementing changes in the certification process and
477.31	requirements. Entities that choose to be CCBHCs must:	399.10	requirements. Entities that choose to be CCBHCs must:
478.1	~~(1) comply with the CCBHC criteria published by the United States Department of~~	399.11	~~(1) comply with the CCBHC criteria published by the United States Department of~~
478.2	~~Health and Human Services;~~	399.12	~~Health and Human Services;~~
478.3	(1) comply with state licensing requirements and other requirements issued by the	399.13	(1) comply with state licensing requirements and other requirements issued by the
478.4	commissioner;	399.14	commissioner;
478.5	(2) employ or contract for clinic staff who have backgrounds in diverse disciplines,	399.15	(2) employ or contract for clinic staff who have backgrounds in diverse disciplines,
478.6	including licensed mental health professionals and licensed alcohol and drug counselors,	399.16	including licensed mental health professionals and licensed alcohol and drug counselors,
478.7	and staff who are culturally and linguistically trained to meet the needs of the population	399.17	and staff who are culturally and linguistically trained to meet the needs of the population
478.8	the clinic serves;	399.18	the clinic serves;
478.9	(3) ensure that clinic services are available and accessible to individuals and families of	399.19	(3) ensure that clinic services are available and accessible to individuals and families of
478.10	all ages and genders and that crisis management services are available 24 hours per day;	399.20	all ages and genders and that crisis management services are available 24 hours per day;
478.11	(4) establish fees for clinic services for individuals who are not enrolled in medical	399.21	(4) establish fees for clinic services for individuals who are not enrolled in medical
478.12	assistance using a sliding fee scale that ensures that services to patients are not denied or	399.22	assistance using a sliding fee scale that ensures that services to patients are not denied or
478.13	limited due to an individual's inability to pay for services;	399.23	limited due to an individual's inability to pay for services;
478.14	(5) comply with quality assurance reporting requirements and other reporting	399.24	(5) comply with quality assurance reporting requirements and other reporting
478.15	requirements, including any required reporting of encounter data, clinical outcomes data,	399.25	requirements, including any required reporting of encounter data, clinical outcomes data,
478.16	and quality data;	399.26	and quality data;
478.17	(6) provide crisis mental health and substance use services, withdrawal management	399.27	(6) provide crisis mental health and substance use services, withdrawal management
478.18	services, emergency crisis intervention services, and stabilization services through existing	399.28	services, emergency crisis intervention services, and stabilization services, through existing
478.19	mobile crisis services; screening, assessment, and diagnosis services, including risk	399.29	mobile crisis services; screening, assessment, and diagnosis services, including risk

478.20 assessments and level of care determinations; person- and family-centered treatment planning;
478.21 outpatient mental health and substance use services; targeted case management; psychiatric
478.22 rehabilitation services; peer support and counselor services and family support services;
478.23 and intensive community-based mental health services, including mental health services
478.24 for members of the armed forces and veterans~~;~~. CCBHCs must directly provide the majority
478.25 of these services to enrollees, but may coordinate some services with another entity through
478.26 a collaboration or agreement, pursuant to paragraph (b);

478.27 (7) provide coordination of care across settings and providers to ensure seamless
478.28 transitions for individuals being served across the full spectrum of health services, including
478.29 acute, chronic, and behavioral needs. Care coordination may be accomplished through
478.30 partnerships or formal contracts with:

478.31 (i) counties, health plans, pharmacists, pharmacies, rural health clinics, federally qualified
478.32 health centers, inpatient psychiatric facilities, substance use and detoxification facilities, or
478.33 community-based mental health providers; and

479.1 (ii) other community services, supports, and providers, including schools, child welfare
479.2 agencies, juvenile and criminal justice agencies, Indian health services clinics, tribally
479.3 licensed health care and mental health facilities, urban Indian health clinics, Department of
479.4 Veterans Affairs medical centers, outpatient clinics, drop-in centers, acute care hospitals,
479.5 and hospital outpatient clinics;

479.6 (8) be certified as mental health clinics under section 245.69, subdivision 2;

479.7 (9) comply with standards established by the commissioner relating to ~~mental health~~
479.8 ~~services in Minnesota Rules, parts 9505.0370 to 9505.0372~~ CCBHC screenings, assessments,
479.9 and evaluations;

479.10 (10) be licensed to provide substance use disorder treatment under chapter 245G;

479.11 (11) be certified to provide children's therapeutic services and supports under section
479.12 256B.0943;

479.13 (12) be certified to provide adult rehabilitative mental health services under section
479.14 256B.0623;

479.15 (13) be enrolled to provide mental health crisis response services under sections
479.16 256B.0624 and 256B.0944;

479.17 (14) be enrolled to provide mental health targeted case management under section
479.18 256B.0625, subdivision 20;

479.19 (15) comply with standards relating to mental health case management in Minnesota
479.20 Rules, parts 9520.0900 to 9520.0926;

479.21 (16) provide services that comply with the evidence-based practices described in
479.22 paragraph (e); and

399.30 assessments and level of care determinations; person- and family-centered treatment planning;
399.31 outpatient mental health and substance use services; targeted case management; psychiatric
399.32 rehabilitation services; peer support and counselor services and family support services;
399.33 and intensive community-based mental health services, including mental health services
400.1 for members of the armed forces and veterans~~;~~. CCBHCs must directly provide the majority
400.2 of these services to enrollees, but may coordinate some services with another entity through
400.3 a collaboration or agreement, pursuant to paragraph (b);

400.4 (7) provide coordination of care across settings and providers to ensure seamless
400.5 transitions for individuals being served across the full spectrum of health services, including
400.6 acute, chronic, and behavioral needs. Care coordination may be accomplished through
400.7 partnerships or formal contracts with:

400.8 (i) counties, health plans, pharmacists, pharmacies, rural health clinics, federally qualified
400.9 health centers, inpatient psychiatric facilities, substance use and detoxification facilities, or
400.10 community-based mental health providers; and

400.11 (ii) other community services, supports, and providers, including schools, child welfare
400.12 agencies, juvenile and criminal justice agencies, Indian health services clinics, tribally
400.13 licensed health care and mental health facilities, urban Indian health clinics, Department of
400.14 Veterans Affairs medical centers, outpatient clinics, drop-in centers, acute care hospitals,
400.15 and hospital outpatient clinics;

400.16 (8) be certified as mental health clinics under section 245.69, subdivision 2;

400.17 (9) comply with standards established by the commissioner relating to ~~mental health~~
400.18 ~~services in Minnesota Rules, parts 9505.0370 to 9505.0372~~ CCBHC screenings, assessments,
400.19 and evaluations;

400.20 (10) be licensed to provide substance use disorder treatment under chapter 245G;

400.21 (11) be certified to provide children's therapeutic services and supports under section
400.22 256B.0943;

400.23 (12) be certified to provide adult rehabilitative mental health services under section
400.24 256B.0623;

400.25 (13) be enrolled to provide mental health crisis response services under ~~sections~~ section
400.26 256B.0624 ~~and 256B.0944~~;

400.27 (14) be enrolled to provide mental health targeted case management under section
400.28 256B.0625, subdivision 20;

400.29 (15) comply with standards relating to mental health case management in Minnesota
400.30 Rules, parts 9520.0900 to 9520.0926;

400.31 (16) provide services that comply with the evidence-based practices described in
400.32 paragraph (e); and

(17) comply with standards relating to peer services under sections 256B.0615, 256B.0616, and 245G.07, subdivision 1, paragraph (a), clause (5), as applicable when peer services are provided.

(b) If ~~an entity~~ a certified CCBHC is unable to provide one or more of the services listed in paragraph (a), clauses (6) to (17), the ~~commissioner may certify the entity as a~~ CCBHC~~,~~ ~~if the entity has a current~~ may contract with another entity that has the required authority to provide that service and that meets ~~federal CCBHC~~ the following criteria as a designated collaborating organization~~, or, to the extent allowed by the federal CCBHC criteria, the commissioner may approve a referral arrangement. The CCBHC must meet federal requirements regarding the type and scope of services to be provided directly by the CCBHC.~~:

(1) the entity has a formal agreement with the CCBHC to furnish one or more of the services under paragraph (a), clause (6);

(2) the entity provides assurances that it will provide services according to CCBHC service standards and provider requirements;

(3) the entity agrees that the CCBHC is responsible for coordinating care and has clinical and financial responsibility for the services that the entity provides under the agreement; and

(4) the entity meets any additional requirements issued by the commissioner.

(c) Notwithstanding any other law that requires a county contract or other form of county approval for certain services listed in paragraph (a), clause (6), a clinic that otherwise meets CCBHC requirements may receive the prospective payment under section 256B.0625, subdivision 5m, for those services without a county contract or county approval. As part of the certification process in paragraph (a), the commissioner shall require a letter of support from the CCBHC's host county confirming that the CCBHC and the county or counties it serves have an ongoing relationship to facilitate access and continuity of care, especially for individuals who are uninsured or who may go on and off medical assistance.

(d) When the standards listed in paragraph (a) or other applicable standards conflict or address similar issues in duplicative or incompatible ways, the commissioner may grant variances to state requirements if the variances do not conflict with federal requirements for services reimbursed under medical assistance. If standards overlap, the commissioner may substitute all or a part of a licensure or certification that is substantially the same as another licensure or certification. The commissioner shall consult with stakeholders, as described in subdivision 4, before granting variances under this provision. For the CCBHC that is certified but not approved for prospective payment under section 256B.0625, subdivision 5m, the commissioner may grant a variance under this paragraph if the variance does not increase the state share of costs.

(e) The commissioner shall issue a list of required evidence-based practices to be delivered by CCBHCs, and may also provide a list of recommended evidence-based practices. The commissioner may update the list to reflect advances in outcomes research and medical

(17) comply with standards relating to peer services under sections 256B.0615, 256B.0616, and 245G.07, subdivision 1, paragraph (a), clause (5), as applicable when peer services are provided.

(b) If ~~an entity~~ a certified CCBHC is unable to provide one or more of the services listed in paragraph (a), clauses (6) to (17), the ~~commissioner may certify the entity as a~~ CCBHC~~,~~ ~~if the entity has a current~~ may contract with another entity that has the required authority to provide that service and that meets ~~federal CCBHC~~ the following criteria as a designated collaborating organization~~, or, to the extent allowed by the federal CCBHC criteria, the commissioner may approve a referral arrangement. The CCBHC must meet federal requirements regarding the type and scope of services to be provided directly by the CCBHC.~~:

(1) the entity has a formal agreement with the CCBHC to furnish one or more of the services under paragraph (a), clause (6);

(2) the entity provides assurances that it will provide services according to CCBHC service standards and provider requirements;

(3) the entity agrees that the CCBHC is responsible for coordinating care and has clinical and financial responsibility for the services that the entity provides under the agreement; and

(4) the entity meets any additional requirements issued by the commissioner.

(c) Notwithstanding any other law that requires a county contract or other form of county approval for certain services listed in paragraph (a), clause (6), a clinic that otherwise meets CCBHC requirements may receive the prospective payment under section 256B.0625, subdivision 5m, for those services without a county contract or county approval. As part of the certification process in paragraph (a), the commissioner shall require a letter of support from the CCBHC's host county confirming that the CCBHC and the county or counties it serves have an ongoing relationship to facilitate access and continuity of care, especially for individuals who are uninsured or who may go on and off medical assistance.

(d) When the standards listed in paragraph (a) or other applicable standards conflict or address similar issues in duplicative or incompatible ways, the commissioner may grant variances to state requirements if the variances do not conflict with federal requirements for services reimbursed under medical assistance. If standards overlap, the commissioner may substitute all or a part of a licensure or certification that is substantially the same as another licensure or certification. The commissioner shall consult with stakeholders, as described in subdivision 4, before granting variances under this provision. For the CCBHC that is certified but not approved for prospective payment under section 256B.0625, subdivision 5m, the commissioner may grant a variance under this paragraph if the variance does not increase the state share of costs.

(e) The commissioner shall issue a list of required evidence-based practices to be delivered by CCBHCs, and may also provide a list of recommended evidence-based practices. The commissioner may update the list to reflect advances in outcomes research and medical

480.30 services for persons living with mental illnesses or substance use disorders. The commissioner
480.31 shall take into consideration the adequacy of evidence to support the efficacy of the practice,
480.32 the quality of workforce available, and the current availability of the practice in the state.
480.33 At least 30 days before issuing the initial list and any revisions, the commissioner shall
480.34 provide stakeholders with an opportunity to comment.

481.1 (f) The commissioner shall recertify CCBHCs at least every three years. The
481.2 commissioner shall establish a process for decertification and shall require corrective action,
481.3 medical assistance repayment, or decertification of a CCBHC that no longer meets the
481.4 requirements in this section or that fails to meet the standards provided by the commissioner
481.5 in the application and certification process.

481.6 Sec. 10. Minnesota Statutes 2020, section 245.735, subdivision 5, is amended to read:

481.7 Subd. 5. **Information systems support.** The commissioner and the state chief information
481.8 officer shall provide information systems support to the projects as necessary to comply
481.9 with state and federal requirements.

481.10 Sec. 11. Minnesota Statutes 2020, section 245.735, is amended by adding a subdivision
481.11 to read:

481.12 Subd. 6. **Demonstration entities.** The commissioner may operate the demonstration
481.13 program established by section 223 of the Protecting Access to Medicare Act if federal
481.14 funding for the demonstration program remains available from the United States Department
481.15 of Health and Human Services. To the extent practicable, the commissioner shall align the
481.16 requirements of the demonstration program with the requirements under this section for
481.17 CCBHCs receiving medical assistance reimbursement. A CCBHC may not apply to
481.18 participate as a billing provider in both the CCBHC federal demonstration and the benefit
481.19 for CCBHCs under the medical assistance program.

402.6 services for persons living with mental illnesses or substance use disorders. The commissioner
402.7 shall take into consideration the adequacy of evidence to support the efficacy of the practice,
402.8 the quality of workforce available, and the current availability of the practice in the state.
402.9 At least 30 days before issuing the initial list and any revisions, the commissioner shall
402.10 provide stakeholders with an opportunity to comment.

402.11 (f) The commissioner shall recertify CCBHCs at least every three years. The
402.12 commissioner shall establish a process for decertification and shall require corrective action,
402.13 medical assistance repayment, or decertification of a CCBHC that no longer meets the
402.14 requirements in this section or that fails to meet the standards provided by the commissioner
402.15 in the application and certification process.

402.16 Sec. 3. Minnesota Statutes 2020, section 245.735, subdivision 5, is amended to read:

402.17 Subd. 5. **Information systems support.** The commissioner and the state chief information
402.18 officer shall provide information systems support to the projects as necessary to comply
402.19 with state and federal requirements.

402.20 Sec. 4. Minnesota Statutes 2020, section 245.735, is amended by adding a subdivision to
402.21 read:

402.22 Subd. 6. **Demonstration entities.** The commissioner may operate the demonstration
402.23 program established by section 223 of the Protecting Access to Medicare Act if federal
402.24 funding for the demonstration program remains available from the United States Department
402.25 of Health and Human Services. To the extent practicable, the commissioner shall align the
402.26 requirements of the demonstration program with the requirements under this section for
402.27 CCBHCs receiving medical assistance reimbursement. A CCBHC may not apply to
402.28 participate as a billing provider in both the CCBHC federal demonstration and the benefit
402.29 for CCBHCs under the medical assistance program.

3.41 Section 1. Minnesota Statutes 2020, section 245F.03, is amended to read:

3.42 **245F.03 APPLICATION.**

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

3.45 (b) This chapter does not apply to a withdrawal management program licensed as a
3.46 hospital under sections 144.50 to 144.581. A withdrawal management program located in
3.47 a hospital licensed under sections 144.50 to 144.581 that chooses to be licensed under this
3.48 chapter is deemed to be in compliance with section 245F.13. This chapter does not apply
4.1 when a license holder is providing pre-treatment coordination services under section 254B.05,
4.2 subdivision 4a.

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

4.5 **EFFECTIVE DATE.** This section is effective January 1, 2022, or upon federal approval,
4.6 whichever is later. The commissioner of human services shall notify the revisor of statutes
4.7 when federal approval is obtained or denied.

4.8 Sec. 2. Minnesota Statutes 2020, section 245G.02, subdivision 2, is amended to read:

4.9 Subd. 2. **Exemption from license requirement.** This chapter does not apply to a county
4.10 or recovery community organization that is providing a service for which the county or
4.11 recovery community organization is an eligible vendor under section 254B.05. This chapter
4.12 does not apply to an organization whose primary functions are information, referral,
4.13 diagnosis, case management, and assessment for the purposes of client placement, education,
4.14 support group services, or self-help programs. This chapter does not apply to the activities
4.15 of a licensed professional in private practice. A license holder providing the initial set of
4.16 substance use disorder services allowable under section 254A.03, subdivision 3, paragraph
4.17 (c), to an individual referred to a licensed nonresidential substance use disorder treatment
4.18 program after a positive screen for alcohol or substance misuse is exempt from sections
4.19 245G.05; 245G.06, subdivisions 1, 2, and 4; 245G.07, subdivisions 1, paragraph (a), clauses
4.20 (2) to (4), and 2, clauses (1) to (7); and 245G.17. This chapter does not apply when a license
4.21 holder is providing pretreatment coordination services under section 254B.05, subdivision
4.22 4a.

4.23 **EFFECTIVE DATE.** This section is effective January 1, 2022, or upon federal approval,
4.24 whichever is later. The commissioner of human services shall notify the revisor of statutes
4.25 when federal approval is obtained or denied.

4.26 Sec. 3. Minnesota Statutes 2020, section 245G.06, subdivision 3, is amended to read:

4.27 Subd. 3. **Documentation of treatment services and pretreatment services; treatment**
4.28 **plan review.** (a) A review of all treatment services must be documented weekly and include
4.29 a review of:

4.30 (1) ~~care~~ treatment coordination activities, including any pretreatment coordination
4.31 services;

4.32 (2) medical and other appointments the client attended;

5.1 (3) issues related to medications that are not documented in the medication administration
5.2 record; and

5.3 (4) issues related to attendance for treatment services, including the reason for any client
5.4 absence from a treatment service.

5.5 (b) A note must be entered immediately following any significant event. A significant
5.6 event is an event that impacts the client's relationship with other clients, staff, the client's
5.7 family, or the client's treatment plan.

5.8 (c) A treatment plan review must be entered in a client's file weekly or after each treatment
5.9 service, whichever is less frequent, by the staff member providing the service. The review

5.10 must indicate the span of time covered by the review and each of the six dimensions listed
5.11 in section 245G.05, subdivision 2, paragraph (c). The review must:

5.12 (1) indicate the date, type, and amount of each treatment service provided and the client's
5.13 response to each service;

5.14 (2) address each goal in the treatment plan and whether the methods to address the goals
5.15 are effective;

5.16 (3) include monitoring of any physical and mental health problems;

5.17 (4) document the participation of others;

5.18 (5) document staff recommendations for changes in the methods identified in the treatment
5.19 plan and whether the client agrees with the change; and

5.20 (6) include a review and evaluation of the individual abuse prevention plan according
5.21 to section 245A.65.

5.22 (d) Each entry in a client's record must be accurate, legible, signed, and dated. A late
5.23 entry must be clearly labeled "late entry." A correction to an entry must be made in a way
5.24 in which the original entry can still be read.

5.25 **EFFECTIVE DATE.** This section is effective January 1, 2022, or upon federal approval,
5.26 whichever is later. The commissioner of human services shall notify the revisor of statutes
5.27 when federal approval is obtained or denied.

5.28 Sec. 4. Minnesota Statutes 2020, section 245G.11, subdivision 7, is amended to read:

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

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

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

6.6 (3) has successfully completed 30 hours of classroom instruction on treatment
6.7 coordination for an individual with substance use disorder;

6.8 (4) has either:

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

6.10 (ii) current certification as an alcohol and drug counselor, level I, by the Upper Midwest
6.11 Indian Council on Addictive Disorders; and

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

481.20 Sec. 12. Minnesota Statutes 2020, section 254B.01, subdivision 4a, is amended to read:

481.21 Subd. 4a. **Culturally specific or culturally responsive program.** (a) "Culturally specific
481.22 or culturally responsive program" means a substance use disorder treatment service program
481.23 or subprogram that is ~~recovery-focused and~~ culturally responsive or culturally specific when
481.24 the program attests that it:

481.25 (1) improves service quality to and outcomes of a specific ~~population~~ community that
481.26 shares a common language, racial, ethnic, or social background by advancing health equity
481.27 to help eliminate health disparities; ~~and~~

481.28 (2) ensures effective, equitable, comprehensive, and respectful quality care services that
481.29 are responsive to an individual within a specific ~~population's~~ community's values, beliefs
481.30 and practices, health literacy, preferred language, and other communication needs~~.~~; and

481.31 (3) is compliant with the national standards for culturally and linguistically appropriate
481.32 services or other equivalent standards, as determined by the commissioner.

482.1 (b) A tribally licensed substance use disorder program that is designated as serving a
482.2 culturally specific population by the applicable tribal government is deemed to satisfy this
482.3 subdivision.

482.4 (c) A program satisfies the requirements of this subdivision if it attests that the program:

482.5 (1) is designed to address the unique needs of individuals who share a common language,
482.6 racial, ethnic, or social background;

482.7 (2) is governed with significant input from individuals of that specific background; and

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

6.18 (c) County staff who conduct chemical use assessments under Minnesota Rules, part
6.19 9530.6615, and are employed as of January 1, 2022, are qualified to provide treatment
6.20 coordination under section 245G.07, subdivision 1, paragraph (a), clause (5). County staff
6.21 who conduct chemical use assessments under Minnesota Rules, part 9530.6615, and are
6.22 employed after January 1, 2021, are qualified to provide treatment coordination under section
6.23 245G.07, subdivision 1, paragraph (a), clause (5), if the county staff person completes the
6.24 classroom instruction in paragraph (a), clause (3).

6.25 **EFFECTIVE DATE.** This section is effective January 1, 2022, or upon federal approval,
6.26 whichever is later. The commissioner of human services shall notify the revisor of statutes
6.27 when federal approval is obtained or denied.

482.8 (3) employs individuals to provide treatment services, at least 50 percent of whom are
482.9 members of the specific community being served.

482.10 **EFFECTIVE DATE.** This section is effective January 1, 2022.

482.11 Sec. 13. Minnesota Statutes 2020, section 254B.01, is amended by adding a subdivision
482.12 to read:

482.13 Subd. 4b. **Disability responsive program.** "Disability responsive program" means a
482.14 program that:

482.15 (1) is designed to serve individuals with disabilities, including individuals with traumatic
482.16 brain injuries, developmental disabilities, cognitive disabilities, and physical disabilities;
482.17 and

482.18 (2) employs individuals to provide treatment services who have the necessary professional
482.19 training, as approved by the commissioner, to serve individuals with the specific disabilities
482.20 that the program is designed to serve.

482.21 **EFFECTIVE DATE.** This section is effective January 1, 2022.

6.28 Sec. 5. Minnesota Statutes 2020, section 254B.05, subdivision 1, is amended to read:

6.29 Subdivision 1. **Licensure required.** (a) Programs licensed by the commissioner are
6.30 eligible vendors. Hospitals may apply for and receive licenses to be eligible vendors,
6.31 notwithstanding the provisions of section 245A.03. American Indian programs that provide
6.32 substance use disorder treatment, extended care, transitional residence, ~~or~~ outpatient treatment
7.1 services, and are licensed by tribal government are eligible vendors. American Indian
7.2 programs are eligible vendors of peer support services according to section 245G.07,
7.3 subdivision 2, clause (8). An alcohol and drug counselor as defined in section 245G.11,
7.4 subdivision 5, must be available to recovery peers for ongoing consultation, as needed.

7.5 (b) A licensed professional in private practice as defined in section 245G.01, subdivision
7.6 17, who meets the requirements of section 245G.11, subdivisions 1 and 4, is an eligible
7.7 vendor of a comprehensive assessment and assessment summary provided according to
7.8 section 245G.05, and treatment services provided according to sections 245G.06 and
7.9 245G.07, subdivision 1, paragraphs (a), clauses (1) to (5), and (b); and subdivision 2, clauses
7.10 (1) to (6).

7.11 (c) A county is an eligible vendor for a comprehensive assessment and assessment
7.12 summary when provided by an individual who meets the staffing credentials of section
7.13 245G.11, subdivisions 1 and 5, and completed according to the requirements of section
7.14 245G.05. A county is an eligible vendor of ~~care~~ treatment coordination services when
7.15 provided by an individual who meets the staffing credentials of section 245G.11, subdivisions
7.16 1 and 7, and provided according to the requirements of section 245G.07, subdivision 1,
7.17 paragraph (a), clause (5). A county is an eligible vendor of peer recovery support services

7.18 according to section 245G.07, subdivision 2, clause (8). An alcohol and drug counselor as
7.19 defined in section 245G.11, subdivision 5, must be available to recovery peers for ongoing
7.20 consultation, as needed.

7.21 (d) Nonresidential programs licensed under chapter 245G, withdrawal management
7.22 programs licensed under chapter 245F, American Indian programs described in paragraph
7.23 (a), and counties are eligible vendors of pretreatment coordination services as defined under
7.24 section 254B.05, subdivision 4a, when the individual providing the services meets the
7.25 staffing credentials in section 245G.11, subdivisions 1 and 7.

7.26 (e) A recovery community organization that meets certification requirements identified
7.27 by the commissioner is an eligible vendor of peer support services.

7.28 ~~(e)~~ (f) Detoxification programs licensed under Minnesota Rules, parts 9530.6510 to
7.29 9530.6590, are not eligible vendors. Programs that are not licensed as a residential or
7.30 nonresidential substance use disorder treatment or withdrawal management program by the
7.31 commissioner or by tribal government or do not meet the requirements of subdivisions 1a
7.32 and 1b are not eligible vendors.

8.1 **EFFECTIVE DATE.** This section is effective January 1, 2022, or upon federal approval,
8.2 whichever is later. The commissioner of human services shall notify the revisor of statutes
8.3 when federal approval is obtained or denied.

8.4 Sec. 6. Minnesota Statutes 2020, section 254B.05, is amended by adding a subdivision to
8.5 read:

8.6 Subd. 4a. **Pretreatment coordination services.** (a) An enrolled provider may provide
8.7 pretreatment coordination services to an individual prior to the individual's comprehensive
8.8 assessment under section 245G.05, to facilitate an individual's access to a comprehensive
8.9 assessment. The total pretreatment coordination services must not exceed 36 units per
8.10 eligibility determination.

8.11 (b) An individual providing pretreatment coordination services must meet the staff
8.12 qualifications in section 245G.11, subdivision 7. Section 245G.05 and Minnesota Rules,
8.13 parts 9530.6600 to 9530.6655, do not apply to pretreatment coordination services.

8.14 (c) To be eligible for pretreatment coordination services, an individual must screen
8.15 positive for alcohol or substance misuse using a screening tool approved by the commissioner.
8.16 The provider may bill the screening as a pretreatment coordination service.

8.17 (d) Pretreatment coordination services include:

8.18 (1) assisting with connecting an individual with a qualified comprehensive assessment
8.19 provider;

8.20 (2) identifying barriers that might inhibit an individual's ability to participate in a
8.21 comprehensive assessment; and

482.22 Sec. 14. Minnesota Statutes 2020, section 254B.05, subdivision 5, is amended to read:

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

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

482.26 (1) outpatient treatment services that are licensed according to sections 245G.01 to
482.27 245G.17, or applicable tribal license;

482.28 (2) comprehensive assessments provided according to sections 245.4863, paragraph (a),
482.29 and 245G.05;

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

483.3 (4) peer recovery support services provided according to section 245G.07, subdivision
483.4 2, clause (8);

483.5 (5) on July 1, 2019, or upon federal approval, whichever is later, withdrawal management
483.6 services provided according to chapter 245F;

483.7 (6) medication-assisted therapy services that are licensed according to sections 245G.01
483.8 to 245G.17 and 245G.22, or applicable tribal license;

483.9 (7) medication-assisted therapy plus enhanced treatment services that meet the
483.10 requirements of clause (6) and provide nine hours of clinical services each week;

8.22 (3) assisting with connecting an individual with resources to mitigate an individual's
8.23 immediate safety risks.

8.24 (e) A license holder is authorized to provide up to 36 units of pretreatment coordination
8.25 services, excluding travel time, and must document the following information in the client's
8.26 case file:

8.27 (1) the dates, number of units, and description of pretreatment coordination services
8.28 provided;

8.29 (2) identifying an individual's safety concerns and developing a plan to address those
8.30 concerns;

8.31 (3) assisting an individual with scheduling an appointment for a comprehensive
8.32 assessment and confirming that the individual and provider keep the appointment; and

9.1 (4) assisting an individual with accessing resources for obtaining a comprehensive
9.2 assessment authorizing substance use disorder treatment services.

9.3 **EFFECTIVE DATE.** This section is effective January 1, 2022, or upon federal approval,
9.4 whichever is later. The commissioner of human services shall notify the revisor of statutes
9.5 when federal approval is obtained or denied.

9.6 Sec. 7. Minnesota Statutes 2020, section 254B.05, subdivision 5, is amended to read:

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

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

9.10 (1) outpatient treatment services that are licensed according to sections 245G.01 to
9.11 245G.17, or applicable tribal license;

9.12 (2) comprehensive assessments provided according to sections 245.4863, paragraph (a),
9.13 and 245G.05;

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

9.16 (4) peer recovery support services provided according to section 245G.07, subdivision
9.17 2, clause (8);

9.18 (5) on July 1, 2019, or upon federal approval, whichever is later, withdrawal management
9.19 services provided according to chapter 245F;

9.20 (6) medication-assisted therapy services that are licensed according to sections 245G.01
9.21 to 245G.17 and 245G.22, or applicable tribal license;

9.22 (7) medication-assisted therapy plus enhanced treatment services that meet the
9.23 requirements of clause (6) and provide nine hours of clinical services each week;

H2128-4		UEH2128-1	
483.11	(8) 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;	9.24	(8) 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;
483.14	(9) 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;	9.27	(9) 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;
483.17	(10) 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;	9.30	(10) 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;
483.21	(11) 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	10.3	(11) 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~~
483.26	(12) room and board facilities that meet the requirements of subdivision 1a.	10.8	(12) room and board facilities that meet the requirements of subdivision 1a; and
		10.9	(13) pretreatment coordination services provided according to subdivision 4a.
483.27	(c) The commissioner shall establish higher rates for programs that meet the requirements of paragraph (b) and one of the following additional requirements:	10.10	(c) The commissioner shall establish higher rates for programs that meet the requirements of paragraph (b) and one of the following additional requirements:
483.29	(1) programs that serve parents with their children if the program:	10.12	(1) programs that serve parents with their children if the program:
483.30	(i) provides on-site child care during the hours of treatment activity that:	10.13	(i) provides on-site child care during the hours of treatment activity that:
483.31	(A) is licensed under chapter 245A as a child care center under Minnesota Rules, chapter 9503; or	10.14	(A) is licensed under chapter 245A as a child care center under Minnesota Rules, chapter 9503; or
484.1	(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	10.16	(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
484.3	(ii) arranges for off-site child care during hours of treatment activity at a facility that is licensed under chapter 245A as:	10.18	(ii) arranges for off-site child care during hours of treatment activity at a facility that is licensed under chapter 245A as:
484.5	(A) a child care center under Minnesota Rules, chapter 9503; or	10.20	(A) a child care center under Minnesota Rules, chapter 9503; or
484.6	(B) a family child care home under Minnesota Rules, chapter 9502~~;~~	10.21	(B) a family child care home under Minnesota Rules, chapter 9502;
484.7	(2) culturally specific or culturally responsive programs as defined in section 254B.01, subdivision 4a~~;~~; or	10.22	(2) culturally specific programs as defined in section 254B.01, subdivision 4a, or programs or subprograms serving special populations, if the program or subprogram meets the following requirements:
484.9	(3) disability responsive programs as defined in section 254B.01, subdivision 4b.		

484.10 ~~programs or subprograms serving special populations, if the program or subprogram~~
484.11 ~~meets the following requirements:~~

484.12 ~~(i) is designed to address the unique needs of individuals who share a common language,~~
484.13 ~~racial, ethnic, or social background;~~

484.14 ~~(ii) is governed with significant input from individuals of that specific background; and~~

484.15 ~~(iii) employs individuals to provide individual or group therapy, at least 50 percent of~~
484.16 ~~whom are of that specific background, except when the common social background of the~~
484.17 ~~individuals served is a traumatic brain injury or cognitive disability and the program employs~~
484.18 ~~treatment staff who have the necessary professional training, as approved by the~~
484.19 ~~commissioner, to serve clients with the specific disabilities that the program is designed to~~
484.20 ~~serve;~~

484.21 ~~(3) programs that offer medical services delivered by appropriately credentialed health~~
484.22 ~~care staff in an amount equal to two hours per client per week if the medical needs of the~~
484.23 ~~client and the nature and provision of any medical services provided are documented in the~~
484.24 ~~client file; and~~

484.25 ~~(4) programs that offer services to individuals with co-occurring mental health and~~
484.26 ~~chemical dependency problems if:~~

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

484.28 ~~(ii) 25 percent of the counseling staff are licensed mental health professionals, as defined~~
484.29 ~~in section 245.462, subdivision 18, clauses (1) to (6), or are students or licensing candidates~~
484.30 ~~under the supervision of a licensed alcohol and drug counselor supervisor and licensed~~
484.31 ~~mental health professional, except that no more than 50 percent of the mental health staff~~
485.1 ~~may be students or licensing candidates with time documented to be directly related to~~
485.2 ~~provisions of co-occurring services;~~

485.3 ~~(iii) clients scoring positive on a standardized mental health screen receive a mental~~
485.4 ~~health diagnostic assessment within ten days of admission;~~

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

485.8 ~~(v) family education is offered that addresses mental health and substance abuse disorders~~
485.9 ~~and the interaction between the two; and~~

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

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

10.25 (i) is designed to address the unique needs of individuals who share a common language,
10.26 racial, ethnic, or social background;

10.27 (ii) is governed with significant input from individuals of that specific background; and

10.28 (iii) employs individuals to provide individual or group therapy, at least 50 percent of
10.29 whom are of that specific background, except when the common social background of the
10.30 individuals served is a traumatic brain injury or cognitive disability and the program employs
10.31 treatment staff who have the necessary professional training, as approved by the
11.1 commissioner, to serve clients with the specific disabilities that the program is designed to
11.2 serve;

11.3 (3) programs that offer medical services delivered by appropriately credentialed health
11.4 care staff in an amount equal to two hours per client per week if the medical needs of the
11.5 client and the nature and provision of any medical services provided are documented in the
11.6 client file; and

11.7 (4) programs that offer services to individuals with co-occurring mental health and
11.8 chemical dependency problems if:

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

11.10 (ii) 25 percent of the counseling staff are licensed mental health professionals, as defined
11.11 in section 245.462, subdivision 18, clauses (1) to (6), or are students or licensing candidates
11.12 under the supervision of a licensed alcohol and drug counselor supervisor and licensed
11.13 mental health professional, except that no more than 50 percent of the mental health staff
11.14 may be students or licensing candidates with time documented to be directly related to
11.15 provisions of co-occurring services;

11.16 (iii) clients scoring positive on a standardized mental health screen receive a mental
11.17 health diagnostic assessment within ten days of admission;

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

11.21 (v) family education is offered that addresses mental health and substance abuse disorders
11.22 and the interaction between the two; and

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

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

485.15 child care services. Programs that provide child care according to paragraph (c), clause (1),
485.16 must be deemed in compliance with the licensing requirements in section 245G.19.

485.17 ~~(e) Adolescent residential programs that meet the requirements of Minnesota Rules,~~
485.18 ~~parts 2960.0430 to 2960.0490 and 2960.0580 to 2960.0690, are exempt from the requirements~~
485.19 ~~in paragraph (c), clause (4), items (i) to (iv).~~

485.20 ~~(f)~~ (e) Subject to federal approval, ~~chemical dependency~~ substance use disorder services
485.21 that are otherwise covered as direct face-to-face services may be provided via two-way
485.22 interactive video according to section 256B.0625, subdivision 3b. ~~The use of two-way~~
485.23 ~~interactive video must be medically appropriate to the condition and needs of the person~~
485.24 ~~being served. Reimbursement shall be at the same rates and under the same conditions that~~
485.25 ~~would otherwise apply to direct face-to-face services. The interactive video equipment and~~
485.26 ~~connection must comply with Medicare standards in effect at the time the service is provided.~~

485.27 ~~(g)~~ (f) For the purpose of reimbursement under this section, substance use disorder
485.28 treatment services provided in a group setting without a group participant maximum or
485.29 maximum client to staff ratio under chapter 245G shall not exceed a client to staff ratio of
485.30 48 to one. At least one of the attending staff must meet the qualifications as established
485.31 under this chapter for the type of treatment service provided. A recovery peer may not be
485.32 included as part of the staff ratio.

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

486.4 **EFFECTIVE DATE.** This section is effective January 1, 2022, or upon federal approval,
486.5 whichever is later, except paragraph (e) is effective July 1, 2021.

486.6 Sec. 15. Minnesota Statutes 2020, section 254B.12, is amended by adding a subdivision
486.7 to read:

486.8 Subd. 4. **Culturally specific or culturally responsive program and disability**
486.9 **responsive program provider rate increase.** For the chemical dependency services listed
486.10 in section 254B.05, subdivision 5, provided by programs that meet the requirements of
486.11 section 254B.05, subdivision 5, paragraph (c), clauses (1), (2), and (3), on or after January
486.12 1, 2022, payment rates shall increase by five percent over the rates in effect on January 1,
486.13 2021. The commissioner shall increase prepaid medical assistance capitation rates as
486.14 appropriate to reflect this increase.

486.15 **EFFECTIVE DATE.** This section is effective January 1, 2022, or upon federal approval,
486.16 whichever is later.

486.17 Sec. 16. **[254B.151] SUBSTANCE USE DISORDER COMMUNITY OF PRACTICE.**

486.18 Subdivision 1. **Establishment; purpose.** The commissioner of human services, in
486.19 consultation with substance use disorder subject matter experts, shall establish a substance

11.28 child care services. Programs that provide child care according to paragraph (c), clause (1),
11.29 must be deemed in compliance with the licensing requirements in section 245G.19.

11.30 (e) Adolescent residential programs that meet the requirements of Minnesota Rules,
11.31 parts 2960.0430 to 2960.0490 and 2960.0580 to 2960.0690, are exempt from the requirements
11.32 in paragraph (c), clause (4), items (i) to (iv).

12.1 (f) Subject to federal approval, chemical dependency services that are otherwise covered
12.2 as direct face-to-face services may be provided via two-way interactive video. The use of
12.3 two-way interactive video must be medically appropriate to the condition and needs of the
12.4 person being served. Reimbursement shall be at the same rates and under the same conditions
12.5 that would otherwise apply to direct face-to-face services. The interactive video equipment
12.6 and connection must comply with Medicare standards in effect at the time the service is
12.7 provided.

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

12.14 **EFFECTIVE DATE.** This section is effective January 1, 2022, or upon federal approval,
12.15 whichever is later. The commissioner of human services shall notify the revisor of statutes
12.16 when federal approval is obtained or denied.

486.20 use disorder community of practice. The purposes of the community of practice are to
486.21 improve treatment outcomes for individuals with substance use disorders and reduce
486.22 disparities by using evidence-based and best practices through peer-to-peer and
486.23 person-to-provider sharing.

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

486.26 (1) researchers or members of the academic community who are substance use disorder
486.27 subject matter experts, who do not have financial relationships with treatment providers;

486.28 (2) substance use disorder treatment providers;

486.29 (3) representatives from recovery community organizations;

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

486.31 (5) a representative from the Department of Health;

487.1 (6) a representative from the Department of Corrections;

487.2 (7) representatives from county social services agencies;

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

487.4 (9) representatives from managed care organizations.

487.5 (b) The community of practice must include individuals who have used substance use
487.6 disorder treatment services and must highlight the voices and experiences of individuals
487.7 who are Black, indigenous, people of color, and people from other communities that are
487.8 disproportionately impacted by substance use disorders.

487.9 (c) The community of practice must meet regularly and must hold its first meeting before
487.10 January 1, 2022.

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

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

487.14 (1) identify gaps in substance use disorder treatment services;

487.15 (2) enhance collective knowledge of issues related to substance use disorder;

487.16 (3) understand evidence-based practices, best practices, and promising approaches to
487.17 address substance use disorder;

487.18 (4) use knowledge gathered through the community of practice to develop strategic plans
487.19 to improve outcomes for individuals who participate in substance use disorder treatment
487.20 and related services in Minnesota;

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

487.23 (6) develop capacity for community advocacy.

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

403.9 Sec. 6. **[254B.17] SCHOOL-LINKED SUBSTANCE ABUSE GRANTS.**

403.10 Subdivision 1. **Establishment.** The commissioner of human services shall establish a
403.11 school-linked substance abuse grant program to provide early identification of and
403.12 intervention for secondary school students with substance use disorder needs, and to build
403.13 the capacity of secondary schools to support students with substance use disorder needs in
403.14 the classroom.

403.15 Subd. 2. **Eligible applicant.** (a) An eligible applicant for a school-linked substance
403.16 abuse grant is an entity or individual that is:

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

403.19 (2) an alcohol and drug counselor licensed under chapter 148F and in compliance with
403.20 section 245G.11, subdivision 5.

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

403.23 (1) identifying and diagnosing substance use disorders of students;

403.24 (2) delivering substance use disorder treatment and services to students and their families,
403.25 including via telemedicine;

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

403.28 (4) providing transportation for students receiving school-linked substance use disorder
403.29 treatment services when school is not in session;

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

404.4 (6) purchasing equipment, connection charges, on-site coordination, setup fees, and site
404.5 fees in order to deliver school-linked substance use disorder treatment services via
404.6 telemedicine.

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

404.11 (c) Prior to issuing a request for proposals for grants under this section, the commissioner
404.12 shall award grants to eligible applicants that are currently providing substance use disorder
404.13 treatment services in secondary schools or that are currently providing school-linked mental
404.14 health services but have the demonstrated capacity to provide allowable substance use
404.15 disorder treatment services in secondary schools.

404.16 Subd. 4. **Data collection and outcome measurement.** Grantees shall provide data to
404.17 the commissioner for the purpose of evaluating the effectiveness of the school-linked
404.18 substance use disorder treatment grant program.

488.1 Sec. 17. Minnesota Statutes 2020, section 256.042, subdivision 2, is amended to read:

488.2 Subd. 2. **Membership.** (a) The council shall consist of the following ~~19~~ 28 voting
488.3 members, appointed by the commissioner of human services except as otherwise specified,
488.4 and three nonvoting members:

488.5 (1) two members of the house of representatives, appointed in the following sequence:
488.6 the first from the majority party appointed by the speaker of the house and the second from
488.7 the minority party appointed by the minority leader. Of these two members, one member
488.8 must represent a district outside of the seven-county metropolitan area, and one member
488.9 must represent a district that includes the seven-county metropolitan area. The appointment
488.10 by the minority leader must ensure that this requirement for geographic diversity in
488.11 appointments is met;

488.12 (2) two members of the senate, appointed in the following sequence: the first from the
488.13 majority party appointed by the senate majority leader and the second from the minority
488.14 party appointed by the senate minority leader. Of these two members, one member must
488.15 represent a district outside of the seven-county metropolitan area and one member must
488.16 represent a district that includes the seven-county metropolitan area. The appointment by
488.17 the minority leader must ensure that this requirement for geographic diversity in appointments
488.18 is met;

488.19 (3) one member appointed by the Board of Pharmacy;

488.20 (4) one member who is a physician appointed by the Minnesota Medical Association;

488.21 (5) one member representing opioid treatment programs, sober living programs, or
488.22 substance use disorder programs licensed under chapter 245G;

488.23 (6) one member appointed by the Minnesota Society of Addiction Medicine who is an
488.24 addiction psychiatrist;

488.25 (7) one member representing professionals providing alternative pain management
488.26 therapies, including, but not limited to, acupuncture, chiropractic, or massage therapy;

488.27 (8) one member representing nonprofit organizations conducting initiatives to address
488.28 the opioid epidemic, with the commissioner's initial appointment being a member
488.29 representing the Steve Rummler Hope Network, and subsequent appointments representing
488.30 this or other organizations;

488.31 (9) one member appointed by the Minnesota Ambulance Association who is serving
488.32 with an ambulance service as an emergency medical technician, advanced emergency
488.33 medical technician, or paramedic;

489.1 (10) one member representing the Minnesota courts who is a judge or law enforcement
489.2 officer;

489.3 (11) one public member who is a Minnesota resident and who is in opioid addiction
489.4 recovery;

489.5 (12) ~~two~~ 11 members representing Indian tribes, one representing ~~the Ojibwe tribes and~~
489.6 ~~one representing the Dakota tribes~~ each of Minnesota's tribal nations;

489.7 (13) one public member who is a Minnesota resident and who is suffering from chronic
489.8 pain, intractable pain, or a rare disease or condition;

489.9 (14) one mental health advocate representing persons with mental illness;

489.10 (15) one member appointed by the Minnesota Hospital Association;

489.11 (16) one member representing a local health department; and

489.12 (17) the commissioners of human services, health, and corrections, or their designees,
489.13 who shall be ex officio nonvoting members of the council.

489.14 (b) The commissioner of human services shall coordinate the commissioner's
489.15 appointments to provide geographic, racial, and gender diversity, and shall ensure that at
489.16 least one-half of council members appointed by the commissioner reside outside of the
489.17 seven-county metropolitan area. Of the members appointed by the commissioner, to the
489.18 extent practicable, at least one member must represent a community of color
489.19 disproportionately affected by the opioid epidemic.

489.20 (c) The council is governed by section 15.059, except that members of the council shall
489.21 serve three-year terms and shall receive no compensation other than reimbursement for
489.22 expenses. Notwithstanding section 15.059, subdivision 6, the council shall not expire.

489.23 (d) The chair shall convene the council at least quarterly, and may convene other meetings
489.24 as necessary. The chair shall convene meetings at different locations in the state to provide

489.25 geographic access, and shall ensure that at least one-half of the meetings are held at locations
489.26 outside of the seven-county metropolitan area.

489.27 (e) The commissioner of human services shall provide staff and administrative services
489.28 for the advisory council.

489.29 (f) The council is subject to chapter 13D.

490.1 Sec. 18. Minnesota Statutes 2020, section 256.042, subdivision 4, is amended to read:

490.2 Subd. 4. **Grants.** (a) The commissioner of human services shall submit a report of the
490.3 grants proposed by the advisory council to be awarded for the upcoming ~~fiscal~~ calendar
490.4 year to the chairs and ranking minority members of the legislative committees with
490.5 jurisdiction over health and human services policy and finance, by ~~March~~ December 1 of
490.6 each year, beginning March 1, 2020.

490.7 (b) The commissioner of human services shall award grants from the opiate epidemic
490.8 response fund under section 256.043. The grants shall be awarded to proposals selected by
490.9 the advisory council that address the priorities in subdivision 1, paragraph (a), clauses (1)
490.10 to (4), unless otherwise appropriated by the legislature. No more than ~~three~~ ten percent of
490.11 the grant amount may be used by a grantee for administration.

490.12 Sec. 19. Minnesota Statutes 2020, section 256.043, subdivision 3, is amended to read:

490.13 Subd. 3. **Appropriations from fund.** (a) After the appropriations in Laws 2019, chapter
490.14 63, article 3, section 1, paragraphs (e), (f), (g), and (h) are made, $249,000 is appropriated
490.15 to the commissioner of human services for the provision of administrative services to the
490.16 Opiate Epidemic Response Advisory Council and for the administration of the grants awarded
490.17 under paragraph (e).

490.18 (b) $126,000 is appropriated to the Board of Pharmacy for the collection of the registration
490.19 fees under section 151.066.

490.20 (c) $672,000 is appropriated to the commissioner of public safety for the Bureau of
490.21 Criminal Apprehension. Of this amount, $384,000 is for drug scientists and lab supplies
490.22 and $288,000 is for special agent positions focused on drug interdiction and drug trafficking.

490.23 (d) After the appropriations in paragraphs (a) to (c) are made, 50 percent of the remaining
490.24 amount is appropriated to the commissioner of human services for distribution to county
490.25 social service and tribal social service agencies to provide child protection services to
490.26 children and families who are affected by addiction. The commissioner shall distribute this
490.27 money proportionally to counties and tribal social service agencies based on out-of-home

13.21 Sec. 10. Minnesota Statutes 2020, section 256.042, subdivision 4, is amended to read:

13.22 Subd. 4. **Grants.** (a) The commissioner of human services shall submit a report ~~of the~~
13.23 ~~grants proposed by the advisory council to be awarded for the upcoming fiscal year~~ to the
13.24 chairs and ranking minority members of the legislative committees with jurisdiction over
13.25 health and human services policy and finance, by March 1 of each year, beginning March
13.26 1, 2020, describing the priorities and specific activities the advisory council intends to
13.27 address for the upcoming fiscal year based on the projected funds available for grant
13.28 distribution.

13.29 (b) ~~The commissioner of human services shall award grants from the opiate epidemic~~
13.30 ~~response fund under section 256.043.~~ The grants shall be awarded to proposals selected by
13.31 the advisory council that address the priorities in subdivision 1, paragraph (a), clauses (1)
13.32 to (4), unless otherwise appropriated by the legislature. The advisory council shall determine
13.33 grant awards and funding amounts based on the funds appropriated to the commissioner
14.1 under section 256.043, subdivision 3, paragraph (e). The commissioner shall award the
14.2 grants from the opiate epidemic response fund and administer the grants in compliance with
14.3 section 16B.97. No more than three percent of the grant amount may be used by a grantee
14.4 for administration.

142.11 Sec. 12. Minnesota Statutes 2020, section 256.043, subdivision 3, is amended to read:

142.12 Subd. 3. **Appropriations from fund.** (a) After the appropriations in Laws 2019, chapter
142.13 63, article 3, section 1, paragraphs (e)~~,~~ and (f), ~~(g), and (h)~~ are made, $249,000 is appropriated
142.14 to the commissioner of human services for the provision of administrative services to the
142.15 Opiate Epidemic Response Advisory Council and for the administration of the grants awarded
142.16 under paragraph (e).

142.17 (b) $126,000 is appropriated to the Board of Pharmacy for the collection of the registration
142.18 fees under section 151.066.

142.19 (c) $672,000 is appropriated to the commissioner of public safety for the Bureau of
142.20 Criminal Apprehension. Of this amount, $384,000 is for drug scientists and lab supplies
142.21 and $288,000 is for special agent positions focused on drug interdiction and drug trafficking.

142.22 (d) After the appropriations in paragraphs (a) to (c) are made, 50 percent of the remaining
142.23 amount is appropriated to the commissioner of human services for distribution to county
142.24 social service and tribal social service agencies to provide child protection services to
142.25 children and families who are affected by addiction. The commissioner shall distribute this
142.26 money proportionally to counties and tribal social service agencies based on out-of-home

490.28 placement episodes where parental drug abuse is the primary reason for the out-of-home
490.29 placement using data from the previous calendar year. County and tribal social service
490.30 agencies receiving funds from the opiate epidemic response fund must annually report to
490.31 the commissioner on how the funds were used to provide child protection services, including
490.32 measurable outcomes, as determined by the commissioner. County social service agencies
490.33 and tribal social service agencies must not use funds received under this paragraph to supplant
491.1 current state or local funding received for child protection services for children and families
491.2 who are affected by addiction.

491.3 (e) After making the appropriations in paragraphs (a) to (d), the remaining amount in
491.4 the fund is appropriated to the commissioner to award grants as specified by the Opiate
491.5 Epidemic Response Advisory Council in accordance with section 256.042, unless otherwise
491.6 appropriated by the legislature.

491.7 (f) Beginning in fiscal year 2022 and each year thereafter, funds for county social service
491.8 and tribal social service agencies under paragraph (d) and grant funds specified by the Opiate
491.9 Epidemic Response Advisory Council under paragraph (e) shall be distributed on a calendar
491.10 year basis.

491.11 Sec. 20. Minnesota Statutes 2020, section 256B.0624, subdivision 7, is amended to read:

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

491.15 (1) a crisis stabilization treatment plan must be developed which meets the criteria in
491.16 subdivision 11;

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

491.18 (3) services must be delivered according to the treatment plan and include face-to-face
491.19 contact with the recipient by qualified staff for further assessment, help with referrals,
491.20 updating of the crisis stabilization treatment plan, supportive counseling, skills training,
491.21 and collaboration with other service providers in the community.

491.22 (b) If crisis stabilization services are provided in a supervised, licensed residential setting,
491.23 the recipient must be contacted face-to-face daily by a qualified mental health practitioner
491.24 or mental health professional. The program must have 24-hour-a-day residential staffing
491.25 which may include staff who do not meet the qualifications in subdivision 8. The residential
491.26 staff must have 24-hour-a-day immediate direct or telephone access to a qualified mental
491.27 health professional or practitioner.

491.28 (c) If crisis stabilization services are provided in a supervised, licensed residential setting
491.29 that serves no more than four adult residents, and one or more individuals are present at the

142.27 placement episodes where parental drug abuse is the primary reason for the out-of-home
142.28 placement using data from the previous calendar year. County and tribal social service
142.29 agencies receiving funds from the opiate epidemic response fund must annually report to
142.30 the commissioner on how the funds were used to provide child protection services, including
142.31 measurable outcomes, as determined by the commissioner. County social service agencies
142.32 and tribal social service agencies must not use funds received under this paragraph to supplant
143.1 current state or local funding received for child protection services for children and families
143.2 who are affected by addiction.

143.3 (e) After making the appropriations in paragraphs (a) to (d), the remaining amount in
143.4 the fund is appropriated to the commissioner to award grants as specified by the Opiate
143.5 Epidemic Response Advisory Council in accordance with section 256.042, unless otherwise
143.6 appropriated by the legislature.

143.7 **EFFECTIVE DATE.** This section is effective July 1, 2024.

404.19 Sec. 7. Minnesota Statutes 2020, section 256B.0624, subdivision 7, is amended to read:

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

404.23 (1) a crisis stabilization treatment plan must be developed which meets the criteria in
404.24 subdivision 11;

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

404.26 (3) services must be delivered according to the treatment plan and include face-to-face
404.27 contact with the recipient by qualified staff for further assessment, help with referrals,
404.28 updating of the crisis stabilization treatment plan, supportive counseling, skills training,
404.29 and collaboration with other service providers in the community.

404.30 (b) If crisis stabilization services are provided in a supervised, licensed residential setting,
404.31 the recipient must be contacted face-to-face daily by a qualified mental health practitioner
404.32 or mental health professional. The program must have 24-hour-a-day residential staffing
405.1 which may include staff who do not meet the qualifications in subdivision 8. The residential
405.2 staff must have 24-hour-a-day immediate direct or telephone access to a qualified mental
405.3 health professional or practitioner.

405.4 (c) If crisis stabilization services are provided in a supervised, licensed residential setting
405.5 that serves no more than four adult residents, and one or more individuals are present at the

491.30 setting to receive residential crisis stabilization services, the residential staff must include,
491.31 for at least eight hours per day, at least one individual who meets the qualifications in
491.32 subdivision 8, paragraph (a), clause (1) or (2). The commissioner shall establish a statewide
491.33 per diem rate for crisis stabilization services provided under this paragraph to medical
492.1 assistance enrollees. The rate for a provider shall not exceed the rate charged by that provider
492.2 for the same service to other payers. Payment shall not be made to more than one entity for
492.3 each individual for services provided under this paragraph on a given day. The commissioner
492.4 shall set rates prospectively for the annual rate period. The commissioner shall require
492.5 providers to submit annual cost reports on a uniform cost reporting form and shall use
492.6 submitted cost reports to inform the rate-setting process. The commissioner shall recalculate
492.7 the statewide per diem every year.

492.8 (d) If crisis stabilization services are provided in a supervised, licensed residential setting
492.9 that serves more than four adult residents, and one or more are recipients of crisis stabilization
492.10 services, the residential staff must include, for 24 hours a day, at least one individual who
492.11 meets the qualifications in subdivision 8. During the first 48 hours that a recipient is in the
492.12 residential program, the residential program must have at least two staff working 24 hours
492.13 a day. Staffing levels may be adjusted thereafter according to the needs of the recipient as
492.14 specified in the crisis stabilization treatment plan.

492.15 **EFFECTIVE DATE.** This section is effective August 1, 2021, or upon federal approval,
492.16 whichever is later. The commissioner of human services shall notify the revisor of statutes
492.17 when federal approval is obtained.

492.18 Sec. 21. Minnesota Statutes 2020, section 256B.0625, subdivision 5m, is amended to read:

492.19 Subd. 5m. **Certified community behavioral health clinic services.** (a) Medical
492.20 assistance covers certified community behavioral health clinic (CCBHC) services that meet
492.21 the requirements of section 245.735, subdivision 3.

492.22 (b) The commissioner shall ~~establish standards and methodologies for a~~ reimburse
492.23 CCBHCs on a per-visit basis under the prospective payment system for medical assistance
492.24 payments ~~for services delivered by a CCBHC, in accordance with guidance issued by the~~
492.25 ~~Centers for Medicare and Medicaid Services~~ as described in paragraph (c). The commissioner
492.26 shall include a quality ~~bonus~~ incentive payment in the prospective payment system ~~based~~
492.27 ~~on federal criteria~~, as described in paragraph (e). There is no county share for medical
492.28 assistance services when reimbursed through the CCBHC prospective payment system.

492.29 (c) ~~Unless otherwise indicated in applicable federal requirements, the prospective payment~~
492.30 ~~system must continue to be based on the federal instructions issued for the federal section~~
492.31 ~~223 CCBHC demonstration, except:~~ The commissioner shall ensure that the prospective
492.32 payment system for CCBHC payments under medical assistance meets the following
492.33 requirements:

493.1 (1) the prospective payment rate shall be a provider-specific rate calculated for each
493.2 CCBHC, based on the daily cost of providing CCBHC services and the total annual allowable

405.6 setting to receive residential crisis stabilization services, the residential staff must include,
405.7 for at least eight hours per day, at least one individual who meets the qualifications in
405.8 subdivision 8, paragraph (a), clause (1) or (2). The commissioner shall establish a statewide
405.9 per diem rate for crisis stabilization services provided under this paragraph to medical
405.10 assistance enrollees. The rate for a provider shall not exceed the rate charged by that provider
405.11 for the same service to other payers. Payment shall not be made to more than one entity for
405.12 each individual for services provided under this paragraph on a given day. The commissioner
405.13 shall set rates prospectively for the annual rate period. The commissioner shall require
405.14 providers to submit annual cost reports on a uniform cost reporting form and shall use
405.15 submitted cost reports to inform the rate-setting process. The commissioner shall recalculate
405.16 the statewide per diem every year.

405.17 (d) If crisis stabilization services are provided in a supervised, licensed residential setting
405.18 that serves more than four adult residents, and one or more are recipients of crisis stabilization
405.19 services, the residential staff must include, for 24 hours a day, at least one individual who
405.20 meets the qualifications in subdivision 8. During the first 48 hours that a recipient is in the
405.21 residential program, the residential program must have at least two staff working 24 hours
405.22 a day. Staffing levels may be adjusted thereafter according to the needs of the recipient as
405.23 specified in the crisis stabilization treatment plan.

405.24 **EFFECTIVE DATE.** This section is effective August 1, 2021, or upon federal approval,
405.25 whichever is later. The commissioner of human services shall notify the revisor of statutes
405.26 when federal approval is obtained.

405.27 Sec. 8. Minnesota Statutes 2020, section 256B.0625, subdivision 5m, is amended to read:

405.28 Subd. 5m. **Certified community behavioral health clinic services.** (a) Medical
405.29 assistance covers certified community behavioral health clinic (CCBHC) services that meet
405.30 the requirements of section 245.735, subdivision 3.

405.31 (b) The commissioner shall ~~establish standards and methodologies for a~~ reimburse
405.32 CCBHCs on a per-visit basis under the prospective payment system for medical assistance
405.33 payments ~~for services delivered by a CCBHC, in accordance with guidance issued by the~~
405.34 ~~Centers for Medicare and Medicaid Services~~ as described in paragraph (c). The commissioner
406.1 shall include a quality ~~bonus~~ incentive payment in the prospective payment system ~~based~~
406.2 ~~on federal criteria~~as described in paragraph (e). There is no county share for medical
406.3 assistance services when reimbursed through the CCBHC prospective payment system.

406.4 (c) ~~Unless otherwise indicated in applicable federal requirements, the prospective payment~~
406.5 ~~system must continue to be based on the federal instructions issued for the federal section~~
406.6 ~~223 CCBHC demonstration, except:~~ The commissioner shall ensure that the prospective
406.7 payment system for CCBHC payments under medical assistance meets the following
406.8 requirements:

406.9 (1) the prospective payment rate shall be a provider-specific rate calculated for each
406.10 CCBHC, based on the daily cost of providing CCBHC services and the total annual allowable

493.3 costs for CCBHCs divided by the total annual number of CCBHC visits. For calculating
493.4 the payment rate, total annual visits include visits covered by medical assistance and visits
493.5 not covered by medical assistance. Allowable costs include but are not limited to the salaries
493.6 and benefits of medical assistance providers; the cost of CCBHC services provided under
493.7 section 245.735, subdivision 3, paragraph (a), clauses (6) and (7); and other costs such as
493.8 insurance or supplies needed to provide CCBHC services;

493.9 (2) payment shall be limited to one payment per day per medical assistance enrollee for
493.10 each CCBHC visit eligible for reimbursement. A CCBHC visit is eligible for reimbursement
493.11 if at least one of the CCBHC services listed under section 245.735, subdivision 3, paragraph
493.12 (a), clause (6), is furnished to a medical assistance enrollee by a health care practitioner or
493.13 licensed agency employed by or under contract with a CCBHC;

493.14 (3) new payment rates set by the commissioner for newly certified CCBHCs under
493.15 section 245.735, subdivision 3, shall be based on rates for established CCBHCs with a
493.16 similar scope of services. If no comparable CCBHC exists, the commissioner shall establish
493.17 a clinic-specific rate using audited historical cost report data adjusted for the estimated cost
493.18 of delivering CCBHC services, including the estimated cost of providing the full scope of
493.19 services and the projected change in visits resulting from the change in scope;

493.20 ~~(1)~~ (4) the commissioner shall rebase CCBHC rates ~~at least~~ once every three years and
493.21 12 months following an initial rate or a rate change due to a change in the scope of services,
493.22 whichever is earlier;

493.23 ~~(2)~~ (5) the commissioner shall provide for a 60-day appeals process after notice of the
493.24 results of the rebasing;

493.25 ~~(3) the prohibition against inclusion of new facilities in the demonstration does not apply~~
493.26 ~~after the demonstration ends;~~

493.27 ~~(4)~~ (6) the prospective payment rate under this section does not apply to services rendered
493.28 by CCBHCs to individuals who are dually eligible for Medicare and medical assistance
493.29 when Medicare is the primary payer for the service. An entity that receives a prospective
493.30 payment system rate that overlaps with the CCBHC rate is not eligible for the CCBHC rate;

493.31 ~~(5)~~ (7) payments for CCBHC services to individuals enrolled in managed care shall be
493.32 coordinated with the state's phase-out of CCBHC wrap payments. The commissioner shall
493.33 complete the phase-out of CCBHC wrap payments within 60 days of the implementation
493.34 of the prospective payment system in the Medicaid Management Information System
494.1 (MMIS), for CCBHCs reimbursed under this chapter, with a final settlement of payments
494.2 due made payable to CCBHCs no later than 18 months thereafter;

494.3 ~~(6) initial prospective payment rates for CCBHCs certified after July 1, 2019, shall be~~
494.4 ~~based on rates for comparable CCBHCs. If no comparable provider exists, the commissioner~~
494.5 ~~shall compute a CCBHC-specific rate based upon the CCBHC's audited costs adjusted for~~
494.6 ~~changes in the scope of services;~~

406.11 costs for CCBHCs divided by the total annual number of CCBHC visits. For calculating
406.12 the payment rate, total annual visits include visits covered by medical assistance and visits
406.13 not covered by medical assistance. Allowable costs include but are not limited to the salaries
406.14 and benefits of medical assistance providers; the cost of CCBHC services provided under
406.15 section 245.735, subdivision 3, paragraph (a), clauses (6) and (7); and other costs such as
406.16 insurance or supplies needed to provide CCBHC services;

406.17 (2) payment shall be limited to one payment per day per medical assistance enrollee for
406.18 each CCBHC visit eligible for reimbursement. A CCBHC visit is eligible for reimbursement
406.19 if at least one of the CCBHC services listed under section 245.735, subdivision 3, paragraph
406.20 (a), clause (6), is furnished to a medical assistance enrollee by a health care practitioner or
406.21 licensed agency employed by or under contract with a CCBHC;

406.22 (3) new payment rates set by the commissioner for newly certified CCBHCs under
406.23 section 245.735, subdivision 3, shall be based on rates for established CCBHCs with a
406.24 similar scope of services. If no comparable CCBHC exists, the commissioner shall establish
406.25 a clinic-specific rate using audited historical cost report data adjusted for the estimated cost
406.26 of delivering CCBHC services, including the estimated cost of providing the full scope of
406.27 services and the projected change in visits resulting from the change in scope;

406.28 ~~(1)~~ (4) the commissioner shall rebase CCBHC rates ~~at least~~ once every three years and
406.29 12 months following an initial rate or a rate change due to a change in the scope of services,
406.30 whichever is earlier;

406.31 ~~(2)~~ (5) the commissioner shall provide for a 60-day appeals process after notice of the
406.32 results of the rebasing;

406.33 ~~(3) the prohibition against inclusion of new facilities in the demonstration does not apply~~
406.34 ~~after the demonstration ends;~~

407.1 ~~(4)~~ (6) the prospective payment rate under this section does not apply to services rendered
407.2 by CCBHCs to individuals who are dually eligible for Medicare and medical assistance
407.3 when Medicare is the primary payer for the service. An entity that receives a prospective
407.4 payment system rate that overlaps with the CCBHC rate is not eligible for the CCBHC rate;

407.5 ~~(5)~~ (7) payments for CCBHC services to individuals enrolled in managed care shall be
407.6 coordinated with the state's phase-out of CCBHC wrap payments. The commissioner shall
407.7 complete the phase-out of CCBHC wrap payments within 60 days of the implementation
407.8 of the prospective payment system in the Medicaid Management Information System
407.9 (MMIS), for CCBHCs reimbursed under this chapter, with a final settlement of payments
407.10 due made payable to CCBHCs no later than 18 months thereafter;

407.11 ~~(6) initial prospective payment rates for CCBHCs certified after July 1, 2019, shall be~~
407.12 ~~based on rates for comparable CCBHCs. If no comparable provider exists, the commissioner~~
407.13 ~~shall compute a CCBHC-specific rate based upon the CCBHC's audited costs adjusted for~~
407.14 ~~changes in the scope of services;~~

~~(7)~~ (8) the prospective payment rate for each CCBHC shall be ~~adjusted annually~~ updated by trending each provider-specific rate by the Medicare Economic Index ~~as defined for the federal section 223 CCBHC demonstration~~ 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. 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.

~~(8) the commissioner shall seek federal approval for a CCBHC rate methodology that allows for rate modifications based on changes in scope for an individual CCBHC, including for changes to the type, intensity, or duration of services. Upon federal approval, a CCBHC may submit a change of scope request to the commissioner if the change in scope would result in a change of 2.5 percent or more in the prospective payment system rate currently received by the CCBHC. CCBHC change of scope requests must be according to a format and timeline to be determined by the commissioner in consultation with CCBHCs.~~

(d) Managed care plans and county-based purchasing plans shall reimburse CCBHC providers at the prospective payment 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 system described in paragraph (c);

~~(7)~~ (8) the prospective payment rate for each CCBHC shall be ~~adjusted annually~~ updated by trending each provider-specific rate by the Medicare Economic Index ~~as defined for the federal section 223 CCBHC demonstration~~ 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. 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.

~~(8) the commissioner shall seek federal approval for a CCBHC rate methodology that allows for rate modifications based on changes in scope for an individual CCBHC, including for changes to the type, intensity, or duration of services. Upon federal approval, a CCBHC may submit a change of scope request to the commissioner if the change in scope would result in a change of 2.5 percent or more in the prospective payment system rate currently received by the CCBHC. CCBHC change of scope requests must be according to a format and timeline to be determined by the commissioner in consultation with CCBHCs.~~

(d) Managed care plans and county-based purchasing plans shall reimburse CCBHC providers at the prospective payment 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 system described in paragraph (c);

495.11 (2) a CCBHC must be certified and enrolled as a CCBHC for the entire measurement
495.12 year to be eligible for incentive payments;

495.13 (3) each CCBHC shall receive written notice of the criteria that must be met in order to
495.14 receive quality incentive payments at least 90 days prior to the measurement year; and

495.15 (4) a CCBHC must provide the commissioner with data needed to determine incentive
495.16 payment eligibility within six months following the measurement year. The commissioner
495.17 shall notify CCBHC providers of their performance on the required measures and the
495.18 incentive payment amount within 12 months following the measurement year.

495.19 (f) All claims to managed care plans for CCBHC services as provided under this section
495.20 shall be submitted directly to, and paid by, the commissioner on the dates specified no later
495.21 than January 1 of the following calendar year, if:

495.22 (1) one or more managed care plans does not comply with the federal requirement for
495.23 payment of clean claims to CCBHCs, as defined in Code of Federal Regulations, title 42,
495.24 section 447.45(b), and the managed care plan does not resolve the payment issue within 30
495.25 days of noncompliance; and

495.26 (2) the total amount of clean claims not paid in accordance with federal requirements
495.27 by one or more managed care plans is 50 percent of, or greater than, the total CCBHC claims
495.28 eligible for payment by managed care plans.

495.29 If the conditions in this paragraph are met between January 1 and June 30 of a calendar
495.30 year, claims shall be submitted to and paid by the commissioner beginning on January 1 of
495.31 the following year. If the conditions in this paragraph are met between July 1 and December
495.32 31 of a calendar year, claims shall be submitted to and paid by the commissioner beginning
495.33 on July 1 of the following year.

496.1 Sec. 22. Minnesota Statutes 2020, section 256B.0625, subdivision 20, is amended to read:

496.2 Subd. 20. **Mental health case management.** (a) To the extent authorized by rule of the
496.3 state agency, medical assistance covers case management services to persons with serious
496.4 and persistent mental illness and children with severe emotional disturbance. Services
496.5 provided under this section must meet the relevant standards in sections 245.461 to 245.4887,
496.6 the Comprehensive Adult and Children's Mental Health Acts, Minnesota Rules, parts
496.7 9520.0900 to 9520.0926, and 9505.0322, excluding subpart 10.

496.8 (b) Entities meeting program standards set out in rules governing family community
496.9 support services as defined in section 245.4871, subdivision 17, are eligible for medical
496.10 assistance reimbursement for case management services for children with severe emotional
496.11 disturbance when these services meet the program standards in Minnesota Rules, parts
496.12 9520.0900 to 9520.0926 and 9505.0322, excluding subparts 6 and 10.

496.13 (c) Medical assistance and MinnesotaCare payment for mental health case management
496.14 shall be made on a monthly basis. In order to receive payment for an eligible child, the
496.15 provider must document at least a face-to-face contact with the child, the child's parents, or

408.20 (2) a CCBHC must be certified and enrolled as a CCBHC for the entire measurement
408.21 year to be eligible for incentive payments;

408.22 (3) each CCBHC shall receive written notice of the criteria that must be met in order to
408.23 receive quality incentive payments at least 90 days prior to the measurement year; and

408.24 (4) a CCBHC must provide the commissioner with data needed to determine incentive
408.25 payment eligibility within six months following the measurement year. The commissioner
408.26 shall notify CCBHC providers of their performance on the required measures and the
408.27 incentive payment amount within 12 months following the measurement year.

408.28 (f) All claims to managed care plans for CCBHC services as provided under this section
408.29 shall be submitted directly to, and paid by, the commissioner on the dates specified no later
408.30 than January 1 of the following calendar year, if:

408.31 (1) one or more managed care plans does not comply with the federal requirement for
408.32 payment of clean claims to CCBHCs, as defined in Code of Federal Regulations, title 42,
409.1 section 447.45(b), and the managed care plan does not resolve the payment issue within 30
409.2 days of noncompliance; and

409.3 (2) the total amount of clean claims not paid in accordance with federal requirements
409.4 by one or more managed care plans is 50 percent of, or greater than, the total CCBHC claims
409.5 eligible for payment by managed care plans.

409.6 If the conditions in this paragraph are met between January 1 and June 30 of a calendar
409.7 year, claims shall be submitted to and paid by the commissioner beginning on January 1 of
409.8 the following year. If the conditions in this paragraph are met between July 1 and December
409.9 31 of a calendar year, claims shall be submitted to and paid by the commissioner beginning
409.10 on July 1 of the following year.

496.16 the child's legal representative. To receive payment for an eligible adult, the provider must
496.17 document:

496.18 (1) at least a face-to-face contact with the adult or the adult's legal representative or a
496.19 contact by interactive video that meets the requirements of subdivision 20b; or

496.20 (2) at least a telephone contact with the adult or the adult's legal representative and
496.21 document a face-to-face contact or a contact by interactive video that meets the requirements
496.22 of subdivision 20b with the adult or the adult's legal representative within the preceding
496.23 two months.

496.24 (d) Payment for mental health case management provided by county or state staff shall
496.25 be based on the monthly rate methodology under section 256B.094, subdivision 6, paragraph
496.26 (b), with separate rates calculated for child welfare and mental health, and within mental
496.27 health, separate rates for children and adults.

496.28 (e) Payment for mental health case management provided by Indian health services or
496.29 by agencies operated by Indian tribes may be made according to this section or other relevant
496.30 federally approved rate setting methodology.

496.31 (f) Payment for mental health case management provided by vendors who contract with
496.32 a county ~~or Indian tribe shall be based on a monthly rate negotiated by the host county or~~
496.33 ~~tribe~~ must be calculated in accordance with section 256B.076, subdivision 2. Payment for
497.1 mental health case management provided by vendors who contract with a Tribe must be
497.2 based on a monthly rate negotiated by the Tribe. The ~~negotiated~~ rate must not exceed the
497.3 rate charged by the vendor for the same service to other payers. If the service is provided
497.4 by a team of contracted vendors, the ~~county or tribe may negotiate a team rate with a vendor~~
497.5 ~~who is a member of the team. The~~ team shall determine how to distribute the rate among
497.6 its members. No reimbursement received by contracted vendors shall be returned to the
497.7 county or tribe, except to reimburse the county or tribe for advance funding provided by
497.8 the county or tribe to the vendor.

497.9 (g) If the service is provided by a team which includes contracted vendors, tribal staff,
497.10 and county or state staff, the costs for county or state staff participation in the team shall be
497.11 included in the rate for county-provided services. In this case, the contracted vendor, the
497.12 tribal agency, and the county may each receive separate payment for services provided by
497.13 each entity in the same month. In order to prevent duplication of services, each entity must
497.14 document, in the recipient's file, the need for team case management and a description of
497.15 the roles of the team members.

497.16 (h) Notwithstanding section 256B.19, subdivision 1, the nonfederal share of costs for
497.17 mental health case management shall be provided by the recipient's county of responsibility,
497.18 as defined in sections 256G.01 to 256G.12, from sources other than federal funds or funds
497.19 used to match other federal funds. If the service is provided by a tribal agency, the nonfederal
497.20 share, if any, shall be provided by the recipient's tribe. When this service is paid by the state

497.21 without a federal share through fee-for-service, 50 percent of the cost shall be provided by
497.22 the recipient's county of responsibility.

497.23 (i) Notwithstanding any administrative rule to the contrary, prepaid medical assistance
497.24 and MinnesotaCare include mental health case management. When the service is provided
497.25 through prepaid capitation, the nonfederal share is paid by the state and the county pays no
497.26 share.

497.27 (j) The commissioner may suspend, reduce, or terminate the reimbursement to a provider
497.28 that does not meet the reporting or other requirements of this section. The county of
497.29 responsibility, as defined in sections 256G.01 to 256G.12, or, if applicable, the tribal agency,
497.30 is responsible for any federal disallowances. The county or tribe may share this responsibility
497.31 with its contracted vendors.

497.32 (k) The commissioner shall set aside a portion of the federal funds earned for county
497.33 expenditures under this section to repay the special revenue maximization account under
497.34 section 256.01, subdivision 2, paragraph (o). The repayment is limited to:

498.1 (1) the costs of developing and implementing this section; and

498.2 (2) programming the information systems.

498.3 (l) Payments to counties and tribal agencies for case management expenditures under
498.4 this section shall only be made from federal earnings from services provided under this
498.5 section. When this service is paid by the state without a federal share through fee-for-service,
498.6 50 percent of the cost shall be provided by the state. Payments to county-contracted vendors
498.7 shall include the federal earnings, the state share, and the county share.

498.8 (m) Case management services under this subdivision do not include therapy, treatment,
498.9 legal, or outreach services.

498.10 (n) If the recipient is a resident of a nursing facility, intermediate care facility, or hospital,
498.11 and the recipient's institutional care is paid by medical assistance, payment for case
498.12 management services under this subdivision is limited to the lesser of:

498.13 (1) the last 180 days of the recipient's residency in that facility and may not exceed more
498.14 than six months in a calendar year; or

498.15 (2) the limits and conditions which apply to federal Medicaid funding for this service.

498.16 (o) Payment for case management services under this subdivision shall not duplicate
498.17 payments made under other program authorities for the same purpose.

498.18 (p) If the recipient is receiving care in a hospital, nursing facility, or residential setting
498.19 licensed under chapter 245A or 245D that is staffed 24 hours a day, seven days a week,
498.20 mental health targeted case management services must actively support identification of
498.21 community alternatives for the recipient and discharge planning.

498.22 Sec. 23. Minnesota Statutes 2020, section 256B.0759, subdivision 2, is amended to read:

498.23 Subd. 2. **Provider participation.** (a) Outpatient substance use disorder treatment
498.24 providers may elect to participate in the demonstration project and meet the requirements
498.25 of subdivision 3. To participate, a provider must notify the commissioner of the provider's
498.26 intent to participate in a format required by the commissioner and enroll as a demonstration
498.27 project provider.

498.28 (b) A program licensed by the Department of Human Services as a residential treatment
498.29 program according to section 245G.21 and that receives payment under this chapter must
498.30 enroll as a demonstration project provider and meet the requirements of subdivision 3 by
498.31 January 1, 2022. The commissioner may grant an extension, for a period not to exceed six
498.32 months, to a program that is unable to meet the requirements of subdivision 3 due to
499.1 demonstrated extraordinary circumstances. A program seeking an extension must apply in
499.2 a format approved by the commissioner by November 1, 2021. A program that does not
499.3 meet the requirements under this paragraph by July 1, 2023, is ineligible for payment for
499.4 services provided under sections 254B.05 and 256B.0625.

499.5 (c) A program licensed by the Department of Human Services as a withdrawal
499.6 management program according to chapter 245F and that receives payment under this
499.7 chapter must enroll as a demonstration project provider and meet the requirements of
499.8 subdivision 3 by January 1, 2022. The commissioner may grant an extension, for a period
499.9 not to exceed six months, to a program that is unable to meet the requirements of subdivision
499.10 3 due to demonstrated extraordinary circumstances. A program seeking an extension must
499.11 apply in a format approved by the commissioner by November 1, 2021. A program that
499.12 does not meet the requirements under this paragraph by July 1, 2023, is ineligible for payment
499.13 for services provided under sections 254B.05 and 256B.0625.

499.14 (d) An out-of-state residential substance use disorder treatment program that receives
499.15 payment under this chapter must enroll as a demonstration project provider and meet the
499.16 requirements of subdivision 3 by January 1, 2022. The commissioner may grant an extension,
499.17 for a period not to exceed six months, to a program that is unable to meet the requirements
499.18 of subdivision 3 due to demonstrated extraordinary circumstances. A program seeking an
499.19 extension must apply in a format approved by the commissioner by November 1, 2021.
499.20 Programs that do not meet the requirements under this paragraph by July 1, 2023, are
499.21 ineligible for payment for services provided under sections 254B.05 and 256B.0625.

499.22 (e) Tribally licensed programs may elect to participate in the demonstration project and
499.23 meet the requirements of subdivision 3. The Department of Human Services must consult
499.24 with tribal nations to discuss participation in the substance use disorder demonstration
499.25 project.

499.26 (f) All rate enhancements for services rendered by demonstration project providers that
499.27 voluntarily enrolled before July 1, 2021, are applicable only to dates of service on or after
499.28 the effective date of the provider's enrollment in the demonstration project, except as
499.29 authorized under paragraph (g). The commissioner shall recoup any rate enhancements paid

409.11 Sec. 9. Minnesota Statutes 2020, section 256B.0759, subdivision 2, is amended to read:

409.12 Subd. 2. **Provider participation.** (a) Outpatient substance use disorder treatment
409.13 providers may elect to participate in the demonstration project and meet the requirements
409.14 of subdivision 3. To participate, a provider must notify the commissioner of the provider's
409.15 intent to participate in a format required by the commissioner and enroll as a demonstration
409.16 project provider.

409.17 (b) Programs licensed by the Department of Human Services as a residential treatment
409.18 program according to section 245G.21 that receive payment under this chapter must enroll
409.19 as demonstration project providers and meet the requirements of subdivision 3 by June 30,
409.20 2025. Programs that do not meet the requirements of this paragraph are ineligible for payment
409.21 for services provided under section 256B.0625.

409.22 (c) Programs licensed by the Department of Human Services as a withdrawal management
409.23 program according to chapter 245F that receive payment under this chapter must enroll as
409.24 demonstration project providers and meet the requirements of subdivision 3 by June 30,
409.25 2025. Programs that do not meet the requirements of this paragraph are ineligible for payment
409.26 for services provided under section 256B.0625.

409.27 (d) Out-of-state residential substance use disorder treatment programs that receive
409.28 payment under this chapter must enroll as demonstration project providers and meet the
409.29 requirements of subdivision 3 by June 30, 2025. Programs that do not meet the requirements
409.30 of this paragraph are ineligible for payment for services provided under section 256B.0625.

409.31 (e) Tribally licensed programs may elect to participate in the demonstration project and
409.32 meet the requirements of subdivision 3. The Department of Human Services must consult
410.1 with Tribal nations to discuss participation in the substance use disorder demonstration
410.2 project.

410.3 (f) All rate enhancements for services rendered by voluntarily enrolled demonstration
410.4 providers enrolled before July 1, 2021, are applicable only to dates of service on or after
410.5 the effective date of the provider's enrollment in the demonstration project, except as
410.6 authorized under paragraph (g). The commissioner shall recoup any rate enhancements paid

499.30 under paragraph (g) to a provider that does not meet the requirements of subdivision 3 by
499.31 July 1, 2021.

499.32 (g) The commissioner may allow providers enrolled in the demonstration project before
499.33 July 1, 2021, to receive applicable rate enhancements authorized under subdivision 4 for
500.1 services provided to fee-for-service enrollees on dates of service no earlier than July 22,
500.2 2020, and to managed care enrollees on dates of service no earlier than January 1, 2021, if:

500.3 (1) the provider attests that during the time period for which it is seeking the rate
500.4 enhancement, it was taking meaningful steps and had a reasonable plan approved by the
500.5 commissioner to meet the demonstration project requirements in subdivision 3;

500.6 (2) the provider submits the attestation and evidence of meeting the requirements of
500.7 subdivision 3, including all information requested by the commissioner, in a format specified
500.8 by the commissioner; and

500.9 (3) the commissioner received the provider's application for enrollment on or before
500.10 June 1, 2021.

500.11 **EFFECTIVE DATE.** This section is effective July 1, 2021, or upon federal approval,
500.12 whichever is later, except paragraphs (f) and (g) are effective the day following final
500.13 enactment.

500.14 Sec. 24. Minnesota Statutes 2020, section 256B.0759, subdivision 4, is amended to read:

500.15 Subd. 4. **Provider payment rates.** (a) Payment rates for participating providers must
500.16 be increased for services provided to medical assistance enrollees. To receive a rate increase,
500.17 participating providers must meet demonstration project requirements, provider standards
500.18 under subdivision 3, and provide evidence of formal referral arrangements with providers
500.19 delivering step-up or step-down levels of care.

500.20 (b) The commissioner may temporarily suspend payments to the provider according to
500.21 section 256B.04, subdivision 21, paragraph (d), if the requirements in paragraph (a) are not
500.22 met. Payments withheld from the provider must be made once the commissioner determines
500.23 that the requirements in paragraph (a) are met.

500.24 ~~(b)~~ (c) For substance use disorder services under section 254B.05, subdivision 5,
500.25 paragraph (b), clause (8), provided on or after July 1, 2020, payment rates must be increased
500.26 by ~~15~~ 30 percent over the rates in effect on December 31, 2019.

410.7 under paragraph (g) to a provider that does not meet the requirements of subdivision 3 by
410.8 July 1, 2021.

410.9 (g) The commissioner may allow providers enrolled before July 1, 2021, to receive any
410.10 applicable rate enhancements authorized under subdivision 4 for services provided on dates
410.11 of service no earlier than July 22, 2020, for fee-for-service enrollees and no earlier than
410.12 January 1, 2021, to managed care enrollees if the provider meets all of the following
410.13 requirements:

410.14 (1) the provider attests that during the time period for which the provider is seeking the
410.15 rate enhancement, the provider took meaningful steps and had a reasonable plan approved
410.16 by the commissioner to meet the demonstration project requirements in subdivision 3;

410.17 (2) the provider submits attestation and evidence, including all information requested
410.18 by the commissioner, of meeting the requirements of subdivision 3 to the commissioner in
410.19 a format required by the commissioner; and

410.20 (3) the commissioner received the provider's application for enrollment on or before
410.21 June 1, 2021.

410.22 **EFFECTIVE DATE.** This section is effective July 1, 2021, or upon federal approval,
410.23 whichever is later, except paragraphs (f) and (g) are effective the day following final
410.24 enactment. The commissioner shall notify the revisor of statutes when federal approval is
410.25 obtained.

410.26 Sec. 10. Minnesota Statutes 2020, section 256B.0759, subdivision 4, is amended to read:

410.27 Subd. 4. **Provider payment rates.** (a) Payment rates for participating providers must
410.28 be increased for services provided to medical assistance enrollees. To receive a rate increase,
410.29 participating providers must meet demonstration project requirements and provide evidence
410.30 of formal referral arrangements with providers delivering step-up or step-down levels of
410.31 care. Providers that have enrolled in the demonstration project but have not met the provider
410.32 standards under subdivision 3 as of July 1, 2022, are not eligible for a rate increase in this
410.33 subdivision until the date that the provider meets the provider standards in subdivision 3.
411.1 Services provided from July 1, 2022, to the date that the provider meets the provider standards
411.2 under subdivision 3 shall be reimbursed at rates according to section 254B.05, subdivision
411.3 5, paragraph (b).

411.4 (b) The commissioner may temporarily suspend payments to the provider according to
411.5 section 256B.04, subdivision 21, paragraph (d), if the provider does not meet the requirements
411.6 in paragraph (a). Payments withheld from the provider must be made once the commissioner
411.7 determines that the requirements in paragraph (a) are met.

411.8 ~~(b)~~ (c) For substance use disorder services under section 254B.05, subdivision 5,
411.9 paragraph (b), clause (8), provided on or after July 1, 2020, payment rates must be increased
411.10 by ~~15~~ 35 percent over the rates in effect on December 31, 2019.

500.27 ~~(c)~~ (d) For substance use disorder services under section 254B.05, subdivision 5,
500.28 paragraph (b), clauses (1), (6), and (7), and adolescent treatment programs that are licensed
500.29 as outpatient treatment programs according to sections 245G.01 to 245G.18, provided on
500.30 or after January 1, 2021, payment rates must be increased by ~~ten~~ 25 percent over the rates
500.31 in effect on December 31, 2020.

501.1 ~~(d)~~ (e) Effective January 1, 2021, and contingent on annual federal approval, managed
501.2 care plans and county-based purchasing plans must reimburse providers of the substance
501.3 use disorder services meeting the criteria described in paragraph (a) who are employed by
501.4 or under contract with the plan an amount that is at least equal to the fee-for-service base
501.5 rate payment for the substance use disorder services described in paragraphs ~~(b)~~ (c) and ~~(c)~~
501.6 (d). The commissioner must monitor the effect of this requirement on the rate of access to
501.7 substance use disorder services and residential substance use disorder rates. Capitation rates
501.8 paid to managed care organizations and county-based purchasing plans must reflect the
501.9 impact of this requirement. This paragraph expires if federal approval is not received at any
501.10 time as required under this paragraph.

501.11 ~~(e)~~ (f) Effective July 1, 2021, contracts between managed care plans and county-based
501.12 purchasing plans and providers to whom paragraph ~~(d)~~ (e) applies must allow recovery of
501.13 payments from those providers if, for any contract year, federal approval for the provisions
501.14 of paragraph ~~(d)~~ (e) is not received, and capitation rates are adjusted as a result. Payment
501.15 recoveries must not exceed the amount equal to any decrease in rates that results from this
501.16 provision.

501.17 **EFFECTIVE DATE.** This section is effective July 1, 2021, except the amendments to
501.18 the payment rate percentage increases in paragraphs (c) and (d) are effective January 1,
501.19 2022.

501.20 Sec. 25. Minnesota Statutes 2020, section 256B.0759, is amended by adding a subdivision
501.21 to read:

501.22 Subd. 6. **Data and outcome measures; public posting.** Beginning July 1, 2021, and at
501.23 least annually thereafter, all data and outcome measures from the previous year of the
501.24 demonstration project shall be posted publicly on the Department of Human Services website
501.25 in an accessible and user-friendly format.

501.26 **EFFECTIVE DATE.** This section is effective July 1, 2021.

411.11 ~~(c)~~ (d) For substance use disorder services under section 254B.05, subdivision 5,
411.12 paragraph (b), clauses (1), (6), and (7), and adolescent treatment programs that are licensed
411.13 as outpatient treatment programs according to sections 245G.01 to 245G.18, provided on
411.14 or after January 1, 2021, payment rates must be increased by ~~ten~~ 30 percent over the rates
411.15 in effect on December 31, 2020.

411.16 ~~(d)~~ (e) Effective January 1, 2021, and contingent on annual federal approval, managed
411.17 care plans and county-based purchasing plans must reimburse providers of the substance
411.18 use disorder services meeting the criteria described in paragraph (a) who are employed by
411.19 or under contract with the plan an amount that is at least equal to the fee-for-service base
411.20 rate payment for the substance use disorder services described in paragraphs ~~(b)~~ (c) and ~~(c)~~
411.21 (d). The commissioner must monitor the effect of this requirement on the rate of access to
411.22 substance use disorder services and residential substance use disorder rates. Capitation rates
411.23 paid to managed care organizations and county-based purchasing plans must reflect the
411.24 impact of this requirement. This paragraph expires if federal approval is not received at any
411.25 time as required under this paragraph.

411.26 ~~(e)~~ (f) Effective July 1, 2021, contracts between managed care plans and county-based
411.27 purchasing plans and providers to whom paragraph ~~(d)~~ (e) applies must allow recovery of
411.28 payments from those providers if, for any contract year, federal approval for the provisions
411.29 of paragraph ~~(d)~~ (e) is not received, and capitation rates are adjusted as a result. Payment
411.30 recoveries must not exceed the amount equal to any decrease in rates that results from this
411.31 provision.

411.32 **EFFECTIVE DATE.** This section is effective July 1, 2021, or upon federal approval,
411.33 whichever occurs later, except paragraphs (c) and (d) are effective January 1, 2022, or upon
412.1 federal approval, whichever is later. The commissioner shall notify the revisor of statutes
412.2 when federal approval is obtained.

412.3 Sec. 11. Minnesota Statutes 2020, section 256B.0759, is amended by adding a subdivision
412.4 to read:

412.5 Subd. 6. **Medium intensity residential program participation.** Medium intensity
412.6 residential programs that qualify to participate in the demonstration project shall use the

H2128-4	UEH2128-1
	412.7 specified base payment rate of $132.90 per day, and shall be eligible for the rate increases 412.8 specified in subdivision 4.
	412.9 **EFFECTIVE DATE.** This section is effective retroactively from July 1, 2020.
	412.10 Sec. 12. Minnesota Statutes 2020, section 256B.0759, is amended by adding a subdivision 412.11 to read:
	412.12 Subd. 7. **Public access.** The state shall post the final documents, for example, monitoring 412.13 reports, close out report, approved evaluation design, interim evaluation report, and 412.14 summative evaluation report, on the state's Medicaid website within 30 calendar days of 412.15 approval by CMS.
	412.16 **EFFECTIVE DATE.** This section is effective July 1, 2021.
501.27 Sec. 26. Minnesota Statutes 2020, section 256B.0759, is amended by adding a subdivision 501.28 to read:	412.17 Sec. 13. Minnesota Statutes 2020, section 256B.0759, is amended by adding a subdivision 412.18 to read:
501.29 Subd. 7. **Federal approval; demonstration project extension.** The commissioner shall 501.30 seek a five-year extension of the demonstration project under this section and to receive 501.31 enhanced federal financial participation.	412.19 Subd. 8. **Federal approval; demonstration project extension.** The commissioner shall 412.20 seek all necessary federal authority to extend the demonstration and must submit the request 412.21 for extension by the federally required date of June 30, 2023.
501.32 **EFFECTIVE DATE.** This section is effective July 1, 2021.	412.22 **EFFECTIVE DATE.** This section is effective July 1, 2021.
502.1 Sec. 27. Minnesota Statutes 2020, section 256B.0759, is amended by adding a subdivision 502.2 to read:	412.23 Sec. 14. Minnesota Statutes 2020, section 256B.0759, is amended by adding a subdivision 412.24 to read:
502.3 Subd. 8. **Demonstration project evaluation work group.** Beginning October 1, 2021, 502.4 the commissioner shall assemble a work group of relevant stakeholders, including but not 502.5 limited to demonstration project participants and the Minnesota Association of Resources 502.6 for Recovery and Chemical Health, that shall meet quarterly for the duration of the 502.7 demonstration to evaluate the long-term sustainability of any improvements to quality or 502.8 access to substance use disorder treatment services caused by participation in the 502.9 demonstration project. The work group shall also determine how to implement successful 502.10 outcomes of the demonstration project once the project expires.	412.25 Subd. 9. **Demonstration project evaluation work group.** Beginning October 1, 2021, 412.26 the commissioner shall assemble a work group of relevant stakeholders, including but not 412.27 limited to demonstration project participants and the Minnesota Association of Resources 412.28 for Recovery and Chemical Health, that shall meet at least quarterly for the duration of the 412.29 demonstration to evaluate the long-term sustainability of any improvements to quality or 412.30 access to substance use disorder treatment services caused by participation in the 413.1 demonstration project. The work group shall also determine how to implement successful 413.2 outcomes of the demonstration project once the project expires.
502.11 **EFFECTIVE DATE.** This section is effective July 1, 2021.	413.3 **EFFECTIVE DATE.** This section is effective July 1, 2021.
	37.15 Sec. 30. Minnesota Statutes 2020, section 256B.0625, is amended by adding a subdivision 37.16 to read:
	37.17 Subd. 67. **Pretreatment coordination services.** Effective January 1, 2022, or upon 37.18 federal approval, whichever is later, medical assistance covers pretreatment coordination 37.19 services provided according to section 254B.05, subdivision 4a.
	37.20 **EFFECTIVE DATE.** This section is effective January 1, 2022. The commissioner of 37.21 human services shall notify the revisor of statutes when federal approval is obtained or 37.22 denied.

502.12 Sec. 28. **[256B.076] CASE MANAGEMENT SERVICES.**

502.13 Subdivision 1. **Generally.** (a) It is the policy of this state to ensure that individuals on
502.14 medical assistance receive cost-effective and coordinated care, including efforts to address
502.15 the profound effects of housing instability, food insecurity, and other social determinants
502.16 of health. Therefore, subject to federal approval, medical assistance covers targeted case
502.17 management services as described in this section.

502.18 (b) The commissioner, in collaboration with tribes, counties, providers, and individuals
502.19 served, must propose further modifications to targeted case management services to ensure
502.20 a program that complies with all federal requirements, delivers services in a cost-effective
502.21 and efficient manner, creates uniform expectations for targeted case management services,
502.22 addresses health disparities, and promotes person- and family-centered services.

502.23 Subd. 2. **Rate setting.** (a) The commissioner must develop and implement a statewide
502.24 rate methodology for any county that subcontracts targeted case management services to a
502.25 vendor. On January 1, 2022, or upon federal approval, whichever is later, a county must
502.26 use this methodology for any targeted case management services paid by medical assistance
502.27 and delivered through a subcontractor.

502.28 (b) In setting this rate, the commissioner must include the following:

502.29 (1) prevailing wages;

502.30 (2) employee-related expense factor;

502.31 (3) paid time off and training factors;

502.32 (4) supervision and span of control;

503.1 (5) distribution of time factor;

503.2 (6) administrative factor;

503.3 (7) absence factor;

503.4 (8) program support factor; and

503.5 (9) caseload sizes as described in subdivision 3.

503.6 (c) A county may request that the commissioner authorize a rate based on a lower caseload
503.7 size when a subcontractor is assigned to serve individuals with needs, such as homelessness
503.8 or specific linguistic or cultural needs, that significantly exceed other eligible populations.
503.9 A county must include the following in the request:

503.10 (1) the number of clients to be served by a full-time equivalent staffer;

503.11 (2) the specific factors that require a case manager to provide significantly more hours
503.12 of reimbursable services to a client; and

503.13 (3) how the county intends to monitor case size and outcomes.

503.14 (d) The commissioner must adjust only the factor for caseload in paragraph (b), clause
503.15 (9), in response to a request under paragraph (c).

503.16 Subd. 3. **Caseload sizes.** A county-subcontracted provider of targeted case management
503.17 services to the following populations must not exceed the following limits:

503.18 (1) for children with severe emotional disturbance, 15 clients to one full-time equivalent
503.19 case manager;

503.20 (2) for adults with severe and persistent mental illness, 30 clients to one full-time
503.21 equivalent case manager;

503.22 (3) for child welfare targeted case management, 25 clients to one full-time equivalent
503.23 case manager; and

503.24 (4) for vulnerable adults and adults who have developmental disabilities, 45 clients to
503.25 one full-time equivalent case manager.

503.26 Sec. 29. Minnesota Statutes 2020, section 256B.0924, subdivision 6, is amended to read:

503.27 Subd. 6. **Payment for targeted case management.** (a) Medical assistance and
503.28 MinnesotaCare payment for targeted case management shall be made on a monthly basis.
503.29 In order to receive payment for an eligible adult, the provider must document at least one
503.30 contact per month and not more than two consecutive months without a face-to-face contact
504.1 with the adult or the adult's legal representative, family, primary caregiver, or other relevant
504.2 persons identified as necessary to the development or implementation of the goals of the
504.3 personal service plan.

504.4 (b) Payment for targeted case management provided by county staff under this subdivision
504.5 shall be based on the monthly rate methodology under section 256B.094, subdivision 6,
504.6 paragraph (b), calculated as one combined average rate together with adult mental health
504.7 case management under section 256B.0625, subdivision 20, except for calendar year 2002.
504.8 In calendar year 2002, the rate for case management under this section shall be the same as
504.9 the rate for adult mental health case management in effect as of December 31, 2001. Billing
504.10 and payment must identify the recipient's primary population group to allow tracking of
504.11 revenues.

504.12 (c) Payment for targeted case management provided by county-contracted vendors shall
504.13 be based on a monthly rate ~~negotiated by the host county~~ calculated in accordance with
504.14 section 256B.076, subdivision 2. The ~~negotiated~~ rate must not exceed the rate charged by
504.15 the vendor for the same service to other payers. If the service is provided by a team of
504.16 contracted vendors, the ~~county may negotiate a team rate with a vendor who is a member~~
504.17 ~~of the team. The~~ team shall determine how to distribute the rate among its members. No
504.18 reimbursement received by contracted vendors shall be returned to the county, except to
504.19 reimburse the county for advance funding provided by the county to the vendor.

504.20 (d) If the service is provided by a team that includes contracted vendors and county staff,
504.21 the costs for county staff participation on the team shall be included in the rate for
504.22 county-provided services. In this case, the contracted vendor and the county may each
504.23 receive separate payment for services provided by each entity in the same month. In order
504.24 to prevent duplication of services, the county must document, in the recipient's file, the need
504.25 for team targeted case management and a description of the different roles of the team
504.26 members.

504.27 (e) Notwithstanding section 256B.19, subdivision 1, the nonfederal share of costs for
504.28 targeted case management shall be provided by the recipient's county of responsibility, as
504.29 defined in sections 256G.01 to 256G.12, from sources other than federal funds or funds
504.30 used to match other federal funds.

504.31 (f) The commissioner may suspend, reduce, or terminate reimbursement to a provider
504.32 that does not meet the reporting or other requirements of this section. The county of
504.33 responsibility, as defined in sections 256G.01 to 256G.12, is responsible for any federal
504.34 disallowances. The county may share this responsibility with its contracted vendors.

505.1 (g) The commissioner shall set aside five percent of the federal funds received under
505.2 this section for use in reimbursing the state for costs of developing and implementing this
505.3 section.

505.4 (h) Payments to counties for targeted case management expenditures under this section
505.5 shall only be made from federal earnings from services provided under this section. Payments
505.6 to contracted vendors shall include both the federal earnings and the county share.

505.7 (i) Notwithstanding section 256B.041, county payments for the cost of case management
505.8 services provided by county staff shall not be made to the commissioner of management
505.9 and budget. For the purposes of targeted case management services provided by county
505.10 staff under this section, the centralized disbursement of payments to counties under section
505.11 256B.041 consists only of federal earnings from services provided under this section.

505.12 (j) If the recipient is a resident of a nursing facility, intermediate care facility, or hospital,
505.13 and the recipient's institutional care is paid by medical assistance, payment for targeted case
505.14 management services under this subdivision is limited to the lesser of:

505.15 (1) the last 180 days of the recipient's residency in that facility; or

505.16 (2) the limits and conditions which apply to federal Medicaid funding for this service.

505.17 (k) Payment for targeted case management services under this subdivision shall not
505.18 duplicate payments made under other program authorities for the same purpose.

505.19 (l) Any growth in targeted case management services and cost increases under this
505.20 section shall be the responsibility of the counties.

505.21 Sec. 30. Minnesota Statutes 2020, section 256B.094, subdivision 6, is amended to read:

505.22 Subd. 6. **Medical assistance reimbursement of case management services.** (a) Medical
505.23 assistance reimbursement for services under this section shall be made on a monthly basis.
505.24 Payment is based on face-to-face or telephone contacts between the case manager and the
505.25 client, client's family, primary caregiver, legal representative, or other relevant person
505.26 identified as necessary to the development or implementation of the goals of the individual
505.27 service plan regarding the status of the client, the individual service plan, or the goals for
505.28 the client. These contacts must meet the minimum standards in clauses (1) and (2):

505.29 (1) there must be a face-to-face contact at least once a month except as provided in clause
505.30 (2); and

505.31 (2) for a client placed outside of the county of financial responsibility, or a client served
505.32 by tribal social services placed outside the reservation, in an excluded time facility under
506.1 section 256G.02, subdivision 6, or through the Interstate Compact for the Placement of
506.2 Children, section 260.93, and the placement in either case is more than 60 miles beyond
506.3 the county or reservation boundaries, there must be at least one contact per month and not
506.4 more than two consecutive months without a face-to-face contact.

506.5 (b) Except as provided under paragraph (c), the payment rate is established using time
506.6 study data on activities of provider service staff and reports required under sections 245.482
506.7 and 256.01, subdivision 2, paragraph (p).

506.8 (c) Payments for tribes may be made according to section 256B.0625 or other relevant
506.9 federally approved rate setting methodology for child welfare targeted case management
506.10 provided by Indian health services and facilities operated by a tribe or tribal organization.

506.11 (d) Payment for case management provided by county ~~or tribal social services~~ contracted
506.12 vendors ~~shall be based on a monthly rate negotiated by the host county or tribal social~~
506.13 ~~services~~ must be calculated in accordance with section 256B.076, subdivision 2. Payment
506.14 for case management provided by vendors who contract with a Tribe must be based on a
506.15 monthly rate negotiated by the Tribe. The ~~negotiated~~ rate must not exceed the rate charged
506.16 by the vendor for the same service to other payers. If the service is provided by a team of
506.17 contracted vendors, the ~~county or tribal social services may negotiate a team rate with a~~
506.18 ~~vendor who is a member of the team. The~~ team shall determine how to distribute the rate
506.19 among its members. No reimbursement received by contracted vendors shall be returned
506.20 to the county or tribal social services, except to reimburse the county or tribal social services
506.21 for advance funding provided by the county or tribal social services to the vendor.

506.22 (e) If the service is provided by a team that includes contracted vendors and county or
506.23 tribal social services staff, the costs for county or tribal social services staff participation in
506.24 the team shall be included in the rate for county or tribal social services provided services.
506.25 In this case, the contracted vendor and the county or tribal social services may each receive
506.26 separate payment for services provided by each entity in the same month. To prevent

506.27 duplication of services, each entity must document, in the recipient's file, the need for team
506.28 case management and a description of the roles and services of the team members.

506.29 Separate payment rates may be established for different groups of providers to maximize
506.30 reimbursement as determined by the commissioner. The payment rate will be reviewed
506.31 annually and revised periodically to be consistent with the most recent time study and other
506.32 data. Payment for services will be made upon submission of a valid claim and verification
506.33 of proper documentation described in subdivision 7. Federal administrative revenue earned
506.34 through the time study, or under paragraph (c), shall be distributed according to earnings,
507.1 to counties, reservations, or groups of counties or reservations which have the same payment
507.2 rate under this subdivision, and to the group of counties or reservations which are not
507.3 certified providers under section 256F.10. The commissioner shall modify the requirements
507.4 set out in Minnesota Rules, parts 9550.0300 to 9550.0370, as necessary to accomplish this.

41.28 Sec. 35. Minnesota Statutes 2020, section 256B.0946, subdivision 1, is amended to read:

41.29 Subdivision 1. **Required covered service components.** (a) Effective May 23, 2013,
41.30 and subject to federal approval, medical assistance covers medically necessary intensive
41.31 treatment services described under paragraph (b) that are provided by a provider entity
41.32 eligible under subdivision 3 to a client eligible under subdivision 2 who is placed in a foster
41.33 home licensed under Minnesota Rules, parts 2960.3000 to 2960.3340, or placed in a foster
41.34 home licensed under the regulations established by a federally recognized Minnesota tribe.

42.1 (b) Intensive treatment services to children with mental illness residing in foster family
42.2 settings that comprise specific required service components provided in clauses (1) to ~~(5)~~
42.3 (6) are reimbursed by medical assistance when they meet the following standards:

42.4 (1) psychotherapy provided by a mental health professional as defined in Minnesota
42.5 Rules, part 9505.0371, subpart 5, item A, or a clinical trainee, as defined in Minnesota
42.6 Rules, part 9505.0371, subpart 5, item C;

42.7 (2) crisis assistance provided according to standards for children's therapeutic services
42.8 and supports in section 256B.0943;

42.9 (3) individual, family, and group psychoeducation services, defined in subdivision 1a,
42.10 paragraph (q), provided by a mental health professional or a clinical trainee;

42.11 (4) clinical care consultation, as defined in subdivision 1a, and provided by a mental
42.12 health professional or a clinical trainee; ~~and~~

42.13 (5) individual treatment plan development as defined in Minnesota Rules, part 9505.0371,
42.14 subpart 7; and

42.15 (6) service delivery payment requirements as provided under subdivision 4.

42.16 **EFFECTIVE DATE.** This section is effective July 1, 2021, or upon federal approval,
42.17 whichever is later. The commissioner of human services shall notify the revisor of statutes
42.18 when federal approval is obtained.

42.19 Sec. 36. Minnesota Statutes 2020, section 256B.0946, subdivision 4, is amended to read:

42.20 Subd. 4. **Service delivery payment requirements.** (a) To be eligible for payment under
42.21 this section, a provider must develop and practice written policies and procedures for
42.22 intensive treatment in foster care, consistent with subdivision 1, paragraph (b), and comply
42.23 with the following requirements in paragraphs (b) to ~~(n)~~ (o).

42.24 (b) A qualified clinical supervisor, as defined in and performing in compliance with
42.25 Minnesota Rules, part 9505.0371, subpart 5, item D, must supervise the treatment and
42.26 provision of services described in this section.

42.27 (c) Each client receiving treatment services must receive an extended diagnostic
42.28 assessment, as described in Minnesota Rules, part 9505.0372, subpart 1, item C, within 30
42.29 days of enrollment in this service unless the client has a previous extended diagnostic
42.30 assessment that the client, parent, and mental health professional agree still accurately
42.31 describes the client's current mental health functioning.

43.1 (d) Each previous and current mental health, school, and physical health treatment
43.2 provider must be contacted to request documentation of treatment and assessments that the
43.3 eligible client has received. This information must be reviewed and incorporated into the
43.4 diagnostic assessment and team consultation and treatment planning review process.

43.5 (e) Each client receiving treatment must be assessed for a trauma history, and the client's
43.6 treatment plan must document how the results of the assessment will be incorporated into
43.7 treatment.

43.8 (f) Each client receiving treatment services must have an individual treatment plan that
43.9 is reviewed, evaluated, and signed every 90 days using the team consultation and treatment
43.10 planning process, as defined in subdivision 1a, paragraph (s).

43.11 (g) Care consultation, as defined in subdivision 1a, paragraph (a), must be provided in
43.12 accordance with the client's individual treatment plan.

43.13 (h) Each client must have a crisis assistance plan within ten days of initiating services
43.14 and must have access to clinical phone support 24 hours per day, seven days per week,
43.15 during the course of treatment. The crisis plan must demonstrate coordination with the local
43.16 or regional mobile crisis intervention team.

43.17 (i) Services must be delivered and documented at least three days per week, equaling at
43.18 least six hours of treatment per week~~, unless reduced units of service are specified on the~~
43.19 ~~treatment plan~~. If the mental health professional, client, and family agree, service units may
43.20 be temporarily reduced for a period of no more than 60 days in order to meet the needs of
43.21 the client and family, or as part of transition or on a discharge plan to another service or
43.22 level of care. The reasons for service reduction must be identified, documented, and included

43.23 on the treatment plan. Billing and payment are prohibited for days on which no services are
43.24 delivered and documented. Documentation must comply with Minnesota Rules, parts
43.25 9505.2175 and 9505.2197.

43.26 (j) Location of service delivery must be in the client's home, day care setting, school, or
43.27 other community-based setting that is specified on the client's individualized treatment plan.

43.28 (k) Treatment must be developmentally and culturally appropriate for the client.

43.29 (l) Services must be delivered in continual collaboration and consultation with the client's
43.30 medical providers and, in particular, with prescribers of psychotropic medications, including
43.31 those prescribed on an off-label basis. Members of the service team must be aware of the
43.32 medication regimen and potential side effects.

44.1 (m) Parents, siblings, foster parents, and members of the child's permanency plan must
44.2 be involved in treatment and service delivery unless otherwise noted in the treatment plan.

44.3 (n) Transition planning for the child must be conducted starting with the first treatment
44.4 plan and must be addressed throughout treatment to support the child's permanency plan
44.5 and postdischarge mental health service needs.

44.6 (o) In order for a provider to receive the daily per-client encounter rate, at least one of
44.7 the services listed in subdivision 1, paragraph (b), clauses (1) to (3), must be provided. The
44.8 services listed in subdivision 1, paragraph (b), clauses (4) and (5), may be included as part
44.9 of the daily per-client encounter rate.

44.10 **EFFECTIVE DATE.** This section is effective July 1, 2021, or upon federal approval,
44.11 whichever is later. The commissioner of human services shall notify the revisor of statutes
44.12 when federal approval is obtained.

413.4 Sec. 15. Minnesota Statutes 2020, section 256B.0947, subdivision 2, is amended to read:

413.5 Subd. 2. **Definitions.** For purposes of this section, the following terms have the meanings
413.6 given them.

413.7 (a) "Intensive nonresidential rehabilitative mental health services" means child
413.8 rehabilitative mental health services as defined in section 256B.0943, except that these
413.9 services are provided by a multidisciplinary staff using a total team approach consistent
413.10 with assertive community treatment, as adapted for youth, and are directed to recipients
413.11 ~~ages 16, 17, 18, 19, or 20~~ who are eight years of age or older and under 26 years of age with
413.12 a serious mental illness or co-occurring mental illness and substance abuse addiction who
413.13 require intensive services to prevent admission to an inpatient psychiatric hospital or
413.14 placement in a residential treatment facility or who require intensive services to step down
413.15 from inpatient or residential care to community-based care.

413.16 (b) "Co-occurring mental illness and substance abuse addiction" means a dual diagnosis
413.17 of at least one form of mental illness and at least one substance use disorder. Substance use
413.18 disorders include alcohol or drug abuse or dependence, excluding nicotine use.

413.19 (c) "Diagnostic assessment" has the meaning given to it in Minnesota Rules, part
413.20 9505.0370, subpart 11. A diagnostic assessment must be provided according to Minnesota
413.21 Rules, part 9505.0372, subpart 1, and for this section must incorporate a determination of
413.22 the youth's necessary level of care using a standardized functional assessment instrument
413.23 approved and periodically updated by the commissioner.

413.24 (d) "Education specialist" means an individual with knowledge and experience working
413.25 with youth regarding special education requirements and goals, special education plans,
413.26 and coordination of educational activities with health care activities.

413.27 (e) "Housing access support" means an ancillary activity to help an individual find,
413.28 obtain, retain, and move to safe and adequate housing. Housing access support does not
413.29 provide monetary assistance for rent, damage deposits, or application fees.

413.30 (f) "Integrated dual disorders treatment" means the integrated treatment of co-occurring
413.31 mental illness and substance use disorders by a team of cross-trained clinicians within the
413.32 same program, and is characterized by assertive outreach, stage-wise comprehensive
413.33 treatment, treatment goal setting, and flexibility to work within each stage of treatment.

414.1 (g) "Medication education services" means services provided individually or in groups,
414.2 which focus on:

414.3 (1) educating the client and client's family or significant nonfamilial supporters about
414.4 mental illness and symptoms;

414.5 (2) the role and effects of medications in treating symptoms of mental illness; and

414.6 (3) the side effects of medications.

414.7 Medication education is coordinated with medication management services and does not
414.8 duplicate it. Medication education services are provided by physicians, pharmacists, or
414.9 registered nurses with certification in psychiatric and mental health care.

414.10 (h) "Peer specialist" means an employed team member who is a mental health certified
414.11 peer specialist according to section 256B.0615 and also a former children's mental health
414.12 consumer who:

414.13 (1) provides direct services to clients including social, emotional, and instrumental
414.14 support and outreach;

414.15 (2) assists younger peers to identify and achieve specific life goals;

414.16 (3) works directly with clients to promote the client's self-determination, personal
414.17 responsibility, and empowerment;

414.18 (4) assists youth with mental illness to regain control over their lives and their
414.19 developmental process in order to move effectively into adulthood;

414.20 (5) provides training and education to other team members, consumer advocacy
414.21 organizations, and clients on resiliency and peer support; and

414.22 (6) meets the following criteria:

414.23 (i) is at least 22 years of age;

414.24 (ii) has had a diagnosis of mental illness, as defined in Minnesota Rules, part 9505.0370,
414.25 subpart 20, or co-occurring mental illness and substance abuse addiction;

414.26 (iii) is a former consumer of child and adolescent mental health services, or a former or
414.27 current consumer of adult mental health services for a period of at least two years;

414.28 (iv) has at least a high school diploma or equivalent;

414.29 (v) has successfully completed training requirements determined and periodically updated
414.30 by the commissioner;

415.1 (vi) is willing to disclose the individual's own mental health history to team members
415.2 and clients; and

415.3 (vii) must be free of substance use problems for at least one year.

415.4 (i) "Provider agency" means a for-profit or nonprofit organization established to
415.5 administer an assertive community treatment for youth team.

415.6 (j) "Substance use disorders" means one or more of the disorders defined in the diagnostic
415.7 and statistical manual of mental disorders, current edition.

415.8 (k) "Transition services" means:

415.9 (1) activities, materials, consultation, and coordination that ensures continuity of the
415.10 client's care in advance of and in preparation for the client's move from one stage of care
415.11 or life to another by maintaining contact with the client and assisting the client to establish
415.12 provider relationships;

415.13 (2) providing the client with knowledge and skills needed posttransition;

415.14 (3) establishing communication between sending and receiving entities;

415.15 (4) supporting a client's request for service authorization and enrollment; and

415.16 (5) establishing and enforcing procedures and schedules.

415.17 A youth's transition from the children's mental health system and services to the adult
415.18 mental health system and services and return to the client's home and entry or re-entry into
415.19 community-based mental health services following discharge from an out-of-home placement
415.20 or inpatient hospital stay.

415.21 (l) "Treatment team" means all staff who provide services to recipients under this section.

415.22 (m) "Family peer specialist" means a staff person qualified under section 256B.0616.

415.23 Sec. 16. Minnesota Statutes 2020, section 256B.0947, subdivision 3, is amended to read:

415.24 Subd. 3. **Client eligibility.** An eligible recipient is an individual who:

415.25 (1) is ~~age 16, 17, 18, 19, or 20~~ eight years of age or older and under 26 years of age; ~~and~~

415.26 (2) is diagnosed with a serious mental illness or co-occurring mental illness and substance
415.27 abuse addiction, for which intensive nonresidential rehabilitative mental health services are
415.28 needed;

416.1 (3) has received a level-of-care determination, using an instrument approved by the
416.2 commissioner, that indicates a need for intensive integrated intervention without 24-hour
416.3 medical monitoring and a need for extensive collaboration among multiple providers;

416.4 (4) has a functional impairment and a history of difficulty in functioning safely and
416.5 successfully in the community, school, home, or job; or who is likely to need services from
416.6 the adult mental health system ~~within the next two years~~ during adulthood; and

416.7 (5) has had a recent diagnostic assessment, as provided in Minnesota Rules, part
416.8 9505.0372, subpart 1, by a mental health professional who is qualified under Minnesota
416.9 Rules, part 9505.0371, subpart 5, item A, that documents that intensive nonresidential
416.10 rehabilitative mental health services are medically necessary to ameliorate identified
416.11 symptoms and functional impairments and to achieve individual transition goals.

416.12 Sec. 17. Minnesota Statutes 2020, section 256B.0947, subdivision 5, is amended to read:

416.13 Subd. 5. **Standards for intensive nonresidential rehabilitative providers.** (a) Services
416.14 must be provided by a provider entity as provided in subdivision 4.

416.15 (b) The treatment team must have specialized training in providing services to the specific
416.16 age group of youth that the team serves. An individual treatment team must serve youth
416.17 who are: (1) at least eight years of age or older and under 16 years of age, or (2) at least 14
416.18 years of age or older and under 26 years of age.

416.19 ~~(b)~~ (c) The treatment team for intensive nonresidential rehabilitative mental health
416.20 services comprises both permanently employed core team members and client-specific team
416.21 members as follows:

416.22 (1) The core treatment team is an entity that operates under the direction of an
416.23 independently licensed mental health professional, who is qualified under Minnesota Rules,
416.24 part 9505.0371, subpart 5, item A, and that assumes comprehensive clinical responsibility
416.25 for clients. Based on professional qualifications and client needs, clinically qualified core
416.26 team members are assigned on a rotating basis as the client's lead worker to coordinate a
416.27 client's care. The core team must comprise at least four full-time equivalent direct care staff
416.28 and must include, but is not limited to:

416.29 (i) an independently licensed mental health professional, qualified under Minnesota
416.30 Rules, part 9505.0371, subpart 5, item A, who serves as team leader to provide administrative
416.31 direction and clinical supervision to the team;

417.1 (ii) an advanced-practice registered nurse with certification in psychiatric or mental
417.2 health care or a board-certified child and adolescent psychiatrist, either of which must be
417.3 credentialed to prescribe medications;

417.4 (iii) a licensed alcohol and drug counselor who is also trained in mental health
417.5 interventions; and

417.6 (iv) a peer specialist as defined in subdivision 2, paragraph (h).

417.7 (2) The core team may also include any of the following:

417.8 (i) additional mental health professionals;

417.9 (ii) a vocational specialist;

417.10 (iii) an educational specialist;

417.11 (iv) a child and adolescent psychiatrist who may be retained on a consultant basis;

417.12 (v) a mental health practitioner, as defined in section 245.4871, subdivision 26;

417.13 (vi) a case management service provider, as defined in section 245.4871, subdivision 4;

417.14 (vii) a housing access specialist; and

417.15 (viii) a family peer specialist as defined in subdivision 2, paragraph (m).

417.16 (3) A treatment team may include, in addition to those in clause (1) or (2), ad hoc
417.17 members not employed by the team who consult on a specific client and who must accept
417.18 overall clinical direction from the treatment team for the duration of the client's placement
417.19 with the treatment team and must be paid by the provider agency at the rate for a typical
417.20 session by that provider with that client or at a rate negotiated with the client-specific
417.21 member. Client-specific treatment team members may include:

417.22 (i) the mental health professional treating the client prior to placement with the treatment
417.23 team;

417.24 (ii) the client's current substance abuse counselor, if applicable;

417.25 (iii) a lead member of the client's individualized education program team or school-based
417.26 mental health provider, if applicable;

417.27 (iv) a representative from the client's health care home or primary care clinic, as needed
417.28 to ensure integration of medical and behavioral health care;

417.29 (v) the client's probation officer or other juvenile justice representative, if applicable;
417.30 and

418.1 (vi) the client's current vocational or employment counselor, if applicable.

418.2 ~~(c)~~ (d) The clinical supervisor shall be an active member of the treatment team and shall
418.3 function as a practicing clinician at least on a part-time basis. The treatment team shall meet
418.4 with the clinical supervisor at least weekly to discuss recipients' progress and make rapid
418.5 adjustments to meet recipients' needs. The team meeting must include client-specific case
418.6 reviews and general treatment discussions among team members. Client-specific case
418.7 reviews and planning must be documented in the individual client's treatment record.

418.8 ~~(d)~~ (e) The staffing ratio must not exceed ten clients to one full-time equivalent treatment
418.9 team position.

418.10 ~~(e)~~ (f) The treatment team shall serve no more than 80 clients at any one time. Should
418.11 local demand exceed the team's capacity, an additional team must be established rather than
418.12 exceed this limit.

418.13 ~~(f)~~ (g) Nonclinical staff shall have prompt access in person or by telephone to a mental
418.14 health practitioner or mental health professional. The provider shall have the capacity to
418.15 promptly and appropriately respond to emergent needs and make any necessary staffing
418.16 adjustments to ensure the health and safety of clients.

418.17 ~~(g)~~ (h) The intensive nonresidential rehabilitative mental health services provider shall
418.18 participate in evaluation of the assertive community treatment for youth (Youth ACT) model
418.19 as conducted by the commissioner, including the collection and reporting of data and the
418.20 reporting of performance measures as specified by contract with the commissioner.

418.21 ~~(h)~~ (i) A regional treatment team may serve multiple counties.

418.22 Sec. 18. Minnesota Statutes 2020, section 256B.0947, subdivision 6, is amended to read:

418.23 Subd. 6. **Service standards.** The standards in this subdivision apply to intensive
418.24 nonresidential rehabilitative mental health services.

418.25 (a) The treatment team must use team treatment, not an individual treatment model.

418.26 (b) Services must be available at times that meet client needs.

418.27 (c) Services must be age-appropriate and meet the specific needs of the client.

418.28 (d) The initial functional assessment must be completed within ten days of intake and
418.29 updated at least every six months or prior to discharge from the service, whichever comes
418.30 first.

419.1 (e) The treatment team must complete an individual treatment plan for each client and
419.2 the individual treatment plan must:

419.3 (1) be based on the information in the client's diagnostic assessment and baselines;

419.4 (2) identify goals and objectives of treatment, a treatment strategy, a schedule for
419.5 accomplishing treatment goals and objectives, and the individuals responsible for providing
419.6 treatment services and supports;

419.7 (3) be developed after completion of the client's diagnostic assessment by a mental health
419.8 professional or clinical trainee and before the provision of children's therapeutic services
419.9 and supports;

419.10 (4) be developed through a child-centered, family-driven, culturally appropriate planning
419.11 process, including allowing parents and guardians to observe or participate in individual
419.12 and family treatment services, assessments, and treatment planning;

419.13 (5) be reviewed at least once every six months and revised to document treatment progress
419.14 on each treatment objective and next goals or, if progress is not documented, to document
419.15 changes in treatment;

419.16 (6) be signed by the clinical supervisor and by the client or by the client's parent or other
419.17 person authorized by statute to consent to mental health services for the client. A client's
419.18 parent may approve the client's individual treatment plan by secure electronic signature or
419.19 by documented oral approval that is later verified by written signature;

419.20 (7) be completed in consultation with the client's current therapist and key providers and
419.21 provide for ongoing consultation with the client's current therapist to ensure therapeutic
419.22 continuity and to facilitate the client's return to the community. For clients under the age of
419.23 18, the treatment team must consult with parents and guardians in developing the treatment
419.24 plan;

419.25 (8) if a need for substance use disorder treatment is indicated by validated assessment:

419.26 (i) identify goals, objectives, and strategies of substance use disorder treatment; develop
419.27 a schedule for accomplishing treatment goals and objectives; and identify the individuals
419.28 responsible for providing treatment services and supports;

419.29 (ii) be reviewed at least once every 90 days and revised, if necessary;

419.30 (9) be signed by the clinical supervisor and by the client and, if the client is a minor, by
419.31 the client's parent or other person authorized by statute to consent to mental health treatment
419.32 and substance use disorder treatment for the client; and

420.1 (10) provide for the client's transition out of intensive nonresidential rehabilitative mental
420.2 health services by defining the team's actions to assist the client and subsequent providers
420.3 in the transition to less intensive or "stepped down" services.

420.4 (f) The treatment team shall actively and assertively engage the client's family members
420.5 and significant others by establishing communication and collaboration with the family and
420.6 significant others and educating the family and significant others about the client's mental
420.7 illness, symptom management, and the family's role in treatment, unless the team knows or

420.8 has reason to suspect that the client has suffered or faces a threat of suffering any physical
420.9 or mental injury, abuse, or neglect from a family member or significant other.

420.10 (g) For a client age 18 or older, the treatment team may disclose to a family member,
420.11 other relative, or a close personal friend of the client, or other person identified by the client,
420.12 the protected health information directly relevant to such person's involvement with the
420.13 client's care, as provided in Code of Federal Regulations, title 45, part 164.502(b). If the
420.14 client is present, the treatment team shall obtain the client's agreement, provide the client
420.15 with an opportunity to object, or reasonably infer from the circumstances, based on the
420.16 exercise of professional judgment, that the client does not object. If the client is not present
420.17 or is unable, by incapacity or emergency circumstances, to agree or object, the treatment
420.18 team may, in the exercise of professional judgment, determine whether the disclosure is in
420.19 the best interests of the client and, if so, disclose only the protected health information that
420.20 is directly relevant to the family member's, relative's, friend's, or client-identified person's
420.21 involvement with the client's health care. The client may orally agree or object to the
420.22 disclosure and may prohibit or restrict disclosure to specific individuals.

420.23 (h) The treatment team shall provide interventions to promote positive interpersonal
420.24 relationships.

420.25 Sec. 19. Minnesota Statutes 2020, section 297E.02, subdivision 3, is amended to read:

420.26 Subd. 3. **Collection; disposition.** (a) Taxes imposed by this section are due and payable
420.27 to the commissioner when the gambling tax return is required to be filed. Distributors must
420.28 file their monthly sales figures with the commissioner on a form prescribed by the
420.29 commissioner. Returns covering the taxes imposed under this section must be filed with
420.30 the commissioner on or before the 20th day of the month following the close of the previous
420.31 calendar month. The commissioner shall prescribe the content, format, and manner of returns
420.32 or other documents pursuant to section 270C.30. The proceeds, along with the revenue
420.33 received from all license fees and other fees under sections 349.11 to 349.191, 349.211,
421.1 and 349.213, must be paid to the commissioner of management and budget for deposit in
421.2 the general fund.

421.3 (b) The sales tax imposed by chapter 297A on the sale of pull-tabs and tipboards by the
421.4 distributor is imposed on the retail sales price. The retail sale of pull-tabs or tipboards by
421.5 the organization is exempt from taxes imposed by chapter 297A and is exempt from all
421.6 local taxes and license fees except a fee authorized under section 349.16, subdivision 8.

421.7 (c) One-half of one percent of the revenue deposited in the general fund under paragraph
421.8 (a), is appropriated to the commissioner of human services for the compulsive gambling
421.9 treatment program established under section 245.98. One-half of one percent of the revenue
421.10 deposited in the general fund under paragraph (a), is appropriated to the commissioner of
421.11 human services for a grant to the state affiliate recognized by the National Council on
421.12 Problem Gambling to increase public awareness of problem gambling, education and training
421.13 for individuals and organizations providing effective treatment services to problem gamblers

507.5 Sec. 31. **DIRECTION TO THE COMMISSIONER; ADULT MENTAL HEALTH**
507.6 **INITIATIVES REFORM.**

507.7 In establishing a legislative proposal for reforming the funding formula to distribute
507.8 adult mental health initiative funds, the commissioner of human services shall ensure that
507.9 funding currently received as a result of the closure of the Moose Lake Regional Treatment
507.10 Center is not reallocated from any region that does not have a community behavioral health
507.11 hospital. Upon finalization of the adult mental health initiatives reform, the commissioner
507.12 shall notify the chairs and ranking minority members of the legislative committees with
507.13 jurisdiction over health and human services finance and policy.

507.14 Sec. 32. **DIRECTION TO THE COMMISSIONER; ALTERNATIVE MENTAL**
507.15 **HEALTH PROFESSIONAL LICENSING PATHWAYS WORK GROUP.**

507.16 (a) The commissioners of human services and health must convene a work group
507.17 consisting of representatives from the Board of Psychology; the Board of Marriage and
507.18 Family Therapy; the Board of Social Work; the Board of Behavioral Health and Therapy;
507.19 five mental health providers from diverse cultural communities; a representative from the
507.20 Minnesota Council of Health Plans; a representative from a state health care program; two
507.21 representatives from mental health associations or community mental health clinics led by
507.22 individuals who are Black, indigenous, or people of color; and representatives from mental
507.23 health professional graduate programs to evaluate and make recommendations on possible
507.24 alternative pathways to mental health professional licensure in Minnesota. The work group
507.25 must:

507.26 (1) identify barriers to licensure in mental health professions;

507.27 (2) collect data on the number of individuals graduating from educational programs but
507.28 not passing licensing exams;

507.29 (3) evaluate the feasibility of alternative pathways for licensure in mental health
507.30 professions, ensuring provider competency and professionalism; and

421.14 and their families, and research relating to problem gambling. Money appropriated by this
421.15 paragraph must supplement and must not replace existing state funding for these programs.

421.16 (d) The commissioner of human services must provide to the state affiliate recognized
421.17 by the National Council on Problem Gambling a monthly statement of the amounts deposited
421.18 under paragraph (c). Beginning January 1, 2022, the commissioner of human services must
421.19 provide to the chairs and ranking minority members of the legislative committees with
421.20 jurisdiction over treatment for problem gambling and to the state affiliate recognized by the
421.21 National Council on Problem Gambling an annual reconciliation of the amounts deposited
421.22 under paragraph (c). The annual reconciliation under this paragraph must include the amount
421.23 allocated to the commissioner of human services for the compulsive gambling treatment
421.24 program established under section 245.98, and the amount allocated to the state affiliate
421.25 recognized by the National Council on Problem Gambling.

507.31 (4) consult with national behavioral health testing entities.

508.1 (b) Mental health providers participating in the work group may be reimbursed for
508.2 expenses in the same manner as authorized by the commissioner's plan adopted under
508.3 Minnesota Statutes, section 43A.18, subdivision 2, upon approval by the commissioner.
508.4 Members who, as a result of time spent attending work group meetings, incur child care
508.5 expenses that would not otherwise have been incurred, may be reimbursed for those expenses
508.6 upon approval by the commissioner. Reimbursements may be approved for no more than
508.7 five individual providers.

508.8 (c) No later than February 1, 2023, the commissioners must submit a written report to
508.9 the members of the legislative committees with jurisdiction over health and human services
508.10 on the work group's findings and recommendations developed on alternative licensing
508.11 pathways.

508.12 Sec. 33. **DIRECTION TO THE COMMISSIONER; CHILDREN'S MENTAL**
508.13 **HEALTH RESIDENTIAL TREATMENT WORK GROUP.**

508.14 The commissioner of human services, in consultation with counties, children's mental
508.15 health residential providers, and children's mental health advocates, must organize a work
508.16 group and develop recommendations on how to efficiently and effectively fund room and
508.17 board costs for children's mental health residential treatment under the children's mental
508.18 health act. The work group may also provide recommendations on how to address systemic
508.19 barriers in transitioning children into the community and community-based treatment options.
508.20 The commissioner shall submit the recommendations to the chairs and ranking minority
508.21 members of the legislative committees with jurisdiction over health and human services
508.22 policy and finance by February 15, 2022.

508.23 Sec. 34. **DIRECTION TO THE COMMISSIONER; CULTURALLY AND**
508.24 **LINGUISTICALLY APPROPRIATE SERVICES.**

508.25 The commissioner of human services, in consultation with substance use disorder
508.26 treatment providers, lead agencies, and individuals who receive substance use disorder
508.27 treatment services, shall develop a statewide implementation and transition plan for culturally
508.28 and linguistically appropriate services (CLAS) national standards, including technical
508.29 assistance for providers to transition to the CLAS standards and to improve disparate
508.30 treatment outcomes. The commissioner must consult with individuals who are Black,
508.31 indigenous, people of color, and linguistically diverse in the development of the
508.32 implementation and transition plans under this section.

509.1 Sec. 35. **DIRECTION TO THE COMMISSIONER; RATE RECOMMENDATIONS**
509.2 **FOR OPIOID TREATMENT PROGRAMS.**

509.3 The commissioner of human services shall evaluate the rate structure for opioid treatment
509.4 programs licensed under Minnesota Statutes, section 245G.22, and report recommendations,
509.5 including a revised rate structure and proposed draft legislation, to the chairs and ranking

509.6 minority members of the legislative committees with jurisdiction over human services policy
509.7 and finance by October 1, 2021.

421.26 Sec. 20. **SUBSTANCE USE DISORDER TREATMENT PATHFINDER**
421.27 **COMPANION PILOT PROJECT.**

421.28 (a) Anoka County and an academic institution acting as a research partner, in consultation
421.29 with the North Metro Mental Health Roundtable, shall conduct a one-year pilot project
421.30 beginning September 1, 2021, to evaluate the effects on treatment outcomes of the use by
421.31 individuals in substance use disorder recovery of the telephone-based Pathfinder Companion
421.32 application, which allows individuals in recovery to connect with peers, resources, providers,
421.33 and others helping with recovery after an individual is discharged from treatment, and the
421.34 use by providers of the computer-based Pathfinder Bridge application, which allows providers
422.1 to prioritize care, connect directly with patients, and monitor long-term outcomes and
422.2 recovery effectiveness.

422.3 (b) Prior to launching the program, Anoka County must secure the participation of an
422.4 academic research institution as a research partner and the project must receive approval
422.5 from the institution's institutional review board.

422.6 (c) The pilot project must monitor and evaluate the effects on treatment outcomes of
422.7 using the Pathfinder Companion and Pathfinder Bridge applications in order to determine
422.8 whether the addition of digital recovery support services alongside traditional methods of
422.9 recovery treatment improves treatment outcomes. The participating research partner shall
422.10 design and conduct the program evaluation.

422.11 (d) Anoka County and the participating research partner, in consultation with the North
422.12 Metro Mental Health Roundtable, shall report to the commissioner of human services and
422.13 the chairs and ranking minority members of the legislative committees with jurisdiction
422.14 over substance use disorder treatment by January 15, 2023, on the results of the pilot project.

422.15 Sec. 21. **FIRST EPISODE OF PSYCHOSIS GRANT PROGRAM; AUTHORIZED**
422.16 **USES OF GRANT FUNDS.**

422.17 (a) Grant funds awarded by the commissioner of human services pursuant to Minnesota
422.18 Statutes, section 245.4889, subdivision 1, paragraph (b), clause (15), must be used to:

422.19 (1) provide intensive treatment and support for adolescents and adults experiencing or
422.20 at risk of experiencing a first psychotic episode. Intensive treatment and support includes
422.21 medication management, psychoeducation for an individual and an individual's family, case
422.22 management, employment support, education support, cognitive behavioral approaches,
422.23 social skills training, peer support, crisis planning, and stress management. Projects must
422.24 use all available funding streams;

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

422.28 (3) ensure access for individuals to first psychotic episode services under this section,
422.29 including ensuring access to first psychotic episode services for individuals who live in
422.30 rural areas.

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

423.1 Sec. 22. **EMERGING MOOD DISORDER GRANT PROGRAM; AUTHORIZED**
423.2 **USES OF GRANT FUNDS.**

423.3 (a) Grant funds awarded by the commissioner of human services pursuant to Minnesota
423.4 Statutes, section 245.4889, subdivision 1, paragraph (b), clause (18), must be used to:

423.5 (1) provide intensive treatment and support to adolescents and young adults experiencing
423.6 or at risk of experiencing an emerging mood disorder. Intensive treatment and support
423.7 includes medication management, psychoeducation for the individual and the individual's
423.8 family, case management, employment support, education support, cognitive behavioral
423.9 approaches, social skills training, peer support, crisis planning, and stress management.
423.10 Grant recipients must use all available funding streams;

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

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

423.16 (b) Grant funds may also be used by the grant recipient to evaluate the efficacy for
423.17 providing intensive services and supports to people with emerging mood disorders.

423.18 Sec. 23. **DIRECTION TO COMMISSIONER OF HUMAN SERVICES; MENTAL**
423.19 **HEALTH GRANT PROGRAMS STATUTE REVISION.**

423.20 The commissioner of human services, in coordination with the Office of Senate Counsel,
423.21 Research, and Fiscal Analysis, the Office of the House Research Department, and the revisor
423.22 of statutes, shall prepare legislation for the 2022 legislative session to enact as statutes the
423.23 grant programs authorized and funded under Minnesota Statutes, section 245.4661,
423.24 subdivision 9. The draft statutes shall at least include the eligibility criteria, target populations,
423.25 authorized uses of grant funds, and outcome measures for each grant. The commissioner
423.26 shall provide a courtesy copy of the proposed legislation to the chairs and ranking minority
423.27 members of the legislative committees with jurisdiction over mental health grants.

509.8 Sec. 36. **DIRECTION TO THE COMMISSIONER; SOBER HOUSING PROGRAM**
509.9 **RECOMMENDATIONS.**

509.10 (a) The commissioner of human services, in consultation with stakeholders, must develop
509.11 recommendations on:

509.12 (1) increasing access to sober housing programs;

509.13 (2) promoting person-centered practices and cultural responsiveness in sober housing
509.14 programs;

509.15 (3) potential oversight of sober housing programs; and

509.16 (4) providing consumer protections for individuals in sober housing programs with
509.17 substance use disorders and individuals with co-occurring mental illnesses.

509.18 (b) Stakeholders include but are not limited to the Minnesota Association of Sober
509.19 Homes, the Minnesota Association of Resources for Recovery and Chemical Health,
509.20 Minnesota Recovery Connection, NAMI Minnesota, the National Alliance of Recovery
509.21 Residencies (NARR), Oxford Houses, Inc., sober housing programs based in Minnesota
509.22 that are not members of the Minnesota Association of Sober Homes, a member of Alcoholics
509.23 Anonymous, and residents and former residents of sober housing programs based in
509.24 Minnesota. Stakeholders must equitably represent various geographic areas of the state and
509.25 must include individuals in recovery and providers representing Black, indigenous, people
509.26 of color, or immigrant communities.

509.27 (c) The commissioner must complete and submit a report on these recommendations to
509.28 the chairs and ranking minority members of the legislative committees with jurisdiction
509.29 over health and human services policy and finance on or before March 1, 2022.

510.1 Sec. 37. **DIRECTION TO THE COMMISSIONER; SUBSTANCE USE DISORDER**
510.2 **TREATMENT PAPERWORK REDUCTION.**

510.3 (a) The commissioner of human services, in consultation with counties, tribes, managed
510.4 care organizations, substance use disorder treatment professional associations, and other
510.5 relevant stakeholders, shall develop, assess, and recommend systems improvements to
510.6 minimize regulatory paperwork and improve systems for substance use disorder programs
510.7 licensed under Minnesota Statutes, chapter 245A, and regulated under Minnesota Statutes,
510.8 chapters 245F and 245G, and Minnesota Rules, chapters 2960 and 9530. The commissioner
510.9 of human services shall make available any resources needed from other divisions within
510.10 the department to implement systems improvements.

510.11 (b) The commissioner of health shall make available needed information and resources
510.12 from the Division of Health Policy.

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

424.29 Sec. 25. **DIRECTION TO THE COMMISSIONER; SOBER HOUSING PROGRAM**
424.30 **RECOMMENDATIONS.**

424.31 (a) The commissioner of human services, in consultation with stakeholders, must develop
424.32 recommendations on:

424.33 (1) increasing access to sober housing programs;

425.1 (2) promoting person-centered practices and cultural responsiveness in sober housing
425.2 programs;

425.3 (3) potential oversight of sober housing programs; and

425.4 (4) providing consumer protections for individuals in sober housing programs with
425.5 substance use disorders and individuals with co-occurring mental illnesses.

425.6 (b) Stakeholders include but are not limited to the Minnesota Association of Sober
425.7 Homes, the Minnesota Association of Resources for Recovery and Chemical Health,
425.8 Minnesota Recovery Connection, NAMI Minnesota, and residents and former residents of
425.9 sober housing programs based in Minnesota. Stakeholders must equitably represent
425.10 geographic areas of the state, and must include individuals in recovery and providers
425.11 representing Black, Indigenous, people of color, or immigrant communities.

425.12 (c) The commissioner must complete and submit a report on the recommendations in
425.13 this section to the chairs and ranking minority members of the legislative committees with
425.14 jurisdiction over health and human services policy and finance on or before September 1,
425.15 2022.

423.29 Sec. 24. **DIRECTION TO THE COMMISSIONER; SUBSTANCE USE DISORDER**
423.30 **TREATMENT PAPERWORK REDUCTION.**

423.31 (a) The commissioner of human services, in consultation with counties, tribes, managed
423.32 care organizations, substance use disorder treatment professional associations, and other
424.1 relevant stakeholders, shall develop, assess, and recommend systems improvements to
424.2 minimize regulatory paperwork and improve systems for substance use disorder programs
424.3 licensed under Minnesota Statutes, chapter 245A, and regulated under Minnesota Statutes,
424.4 chapters 245F and 245G, and Minnesota Rules, chapters 2960 and 9530. The commissioner
424.5 of human services shall make available any resources needed from other divisions within
424.6 the department to implement systems improvements.

424.7 (b) The commissioner of health shall make available needed information and resources
424.8 from the Division of Health Policy.

510.13 (c) The Office of MN.IT Services shall provide advance consultation and implementation
510.14 of the changes needed in data systems.

510.15 (d) The commissioner of human services shall contract with a vendor that has experience
510.16 with developing statewide system changes for multiple states at the payer and provider
510.17 levels. If the commissioner, after exercising reasonable diligence, is unable to secure a
510.18 vendor with the requisite qualifications, then the commissioner may select the best qualified
510.19 vendor available. When developing recommendations, the commissioner shall consider
510.20 input from all stakeholders. The commissioner's recommendations shall maximize benefits
510.21 for clients and utility for providers, regulatory agencies, and payers.

510.22 (e) The commissioner of human services and contracted vendor shall follow the
510.23 recommendations from the report issued in response to Laws 2019, First Special Session
510.24 chapter 9, article 6, section 76.

510.25 (f) By December 15, 2022, the commissioner of human services shall take steps to
510.26 implement paperwork reductions and systems improvements within the commissioner's
510.27 authority and submit to the chairs and ranking minority members of the legislative committees
510.28 with jurisdiction over health and human services a report that includes recommendations
510.29 for changes in statutes that would further enhance systems improvements to reduce
510.30 paperwork. The report shall include a summary of the approaches developed and assessed
510.31 by the commissioner of human services and stakeholders and the results of any assessments
510.32 conducted.

511.1 Sec. 38. **DIRECTION TO THE COMMISSIONER; TRIBAL OVERPAYMENT**
511.2 **PROTOCOLS.**

511.3 The commissioner of human services, in consultation with the Tribal nations, shall
511.4 develop protocols that must be used to address and attempt to resolve any future overpayment
511.5 involving any Tribal nation in Minnesota.

511.6 Sec. 39. **SUBSTANCE USE DISORDER TREATMENT RATE RESTRUCTURE**
511.7 **ANALYSIS.**

511.8 (a) By January 1, 2022, the commissioner shall issue a request for proposals for
511.9 frameworks and modeling of substance use disorder rates. Rates must be predicated on a
511.10 uniform methodology that is transparent, culturally responsive, supports staffing needed to
511.11 treat a patient's assessed need, and promotes quality service delivery and patient choice.
511.12 The commissioner must consult with substance use disorder treatment programs across the
511.13 spectrum of services, substance use disorder treatment programs from across each region
511.14 of the state, and culturally responsive providers in the development of the request for proposal
511.15 process and for the duration of the contract.

511.16 (b) By January 15, 2023, the commissioner of human services shall submit a report to
511.17 the chairs and ranking minority members of the legislative committees with jurisdiction
511.18 over human services policy and finance on the results of the vendor's work. The report must

424.9 (c) The Office of MN.IT Services shall provide advance consultation and implementation
424.10 of the changes needed in data systems.

424.11 (d) The commissioner of human services shall contract with a vendor that has experience
424.12 with developing statewide system changes for multiple states at the payer and provider
424.13 levels. If the commissioner, after exercising reasonable diligence, is unable to secure a
424.14 vendor with the requisite qualifications, the commissioner may select the best qualified
424.15 vendor available. When developing recommendations, the commissioner shall consider
424.16 input from all stakeholders. The commissioner's recommendations shall maximize benefits
424.17 for clients and utility for providers, regulatory agencies, and payers.

424.18 (e) The commissioner of human services and the contracted vendor shall follow the
424.19 recommendations from the report issued in response to Laws 2019, First Special Session
424.20 chapter 9, article 6, section 76.

424.21 (f) By December 15, 2022, the commissioner of human services shall take steps to
424.22 implement paperwork reductions and systems improvements within the commissioner's
424.23 authority and submit to the chairs and ranking minority members of the legislative committees
424.24 with jurisdiction over health and human services a report that includes recommendations
424.25 for changes in statutes that would further enhance systems improvements to reduce
424.26 paperwork. The report shall include a summary of the approaches developed and assessed
424.27 by the commissioner of human services and stakeholders and the results of any assessments
424.28 conducted.

426.7 Sec. 28. **DIRECTION TO THE COMMISSIONER; SUBSTANCE USE DISORDER**
426.8 **TREATMENT RATE RESTRUCTURE.**

426.9 (a) By January 1, 2022, the commissioner shall issue a request for proposal for
426.10 frameworks and modeling of substance use disorder rates. Rates must be predicated on a
426.11 uniform methodology that is transparent, culturally responsive, supports staffing needed to
426.12 treat a patient's assessed need, and promotes quality service delivery and patient choice.
426.13 The commissioner must consult with substance use disorder treatment programs across the
426.14 spectrum of services, substance use disorder treatment programs from across each region
426.15 of the state, and culturally responsive providers in the development of the request for proposal
426.16 process and for the duration of the contract.

426.17 (b) By January 15, 2023, the commissioner of human services shall submit a report to
426.18 the chairs and ranking minority members of the legislative committees with jurisdiction
426.19 over human services policy and finance on the results of the vendor's work. The report must

511.19 include legislative language necessary to implement a new substance use disorder treatment
511.20 rate methodology and a detailed fiscal analysis.

426.20 include legislative language necessary to implement a new substance use disorder treatment
426.21 rate methodology and a detailed fiscal analysis.

425.16 Sec. 26. **DIRECTION TO COMMISSIONERS OF HEALTH AND HUMAN**
425.17 **SERVICES; COMPULSIVE GAMBLING PROGRAMMING AND FUNDING.**

425.18 By September 1, 2022, the commissioner of human services shall consult with the
425.19 commissioner of health and report to the chairs and ranking minority members of the
425.20 legislative committees with jurisdiction over health and human services with a
425.21 recommendation on whether the revenue appropriated to the commissioner of human services
425.22 for a grant to the state affiliate recognized by the National Council on Problem Gambling
425.23 under Minnesota Statutes, section 297E.02, subdivision 3, paragraph (c), is more properly
425.24 appropriated to and managed by an agency other than the Department of Human Services.
425.25 The commissioners shall also recommend whether the compulsive gambling treatment
425.26 program in Minnesota Statutes, section 245.98, should continue to be managed by the
425.27 Department of Human Services or be managed by another agency.

425.28 Sec. 27. **DIRECTION TO THE COMMISSIONER OF HUMAN SERVICES; SUD**
425.29 **DEMONSTRATION PROJECT ENROLLMENT REPORT.**

425.30 Beginning with the November 2021 budget forecast and for each budget forecast
425.31 thereafter, the commissioner of human services shall report to the chairs and ranking minority
425.32 members of the legislative committees with jurisdiction over human services on the number
426.1 of institutions for mental disease providers enrolled in the demonstration project under
426.2 Minnesota Statutes, section 256B.0759, and the amount of the federal financial participation
426.3 for institutions for mental disease providers enrolled in the demonstration project and the
426.4 amount of the federal financial participation that exceeds the commissioner's projected
426.5 enrollment as of the November 2021 forecast. This report shall be provided for the duration
426.6 of the demonstration project.

426.22 Sec. 29. **DIRECTION TO THE COMMISSIONER; SUBSTANCE USE DISORDER**
426.23 **TECHNICAL ASSISTANCE CENTERS.**

426.24 The commissioner shall establish one or more community-based technical assistance
426.25 centers for substance use disorder treatment providers that offer both virtual learning
426.26 environments and in-person opportunities. The technical assistance centers must provide
426.27 guidance to substance use disorder providers concerning the enrollment process for the
426.28 substance use disorder reform demonstration project under Minnesota Statutes, section
426.29 256B.0759, and provide advice concerning bringing the provider's treatment practices into
426.30 compliance with American Society of Addiction Medicine standards during the one-year
426.31 transition period. Technical assistance centers may also promote awareness of new and
426.32 evidence-based practices and services for the treatment of substance use disorders, and offer
426.33 education, training, resources, and information for the behavioral health care workforce.
427.1 The commissioner must award funding to technical assistance centers by March 1, 2022,
427.2 to initiate operations.

427.3 Sec. 30. **FEDERAL COMMUNITY MENTAL HEALTH SERVICES BLOCK**
427.4 **GRANT ALLOCATION; CHILDREN'S MENTAL HEALTH GRANTS FOR**
427.5 **EMERGING MOOD DISORDERS PROGRAMS.**

427.6 From the amount that Minnesota received under title II of the federal Consolidated
427.7 Appropriations Act, Public Law 116-260, for the community mental health services block
427.8 grant, the commissioner of human services shall allocate $400,000 in fiscal year 2022,
427.9 $400,000 in fiscal year 2023, $400,000 in fiscal year 2024, and $400,000 in fiscal year
427.10 2025, for children's mental health grants for emerging mood disorder programs under
427.11 Minnesota Statutes, section 245.4889, subdivision 1, paragraph (b), clause (18).

427.12 Sec. 31. **FEDERAL COMMUNITY MENTAL HEALTH SERVICES BLOCK**
427.13 **GRANT ALLOCATION; CHILDREN'S MENTAL HEALTH GRANTS FOR FIRST**
427.14 **EPISODE OF PSYCHOSIS PROGRAMS.**

427.15 (a) From the amount that Minnesota received under title II of the federal Consolidated
427.16 Appropriations Act, Public Law 116-260, for the community mental health services block
427.17 grant, the commissioner of human services shall allocate $1,600,000 in fiscal year 2022,
427.18 $1,500,000 in fiscal year 2023, and $222,000 in fiscal year 2024, for children's mental health
427.19 grants for first episode of psychosis programs under Minnesota Statutes, section 245.4889,
427.20 subdivision 1, paragraph (b), clause (15).

427.21 (b) From the amount that Minnesota received under section 2701 of the federal American
427.22 Rescue Plan Act, Public Law 117-2, for the community mental health services block grant,
427.23 the commissioner of human services shall allocate $1,278,000 in fiscal year 2024 and
427.24 $1,500,000 in fiscal year 2025, for children's mental health grants for first episode of
427.25 psychosis programs under Minnesota Statutes, section 245.4889, subdivision 1, paragraph
427.26 (b), clause (15).

427.27 (c) From the amount that Minnesota received under section 2701 of the federal American
427.28 Rescue Plan Act, Public Law 117-2, for the community mental health services block grant,
427.29 the commissioner of human services shall allocate $200,000 in fiscal year 2022 and $200,000
427.30 in fiscal year 2023, foradditional funding to four existing first episode of psychosis programs
427.31 that receive children's mental health grants funding under Minnesota Statutes, section
427.32 245.4889, subdivision 1, paragraph (b), clause (15).

428.1 (d) From the amount that Minnesota received under title II of the federal Consolidated
428.2 Appropriations Act, Public Law 116-260, for the community mental health services block
428.3 grant, the commissioner of human services shall allocate $200,000 in fiscal year 2024 and
428.4 $200,000 in fiscal year 2025, for additional funding to four existing first episode of psychosis
428.5 programs that receive children's mental health grants funding under Minnesota Statutes,
428.6 section 245.4889, subdivision 1, paragraph (b), clause (15).

428.7 Sec. 32. **FEDERAL COMMUNITY MENTAL HEALTH SERVICES BLOCK**
428.8 **GRANT ALLOCATION; ADULT MENTAL HEALTH INITIATIVE GRANTS.**

428.9 (a) From the amount that Minnesota received under title II of the federal Consolidated
428.10 Appropriations Act, Public Law 116-260, for the community mental health services block
428.11 grant, the commissioner of human services shall allocate $2,350,000 in fiscal year 2022
428.12 and $2,350,000 in fiscal year 2023, for adult mental health initiative grants under Minnesota
428.13 Statutes, section 245.4661, subdivision 1.

428.14 (b) From the amount that Minnesota received under section 2701 of the federal American
428.15 Rescue Plan Act, Public Law 117-2, the commissioner of human services shall allocate
428.16 $2,350,000 in fiscal year 2024 and $2,350,000 in fiscal year 2025, for the adult mental
428.17 health initiative grants under Minnesota Statutes, section 245.4661, subdivision 1.

428.18 Sec. 33. **FEDERAL COMMUNITY MENTAL HEALTH SERVICES BLOCK**
428.19 **GRANT ALLOCATION; SCHOOL-LINKED MENTAL HEALTH GRANTS.**

428.20 (a) From the amount that Minnesota received under title II of the federal Consolidated
428.21 Appropriations Act, Public Law 116-260, for the community mental health services block
428.22 grant, the commissioner of human services shall allocate $2,500,000 in fiscal year 2022
428.23 and $2,500,000 in fiscal year 2023, for school-linked mental health grants under Minnesota
428.24 Statutes, section 245.4901.

428.25 (b) From the amount that Minnesota received under section 2701 of the federal American
428.26 Rescue Plan Act, Public Law 117-2, for the community mental health services block grant,
428.27 the commissioner of human services shall allocate $2,500,000 in fiscal year 2024 and
428.28 $2,500,000 in fiscal year 2025, for school-linked mental health grants under Minnesota
428.29 Statutes, section 245.4901.

429.1 Sec. 34. **FEDERAL SUBSTANCE ABUSE PREVENTION AND TREATMENT**
429.2 **BLOCK GRANT ALLOCATION; SCHOOL-LINKED SUBSTANCE ABUSE**
429.3 **GRANTS.**

429.4 (a) From the amount that Minnesota received under title II of the federal Consolidated
429.5 Appropriations Act of 2020, Public Law 116-260, for the substance abuse prevention and
429.6 treatment block grant, the commissioner of human services shall allocate $1,500,000 in
429.7 fiscal year 2022, $1,500,000 in fiscal year 2023, and $1,079,000 in fiscal year 2024, for
429.8 school-linked substance abuse grants under Minnesota Statutes, section 245.4901.

429.9 (b) From the amount that Minnesota received under section 2702 of the federal American
429.10 Rescue Plan Act, Public Law 117-2, for the substance abuse prevention and treatment block
429.11 grant, the commissioner shall allocate $421,000 in fiscal year 2024 and $1,500,000 in fiscal
429.12 year 2025, for school-linked substance abuse grants under Minnesota Statutes, section
429.13 245.4901.

429.14 Sec. 35. **FEDERAL SUBSTANCE ABUSE PREVENTION AND TREATMENT**
429.15 **BLOCK GRANT ALLOCATION; SUBSTANCE USE DISORDER TREATMENT**
429.16 **PATHFINDER COMPANION PILOT PROJECT.**

429.17 (a) From the amount that Minnesota received under title II of the federal Consolidated
429.18 Appropriations Act of 2020, Public Law 116-260, for the substance abuse prevention and
429.19 treatment block grant, the commissioner of human services shall allocate $250,000 in fiscal
429.20 year 2022 for a grant to Anoka County to conduct a substance use disorder treatment
429.21 pathfinder companion pilot project. This is a onetime allocation and is available until January
429.22 15, 2023.

429.23 (b) Of this allocation, up to $200,000 is for licensed use of the pathfinder companion
429.24 application for individuals participating in the pilot project and up to $50,000 is for licensed
429.25 use of the pathfinder bridge application for providers participating in the pilot project.

429.26 (c) From the amount that Minnesota received under section 2702 of the federal American
429.27 Rescue Plan Act, Public Law 117-2, for the substance abuse prevention and treatment block
429.28 grant, the commissioner shall allocate $300,000 in fiscal year 2022 for a grant to Anoka
429.29 County to conduct the substance use disorder treatment pathfinder companion pilot project.
429.30 This is a onetime allocation and is available until January 15, 2023.

430.1 Sec. 36. **FEDERAL SUBSTANCE ABUSE PREVENTION AND TREATMENT**
430.2 **BLOCK GRANT ALLOCATION; OPIOID EPIDEMIC RESPONSE GRANTS.**

430.3 (a) From the amount that Minnesota received under title II of the federal Consolidated
430.4 Appropriations Act of 2020, Public Law 116-260, for the substance abuse prevention and
430.5 treatment block grant, the commissioner of human services shall allocate $3,500,000 in
430.6 fiscal year 2022 and $3,500,000 in fiscal year 2023, for grants to be awarded according to
430.7 recommendations of the Opioid Epidemic Response Advisory Council under Minnesota
430.8 Statutes, section 256.042.

430.9 (b) From the amount that Minnesota received under Section 2702 of the federal American
430.10 Rescue Plan Act, Public Law 117-2, for the substance abuse prevention and treatment block
430.11 grant, the commissioner shall allocate $3,500,000 in fiscal year 2024 and $3,500,000 in
430.12 fiscal year 2025, for grants to be awarded according to recommendations of the Opioid
430.13 Epidemic Response Advisory Council under Minnesota Statutes, section 256.042.

430.14 (c) The commissioner shall include information on the grants awarded under this section
430.15 in the annual report under Minnesota Statutes, section 256.042, subdivision 5, paragraph
430.16 (a).

430.17 Sec. 37. **FEDERAL SUBSTANCE ABUSE PREVENTION AND TREATMENT**
430.18 **BLOCK GRANT ALLOCATION; RECOVERY COMMUNITY ORGANIZATION**
430.19 **INFRASTRUCTURE GRANTS.**

430.20 (a) From the amount that Minnesota received under title II of the federal Consolidated
430.21 Appropriations Act of 2020, Public Law 116-260, for the substance abuse prevention and

430.22 treatment block grant, the commissioner of human services shall allocate $2,000,000 in
430.23 fiscal year 2022 and $2,000,000 in fiscal year 2023, for grants to recovery community
430.24 organizations, as defined in Minnesota Statutes, section 254B.01, subdivision 8, to provide
430.25 community-based peer recovery support services that are not otherwise eligible for
430.26 reimbursement under Minnesota Statutes, section 254B.05.

430.27 (b) From the amount that Minnesota received under Section 2702 of the federal American
430.28 Rescue Plan Act, Public Law 117-2, for the substance abuse prevention and treatment block
430.29 grant for grants, the commissioner of human services shall allocate $2,000,000 in fiscal
430.30 year 2024 and $2,000,000 in fiscal year 2025, to recovery community organizations, as
430.31 defined in Minnesota Statutes, section 254B.01, subdivision 8, to provide community-based
430.32 peer recovery support services that are not otherwise eligible for reimbursement under
430.33 Minnesota Statutes, section 254B.05.

61.22 Sec. 55. **OPIATE EPIDEMIC RESPONSE ADVISORY COUNCIL; INITIAL**
61.23 **MEMBERSHIP TERMS.**

61.24 Notwithstanding Minnesota Statutes, section 256.042, subdivision 2, paragraph (c), the
61.25 initial term for members of the Opiate Epidemic Response Advisory Council established
61.26 under Minnesota Statutes, section 256.042, identified in Minnesota Statutes, section 256.042,
61.27 subdivision 2, paragraph (a), clauses (1), (3), (5), (7), (9), (11), (13), (15), and (17), ends
61.28 September 30, 2022. The initial term for members identified under Minnesota Statutes,
61.29 section 256.042, subdivision 2, paragraph (a), clauses (2), (4), (6), (8), (10), (12), (14), and
61.30 (16), ends September 30, 2023.

62.8 Sec. 57. **DIRECTIONS TO COMMISSIONER; SCREENING TOOL; SUBSTANCE**
62.9 **USE DISORDER REFORM EVALUATION; SUBSTANCE USE DISORDER**
62.10 **REFORM EDUCATION.**

62.11 (a) By July 1, 2022, the commissioner of human services shall develop or authorize a
62.12 tool for screening individuals for pretreatment coordination services and a template to
62.13 document an individual's screening result.

62.14 (b) By July 1, 2022, the commissioner of human services shall, in consultation with
62.15 counties and substance use disorder treatment providers, develop a tool to evaluate the
62.16 effects of substance use disorder treatment reform proposals enacted during the 2019 and
62.17 2021 legislative sessions, including access to services, appropriateness of services, and
62.18 accuracy of billing service units.

62.19 (c) By July 1, 2022, the commissioner of human services shall, in consultation with
62.20 counties and substance use disorder treatment providers, develop educational materials for
62.21 county staff, providers, and the general public regarding the content and timing of changes
62.22 for implementation pursuant to substance use disorder treatment reform proposals enacted
62.23 during the 2019 and 2021 legislative sessions.

63.3 Sec. 59. **FUNDING RECOMMENDATIONS FOR PRETREATMENT**
63.4 **COORDINATION SERVICES.**

63.5 If federal approval is not obtained for pretreatment coordination services under Minnesota
63.6 Statutes, section 256B.0625, subdivision 67, the commissioner of human services, in
63.7 consultation with the counties, shall submit recommendations on a funding mechanism for
63.8 pretreatment coordination services to the chairs and ranking minority members of the
63.9 legislative committees with jurisdiction over health hand human services policy and finance
63.10 by March 15, 2022.

H2128-4	UEH2128-1
511.21 Sec. 40. **REVISOR INSTRUCTION.**	431.1 Sec. 38. **REVISOR INSTRUCTION.**
511.22 The revisor of statutes shall replace "EXCELLENCE IN MENTAL HEALTH 511.23 DEMONSTRATION PROJECT" with "CERTIFIED COMMUNITY BEHAVIORAL 511.24 HEALTH CLINIC SERVICES" in the section headnote for Minnesota Statutes, section 511.25 245.735.	431.2 The revisor of statutes shall replace "EXCELLENCE IN MENTAL HEALTH 431.3 DEMONSTRATION PROJECT" with "CERTIFIED COMMUNITY BEHAVIORAL 431.4 HEALTH CLINIC SERVICES" in the section headnote for Minnesota Statutes, section 431.5 245.735.
511.26 Sec. 41. **REPEALER.**	431.6 Sec. 39. **REPEALER.**
511.27 (a) Minnesota Statutes 2020, section 256B.0596, is repealed.	
511.28 (b) Minnesota Statutes 2020, section 245.735, subdivisions 1, 2, and 4, are repealed.	431.7 Minnesota Statutes 2020, section 245.735, subdivisions 1, 2, and 4, are repealed.
511.29 (c) Minnesota Statutes 2020, section 245.4871, subdivision 32a, is repealed.	
511.30 **EFFECTIVE DATE.** Paragraph (c) is effective September 30, 2021.	431.8 **EFFECTIVE DATE.** This section is effective the day following final enactment.