ARTICLE 4

BEHAVIORAL HEALTH

Section 1. Minnesota Statutes 2022, section 4.046, subdivision 6, is amended to read:

Subd. 6. ~~**Addiction and recovery**~~ **Office of Addiction and Recovery; director.** An Office of Addiction and Recovery is created in the Department of Management and Budget. The governor must appoint an addiction and recovery director, who shall serve as chair of the subcabinet and administer the Office of Addiction and Recovery. The director shall serve in the unclassified service and shall report to the governor. The director must:

(1) make efforts to break down silos and work across agencies to better target the state's role in addressing addiction, treatment, and recovery;

(2) assist in leading the subcabinet and the advisory council toward progress on measurable goals that track the state's efforts in combatting addiction; and

(3) establish and manage external partnerships and build relationships with communities, community leaders, and those who have direct experience with addiction to ensure that all voices of recovery are represented in the work of the subcabinet and advisory council.

Sec. 2. Minnesota Statutes 2022, section 4.046, subdivision 7, is amended to read:

Subd. 7. **Staff and administrative support.** The commissioner of ~~human services~~ management and budget, in coordination with other state agencies and boards as applicable, must provide staffing and administrative support to the addiction and recovery director, the subcabinet, ~~and~~ the advisory council, and the Office of Addiction and Recovery established in this section.

Sec. 3. Minnesota Statutes 2022, section 4.046, is amended by adding a subdivision to read:

Subd. 8. **Division of Youth Substance Use and Addiction Recovery.** (a) A Division of Youth Substance Use and Addiction Recovery is created in the Office of Addiction and Recovery to focus on preventing adolescent substance use and addiction. The addiction and recovery director shall employ a director to lead the Division of Youth Substance Use and Addiction Recovery and staff necessary to fulfill its purpose.

(b) The director of the division shall:

(1) make efforts to bridge mental health and substance abuse treatment silos and work across agencies to focus the state's role and resources in preventing youth substance use and addiction;

(2) develop and share resources on evidence-based strategies and programs for addressing youth substance use and prevention;

ARTICLE 3

BEHAVIORAL HEALTH

Section 1. Minnesota Statutes 2022, section 4.046, subdivision 6, is amended to read:

Subd. 6. **Office of Addiction and** ~~**recovery**~~**Recovery; director.** The Office of Addiction and Recovery is created in the Department of Management and Budget. The governor must appoint an addiction and recovery director, who shall serve as chair of the subcabinet and administer the Office of Addiction and Recovery. The director shall serve in the unclassified service and shall report to the governor. The director must:

(1) make efforts to break down silos and work across agencies to better target the state's role in addressing addiction, treatment, and recovery for youth and adults;

(2) assist in leading the subcabinet and the advisory council toward progress on measurable goals that track the state's efforts in combatting addiction for youth and adults, and preventing substance use and addiction among the state's youth population; and

(3) establish and manage external partnerships and build relationships with communities, community leaders, and those who have direct experience with addiction to ensure that all voices of recovery are represented in the work of the subcabinet and advisory council.

Sec. 2. Minnesota Statutes 2022, section 4.046, subdivision 7, is amended to read:

Subd. 7. **Staff and administrative support.** The commissioner of ~~human services~~ management and budget, in coordination with other state agencies and boards as applicable, must provide staffing and administrative support to the Office of Addiction and Recovery, the addiction and recovery director, the subcabinet, and the advisory council established in this section.

(3) establish and manage external partnerships and build relationships with communities, community leaders, and persons and organizations with direct experience with youth substance use and addiction; and

(4) work to achieve progress on established measurable goals that track the state's efforts in preventing substance use and addiction among the state's youth population.

Sec. 3. Minnesota Statutes 2022, section 245.91, subdivision 4, is amended to read:

Subd. 4. **Facility or program.** "Facility" or "program" means a nonresidential or residential program as defined in section 245A.02, subdivisions 10 and 14, and any agency, facility, or program that provides services or treatment for mental illness, developmental disability, substance use disorder, or emotional disturbance that is required to be licensed, certified, or registered by the commissioner of human services, health, or education; a sober home under section 254B.18; and an acute care inpatient facility that provides services or treatment for mental illness, developmental disability, substance use disorder, or emotional disturbance.

Sec. 4. Minnesota Statutes 2022, section 245G.01, is amended by adding a subdivision to read:

Subd. 4a. **American Society of Addiction Medicine criteria or ASAM criteria.** "American Society of Addiction Medicine criteria" or "ASAM criteria" has the meaning provided in section 254B.01, subdivision 2a.

EFFECTIVE DATE. This section is effective January 1, 2024.

Sec. 4. Minnesota Statutes 2022, section 245G.01, is amended by adding a subdivision to read:

Subd. 4a. **American Society of Addiction Medicine criteria or ASAM criteria.** "American Society of Addiction Medicine criteria" or "ASAM criteria" has the meaning provided in section 254B.01, subdivision 2a.

Sec. 5. Minnesota Statutes 2022, section 245G.01, is amended by adding a subdivision to read:

Subd. 20c. **Protective factors.** "Protective factors" means the actions or efforts a person can take to reduce the negative impact of certain issues, such as substance use disorders, mental health disorders, and risk of suicide. Protective factors include connecting to positive supports in the community, a good diet, exercise, attending counseling or 12-step groups, and taking medications.

EFFECTIVE DATE. This section is effective January 1, 2024.

Sec. 5. Minnesota Statutes 2022, section 245G.01, is amended by adding a subdivision to read:

Subd. 20c. **Protective factors.** "Protective factors" means the actions or efforts a person can take to reduce the negative impact of certain issues, such as substance use disorders, mental health disorders, and risk of suicide. Protective factors include connecting to positive supports in the community, a nutritious diet, exercise, attending counseling or 12-step groups, and taking appropriate medications.

Sec. 6. Minnesota Statutes 2022, section 245G.02, subdivision 2, is amended to read:

Subd. 2. **Exemption from license requirement.** This chapter does not apply to a county or recovery community organization that is providing a service for which the county or recovery community organization is an eligible vendor under section 254B.05. This chapter does not apply to an organization whose primary functions are information, referral, diagnosis, case management, and assessment for the purposes of client placement, education, support group services, or self-help programs. This chapter does not apply to the activities

Sec. 6. Minnesota Statutes 2022, section 245G.02, subdivision 2, is amended to read:

Subd. 2. **Exemption from license requirement.** This chapter does not apply to a county or recovery community organization that is providing a service for which the county or recovery community organization is an eligible vendor under section 254B.05. This chapter does not apply to an organization whose primary functions are information, referral, diagnosis, case management, and assessment for the purposes of client placement, education, support group services, or self-help programs. This chapter does not apply to the activities

of a licensed professional in private practice. A license holder providing the initial set of substance use disorder services allowable under section 254A.03, subdivision 3, paragraph (c), to an individual referred to a licensed nonresidential substance use disorder treatment program after a positive screen for alcohol or substance misuse is exempt from sections 245G.05; 245G.06, subdivisions 1, 1a, 2, and 4; 245G.07, subdivisions 1, paragraph (a), clauses (2) to (4), and 2, clauses (1) to (7); and 245G.17.

EFFECTIVE DATE. This section is effective January 1, 2024.

Sec. 7. Minnesota Statutes 2022, section 245G.05, subdivision 1, is amended to read:

Subdivision 1. **Comprehensive assessment.** ~~(a)~~ A comprehensive assessment of the client's substance use disorder must be administered face-to-face by an alcohol and drug counselor within ~~three~~ five calendar days from the day of service initiation for a residential program or ~~within three calendar days on which a treatment session has been provided of the day of service initiation for a client~~ by the end of the fifth day on which a treatment service is provided in a nonresidential program. The number of days to complete the comprehensive assessment excludes the day of service initiation. If the comprehensive assessment is not completed within the required time frame, the person-centered reason for the delay and the planned completion date must be documented in the client's file. The comprehensive assessment is complete upon a qualified staff member's dated signature. If the client received a comprehensive assessment that authorized the treatment service, an alcohol and drug counselor may use the comprehensive assessment for requirements of this subdivision but must document a review of the comprehensive assessment and update the comprehensive assessment as clinically necessary to ensure compliance with this subdivision within applicable timelines. ~~The comprehensive assessment must include sufficient information to complete the assessment summary according to subdivision 2 and the individual treatment plan according to section 245G.06. The comprehensive assessment must include information about the client's needs that relate to substance use and personal strengths that support recovery, including:~~

~~(1) age, sex, cultural background, sexual orientation, living situation, economic status, and level of education;~~

~~(2) a description of the circumstances on the day of service initiation;~~

~~(3) a list of previous attempts at treatment for substance misuse or substance use disorder, compulsive gambling, or mental illness;~~

~~(4) a list of substance use history including amounts and types of substances used, frequency and duration of use, periods of abstinence, and circumstances of relapse, if any. For each substance used within the previous 30 days, the information must include the date of the most recent use and address the absence or presence of previous withdrawal symptoms;~~

~~(5) specific problem behaviors exhibited by the client when under the influence of substances;~~

~~(6) the client's desire for family involvement in the treatment program, family history of substance use and misuse, history or presence of physical or sexual abuse, and level of family support;~~

~~(7) physical and medical concerns or diagnoses, current medical treatment needed or being received related to the diagnoses, and whether the concerns need to be referred to an appropriate health care professional;~~

~~(8) mental health history, including symptoms and the effect on the client's ability to function; current mental health treatment; and psychotropic medication needed to maintain stability. The assessment must utilize screening tools approved by the commissioner pursuant to section 245.4863 to identify whether the client screens positive for co-occurring disorders;~~

~~(9) arrests and legal interventions related to substance use;~~

~~(10) a description of how the client's use affected the client's ability to function appropriately in work and educational settings;~~

~~(11) ability to understand written treatment materials, including rules and the client's rights;~~

~~(12) a description of any risk-taking behavior, including behavior that puts the client at risk of exposure to blood-borne or sexually transmitted diseases;~~

~~(13) social network in relation to expected support for recovery;~~

~~(14) leisure time activities that are associated with substance use;~~

~~(15) whether the client is pregnant and, if so, the health of the unborn child and the client's current involvement in prenatal care;~~

~~(16) whether the client recognizes needs related to substance use and is willing to follow treatment recommendations; and~~

~~(17) information from a collateral contact may be included, but is not required.~~

~~(b) If the client is identified as having opioid use disorder or seeking treatment for opioid use disorder, the program must provide educational information to the client concerning:~~

~~(1) risks for opioid use disorder and dependence;~~

~~(2) treatment options, including the use of a medication for opioid use disorder;~~

~~(3) the risk of and recognizing opioid overdose; and~~

~~(4) the use, availability, and administration of naloxone to respond to opioid overdose.~~

~~(c) The commissioner shall develop educational materials that are supported by research and updated periodically. The license holder must use the educational materials that are approved by the commissioner to comply with this requirement.~~

~~(6) the client's desire for family involvement in the treatment program, family history of substance use and misuse, history or presence of physical or sexual abuse, and level of family support;~~

~~(7) physical and medical concerns or diagnoses, current medical treatment needed or being received related to the diagnoses, and whether the concerns need to be referred to an appropriate health care professional;~~

~~(8) mental health history, including symptoms and the effect on the client's ability to function; current mental health treatment; and psychotropic medication needed to maintain stability. The assessment must utilize screening tools approved by the commissioner pursuant to section 245.4863 to identify whether the client screens positive for co-occurring disorders;~~

~~(9) arrests and legal interventions related to substance use;~~

~~(10) a description of how the client's use affected the client's ability to function appropriately in work and educational settings;~~

~~(11) ability to understand written treatment materials, including rules and the client's rights;~~

~~(12) a description of any risk-taking behavior, including behavior that puts the client at risk of exposure to blood-borne or sexually transmitted diseases;~~

~~(13) social network in relation to expected support for recovery;~~

~~(14) leisure time activities that are associated with substance use;~~

~~(15) whether the client is pregnant and, if so, the health of the unborn child and the client's current involvement in prenatal care;~~

~~(16) whether the client recognizes needs related to substance use and is willing to follow treatment recommendations; and~~

~~(17) information from a collateral contact may be included, but is not required.~~

~~(b) If the client is identified as having opioid use disorder or seeking treatment for opioid use disorder, the program must provide educational information to the client concerning:~~

~~(1) risks for opioid use disorder and dependence;~~

~~(2) treatment options, including the use of a medication for opioid use disorder;~~

~~(3) the risk of and recognizing opioid overdose; and~~

~~(4) the use, availability, and administration of naloxone to respond to opioid overdose.~~

~~(c) The commissioner shall develop educational materials that are supported by research and updated periodically. The license holder must use the educational materials that are approved by the commissioner to comply with this requirement.~~

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~~(d) If the comprehensive assessment is completed to authorize treatment service for the client, at the earliest opportunity during the assessment interview the assessor shall determine if:~~

~~(1) the client is in severe withdrawal and likely to be a danger to self or others;~~

~~(2) the client has severe medical problems that require immediate attention; or~~

~~(3) the client has severe emotional or behavioral symptoms that place the client or others at risk of harm.~~

~~If one or more of the conditions in clauses (1) to (3) are present, the assessor must end the assessment interview and follow the procedures in the program's medical services plan under section 245G.08, subdivision 2, to help the client obtain the appropriate services. The assessment interview may resume when the condition is resolved.~~ An alcohol and drug counselor must sign and date the comprehensive assessment review and update.

EFFECTIVE DATE. This section is effective January 1, 2024.

Sec. 8. Minnesota Statutes 2022, section 245G.05, is amended by adding a subdivision to read:

Subd. 3. **Comprehensive assessment requirements.** (a) A comprehensive assessment must meet the requirements under section 245I.10, subdivision 6, paragraphs (b) and (c). A comprehensive assessment must also include:

(1) a diagnosis of a substance use disorder or a finding that the client does not meet the criteria for a substance use disorder;

(2) a determination of whether the individual screens positive for co-occurring mental health disorders using a screening tool approved by the commissioner pursuant to section 245.4863, except when the comprehensive assessment is being completed as part of a diagnostic assessment; and

(3) a recommendation for the ASAM level of care identified in section 254B.19, subdivision 1.

(b) If the individual is assessed for opioid use disorder, the program must provide educational material to the client within 24 hours of service initiation on:

(1) risks for opioid use disorder and dependence;

(2) treatment options, including the use of a medication for opioid use disorder;

(3) the risk of recognizing opioid overdose; and

House Language UES2934-2

~~(d) If the comprehensive assessment is completed to authorize treatment service for the client, at the earliest opportunity during the assessment interview the assessor shall determine if:~~

~~(1) the client is in severe withdrawal and likely to be a danger to self or others;~~

~~(2) the client has severe medical problems that require immediate attention; or~~

~~(3) the client has severe emotional or behavioral symptoms that place the client or others at risk of harm.~~

~~If one or more of the conditions in clauses (1) to (3) are present, the assessor must end the assessment interview and follow the procedures in the program's medical services plan under section 245G.08, subdivision 2, to help the client obtain the appropriate services. The assessment interview may resume when the condition is resolved.~~ An alcohol and drug counselor must sign and date the comprehensive assessment review and update.

EFFECTIVE DATE. This section is effective January 1, 2024.

Sec. 8. Minnesota Statutes 2022, section 245G.05, is amended by adding a subdivision to read:

Subd. 3. **Comprehensive assessment requirements.** (a) A comprehensive assessment must meet the requirements under section 245I.10, subdivision 6, paragraphs (b) and (c). It must also include:

(1) a diagnosis of a substance use disorder or a finding that the client does not meet the criteria for a substance use disorder;

(2) a determination of whether the individual screens positive for co-occurring mental health disorders using a screening tool approved by the commissioner pursuant to section 245.4863;

(3) a risk rating and summary to support the risk ratings within each of the dimensions listed in section 254B.04, subdivision 4; and

(4) a recommendation for the ASAM level of care identified in section 254B.19, subdivision 1.

(b) If the individual is assessed for opioid use disorder, the program must provide educational material to the client within 24 hours of service initiation on:

(1) risks for opioid use disorder and dependence;

(2) treatment options, including the use of a medication for opioid use disorder;

(3) the risk and recognition of opioid overdose; and

(4) the use, availability, and administration of naloxone to respond to opioid overdose.

If the client is identified as having opioid use disorder at a later point, the education must be provided at that point. The license holder must use the educational materials that are approved by the commissioner to comply with this requirement.

EFFECTIVE DATE. This section is effective January 1, 2024.

Sec. 9. Minnesota Statutes 2022, section 245G.06, subdivision 1, is amended to read:

Subdivision 1. **General.** Each client must have a person-centered individual treatment plan developed by an alcohol and drug counselor within ten days from the day of service initiation for a residential program ~~and within five calendar days~~ by the end of the tenth day on which a treatment session has been provided from the day of service initiation for a client in a nonresidential program, not to exceed 30 days. Opioid treatment programs must complete the individual treatment plan within 21 days from the day of service initiation. The number of days to complete the individual treatment plan excludes the day of service initiation. The individual treatment plan must be signed by the client and the alcohol and drug counselor and document the client's involvement in the development of the plan. The individual treatment plan is developed upon the qualified staff member's dated signature. Treatment planning must include ongoing assessment of client needs. An individual treatment plan must be updated based on new information gathered about the client's condition, the client's level of participation, and on whether methods identified have the intended effect. A change to the plan must be signed by the client and the alcohol and drug counselor. If the client chooses to have family or others involved in treatment services, the client's individual treatment plan must include how the family or others will be involved in the client's treatment. If a client is receiving treatment services or an assessment via telehealth and the alcohol and drug counselor documents the reason the client's signature cannot be obtained, the alcohol and drug counselor may document the client's verbal approval or electronic written approval of the treatment plan or change to the treatment plan in lieu of the client's signature.

EFFECTIVE DATE. This section is effective January 1, 2024.

Sec. 10. Minnesota Statutes 2022, section 245G.06, is amended by adding a subdivision to read:

Subd. 1a. **Individual treatment plan contents and process.** (a) After completing a client's comprehensive assessment, the license holder must complete an individual treatment plan. The license holder must:

(1) base the client's individual treatment plan on the client's comprehensive assessment;

(2) use a person-centered, culturally appropriate planning process that allows the client's family and other natural supports to observe and participate in the client's individual treatment services, assessments, and treatment planning;

(4) the use, availability, and administration of an opiate antagonist to respond to opioid overdose.

If the client is identified as having opioid use disorder at a later point, the required educational material must be provided at that point. The license holder must use the educational materials that are approved by the commissioner to comply with this requirement.

EFFECTIVE DATE. This section is effective January 1, 2024.

Sec. 9. Minnesota Statutes 2022, section 245G.06, subdivision 1, is amended to read:

Subdivision 1. **General.** Each client must have a person-centered individual treatment plan developed by an alcohol and drug counselor within ten days from the day of service initiation for a residential program ~~and within five calendar days,~~ by the end of the tenth day on which a treatment session has been provided from the day of service initiation for a client in a nonresidential program, not to exceed 30 days. Opioid treatment programs must complete the individual treatment plan within 21 days from the day of service initiation. The number of days to complete the individual treatment plan excludes the day of service initiation. The individual treatment plan must be signed by the client and the alcohol and drug counselor and document the client's involvement in the development of the plan. The individual treatment plan is developed upon the qualified staff member's dated signature. Treatment planning must include ongoing assessment of client needs. An individual treatment plan must be updated based on new information gathered about the client's condition, the client's level of participation, and on whether methods identified have the intended effect. A change to the plan must be signed by the client and the alcohol and drug counselor. If the client chooses to have family or others involved in treatment services, the client's individual treatment plan must include how the family or others will be involved in the client's treatment. If a client is receiving treatment services or an assessment via telehealth and the alcohol and drug counselor documents the reason the client's signature cannot be obtained, the alcohol and drug counselor may document the client's verbal approval or electronic written approval of the treatment plan or change to the treatment plan in lieu of the client's signature.

EFFECTIVE DATE. This section is effective January 1, 2024.

Sec. 10. Minnesota Statutes 2022, section 245G.06, is amended by adding a subdivision to read:

Subd. 1a. **Individual treatment plan contents and process.** (a) After completing a client's comprehensive assessment, the license holder must complete an individual treatment plan. The license holder must:

(1) base the client's individual treatment plan on the client's comprehensive assessment;

(2) use a person-centered, culturally appropriate planning process that allows the client's family and other natural supports to observe and participate in the client's individual treatment services, assessments, and treatment planning;

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(3) identify the client's treatment goals in relation to any or all of the applicable ASAM six dimensions identified in section 254B.04, subdivision 4, to ensure measurable treatment objectives, a treatment strategy, and a schedule for accomplishing the client's treatment goals and objectives;

(4) document in the treatment plan the ASAM level of care identified in section 254B.19, subdivision 1, that the client is receiving services under;

(5) identify the participants involved in the client's treatment planning. The client must be a participant in the client's treatment planning. If applicable, the license holder must document the reasons that the license holder did not involve the client's family or other natural supports in the client's treatment planning;

(6) identify resources to refer the client to when the client's needs are to be addressed concurrently by another provider; and

(7) identify maintenance strategy goals and methods designed to address relapse prevention and to strengthen the client's protective factors.

EFFECTIVE DATE. This section is effective January 1, 2024.

Sec. 11. Minnesota Statutes 2022, section 245G.06, subdivision 3, is amended to read:

Subd. 3. **Treatment plan review.** A treatment plan review must be ~~entered in a client's file weekly or after each treatment service, whichever is less frequent,~~ completed by the alcohol and drug counselor responsible for the client's treatment plan. The review must indicate the span of time covered by the review ~~and each of the six dimensions listed in section 245G.05, subdivision 2, paragraph (c)~~. The review must:

(1) ~~address each goal in the~~ document client goals addressed since the last treatment plan review and whether the identified methods ~~to address the goals are~~ continue to be effective;

(2) ~~include~~ document monitoring of any physical and mental health problems and include toxicology results for alcohol and substance use, when available;

(3) document the participation of others involved in the individual's treatment planning, including when services are offered to the client's family or natural supports;

(4) if changes to the treatment plan are determined to be necessary, document staff recommendations for changes in the methods identified in the treatment plan and whether the client agrees with the change; ~~and~~

(5) include a review and evaluation of the individual abuse prevention plan according to section 245A.65~~.~~; and

(6) document any referrals made since the previous treatment plan review.

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(3) identify the client's treatment goals in relation to any or all of the applicable ASAM six dimensions identified in section 254B.04, subdivision 4, to ensure measurable treatment objectives, a treatment strategy, and a schedule for accomplishing the client's treatment goals and objectives;

(4) document in the treatment plan the ASAM level of care identified in section 254B.19, subdivision 1, under which the client is receiving services;

(5) identify the participants involved in the client's treatment planning. The client must participate in the client's treatment planning. If applicable, the license holder must document the reasons that the license holder did not involve the client's family or other natural supports in the client's treatment planning;

(6) identify resources to refer the client to when the client's needs will be addressed concurrently by another provider; and

(7) identify maintenance strategy goals and methods designed to address relapse prevention and to strengthen the client's protective factors.

EFFECTIVE DATE. This section is effective January 1, 2024.

Sec. 11. Minnesota Statutes 2022, section 245G.06, subdivision 3, is amended to read:

Subd. 3. **Treatment plan review.** A treatment plan review must be ~~entered in a client's file weekly or after each treatment service, whichever is less frequent,~~ completed by the alcohol and drug counselor responsible for the client's treatment plan. The review must indicate the span of time covered by the review ~~and each of the six dimensions listed in section 245G.05, subdivision 2, paragraph (c). The review~~ and must:

(1) ~~address each goal in the~~ document client goals addressed since the last treatment plan review and whether the identified methods ~~to address the goals are~~ continue to be effective;

(2) ~~include~~ document monitoring of any physical and mental health problems and include toxicology results for alcohol and substance use, when available;

(3) document the participation of others involved in the individual's treatment planning, including when services are offered to the client's family or significant others;

(4) if changes to the treatment plan are determined to be necessary, document staff recommendations for changes in the methods identified in the treatment plan and whether the client agrees with the change; ~~and~~

(5) include a review and evaluation of the individual abuse prevention plan according to section 245A.65~~.~~; and

(6) document any referrals made since the previous treatment plan review.

EFFECTIVE DATE. This section is effective January 1, 2024.

Sec. 12. Minnesota Statutes 2022, section 245G.06, is amended by adding a subdivision to read:

Subd. 3a. **Frequency of treatment plan reviews.** (a) A license holder must ensure that the alcohol and drug counselor responsible for a client's treatment plan completes and documents a treatment plan review that meets the requirements of subdivision 3 in each client's file according to the frequencies required in this subdivision. All ASAM levels referred to in this chapter are those described in section 254B.19, subdivision 1.

(b) For a client receiving residential ASAM level 3.3 or 3.5 high-intensity services or residential hospital-based services, a treatment plan review must be completed once every 14 days.

(c) For a client receiving residential ASAM level 3.1 low-intensity services or any other residential level not listed in paragraph (b), a treatment plan review must be completed once every 30 days.

(d) For a client receiving nonresidential ASAM level 2.5 partial hospitalization services, a treatment plan review must be completed once every 14 days.

(e) For a client receiving nonresidential ASAM level 1.0 outpatient or 2.1 intensive outpatient services or any other nonresidential level not included in paragraph (d), a treatment plan review must be completed once every 30 days.

(f) For a client receiving nonresidential opioid treatment program services according to section 245G.22, a treatment plan review must be completed weekly for the ten weeks following completion of the treatment plan and monthly thereafter. Treatment plan reviews must be completed more frequently when clinical needs warrant.

(g) Notwithstanding paragraphs (e) and (f), for a client in a nonresidential program with a treatment plan that clearly indicates less than five hours of skilled treatment services will be provided to the client each month, a treatment plan review must be completed once every 90 days.

EFFECTIVE DATE. This section is effective January 1, 2024.

Sec. 13. Minnesota Statutes 2022, section 245G.06, subdivision 4, is amended to read:

Subd. 4. **Service discharge summary.** (a) An alcohol and drug counselor must write a service discharge summary for each client. The service discharge summary must be completed within five days of the client's service termination. A copy of the client's service discharge summary must be provided to the client upon the client's request.

(b) The service discharge summary must be recorded in the six dimensions listed in section ~~245G.05, subdivision 2, paragraph (c)~~ 254B.04, subdivision 4, and include the following information:

(1) the client's issues, strengths, and needs while participating in treatment, including services provided;

(2) the client's progress toward achieving each goal identified in the individual treatment plan;

(3) a risk description according to section ~~245G.05~~ 254B.04, subdivision 4;

(4) the reasons for and circumstances of service termination. If a program discharges a client at staff request, the reason for discharge and the procedure followed for the decision to discharge must be documented and comply with the requirements in section 245G.14, subdivision 3, clause (3);

(5) the client's living arrangements at service termination;

(6) continuing care recommendations, including transitions between more or less intense services, or more frequent to less frequent services, and referrals made with specific attention to continuity of care for mental health, as needed; and

(7) service termination diagnosis.

Sec. 14. Minnesota Statutes 2022, section 245G.09, subdivision 3, is amended to read:

Subd. 3. **Contents.** Client records must contain the following:

(1) documentation that the client was given information on client rights and responsibilities, grievance procedures, tuberculosis, and HIV, and that the client was provided an orientation to the program abuse prevention plan required under section 245A.65, subdivision 2, paragraph (a), clause (4). If the client has an opioid use disorder, the record must contain documentation that the client was provided educational information according to section 245G.05, subdivision ~~1~~ 3, paragraph (b);

(2) an initial services plan completed according to section 245G.04;

(3) a comprehensive assessment completed according to section 245G.05;

~~(4) an assessment summary completed according to section 245G.05, subdivision 2;~~

~~(5)~~ an individual abuse prevention plan according to sections 245A.65, subdivision 2, and 626.557, subdivision 14, when applicable;

~~(6)~~ (5) an individual treatment plan according to section 245G.06, subdivisions 1 and ~~2~~ 1a;

~~(7)~~ (6) documentation of treatment services, significant events, appointments, concerns, and treatment plan reviews according to section 245G.06, subdivisions 2a, 2b, ~~and~~ 3, and 3a; and

(1) the client's issues, strengths, and needs while participating in treatment, including services provided;

(2) the client's progress toward achieving each goal identified in the individual treatment plan;

(3) a risk description according to section ~~245G.05~~ 254B.04, subdivision 4;

(4) the reasons for and circumstances of service termination. If a program discharges a client at staff request, the reason for discharge and the procedure followed for the decision to discharge must be documented and comply with the requirements in section 245G.14, subdivision 3, clause (3);

(5) the client's living arrangements at service termination;

(6) continuing care recommendations, including transitions between more or less intense services, or more frequent to less frequent services, and referrals made with specific attention to continuity of care for mental health, as needed; and

(7) service termination diagnosis.

EFFECTIVE DATE. This section is effective January 1, 2024.

Sec. 14. Minnesota Statutes 2022, section 245G.09, subdivision 3, is amended to read:

Subd. 3. **Contents.** Client records must contain the following:

(1) documentation that the client was given information on client rights and responsibilities, grievance procedures, tuberculosis, and HIV, and that the client was provided an orientation to the program abuse prevention plan required under section 245A.65, subdivision 2, paragraph (a), clause (4). If the client has an opioid use disorder, the record must contain documentation that the client was provided educational information according to section 245G.05, subdivision ~~1~~ 3, paragraph (b);

(2) an initial services plan completed according to section 245G.04;

(3) a comprehensive assessment completed according to section 245G.05;

~~(4) an assessment summary completed according to section 245G.05, subdivision 2;~~

~~(5)~~ (4) an individual abuse prevention plan according to sections 245A.65, subdivision 2, and 626.557, subdivision 14, when applicable;

~~(6)~~ (5) an individual treatment plan according to section 245G.06, subdivisions 1 and 2;

~~(7)~~ (6) documentation of treatment services, significant events, appointments, concerns, and treatment plan reviews according to section 245G.06, subdivisions 2a, 2b, ~~and~~ 3, and 3a; and

~~(8)~~ (7) a summary at the time of service termination according to section 245G.06, subdivision 4.

Sec. 15. Minnesota Statutes 2022, section 245G.22, subdivision 15, is amended to read:

Subd. 15. **Nonmedication treatment services; documentation.** (a) The program must ~~offer at least 50 consecutive minutes of individual or group therapy treatment services as defined in section 245G.07, subdivision 1, paragraph (a), clause (1), per week, for the first ten weeks following the day of service initiation, and at least 50 consecutive minutes per month thereafter. As clinically appropriate, the program may offer these services cumulatively and not consecutively in increments of no less than 15 minutes over the required time period, and for a total of 60 minutes of treatment services over the time period, and must document the reason for providing services cumulatively in the client's record. The program may offer additional levels of service when deemed clinically necessary~~ meet the requirements in section 245G.07, subdivision 1, paragraph (a), and must document each time the client was offered an individual or group counseling service. If the individual or group counseling service was offered but not provided to the client, the license holder must document the reason the service was not provided. If the service was provided, the license holder must ensure the service is documented according to the requirements in section 245G.06, subdivision 2a.

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

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

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

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

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

EFFECTIVE DATE. This section is effective January 1, 2024.

Sec. 16. Minnesota Statutes 2022, section 245I.10, subdivision 6, is amended to read:

Subd. 6. **Standard diagnostic assessment; required elements.** (a) Only a mental health professional or a clinical trainee may complete a standard diagnostic assessment of a client. A standard diagnostic assessment of a client must include a face-to-face interview with a

~~(8)~~ (7) a summary at the time of service termination according to section 245G.06, subdivision 4.

EFFECTIVE DATE. This section is effective January 1, 2024.

Sec. 15. Minnesota Statutes 2022, section 245G.22, subdivision 15, is amended to read:

Subd. 15. **Nonmedication treatment services; documentation.** (a) The program must ~~offer at least 50 consecutive minutes of individual or group therapy treatment services as defined in section 245G.07, subdivision 1, paragraph (a), clause (1), per week, for the first ten weeks following the day of service initiation, and at least 50 consecutive minutes per month thereafter. As clinically appropriate, the program may offer these services cumulatively and not consecutively in increments of no less than 15 minutes over the required time period, and for a total of 60 minutes of treatment services over the time period, and must document the reason for providing services cumulatively in the client's record. The program may offer additional levels of service when deemed clinically necessary~~ meet the requirements in section 245G.07, subdivision 1, paragraph (a), and must document each time the client was offered an individual or group counseling service. If the individual or group counseling service was offered but not provided to the client, the license holder must document the reason the service was not provided. If the service was provided, the license holder must ensure that the service is documented according to the requirements in section 245G.06, subdivision 2a.

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

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

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

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

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

EFFECTIVE DATE. This section is effective January 1, 2024.

Sec. 16. Minnesota Statutes 2022, section 245I.10, subdivision 6, is amended to read:

Subd. 6. **Standard diagnostic assessment; required elements.** (a) Only a mental health professional or a clinical trainee may complete a standard diagnostic assessment of a client. A standard diagnostic assessment of a client must include a face-to-face interview with a

client and a written evaluation of the client. The assessor must complete a client's standard diagnostic assessment within the client's cultural context. An alcohol and drug counselor may gather and document the information in paragraphs (b) and (c) when completing a comprehensive assessment according to section 245G.05.

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

(1) the client's age;

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

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

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

(5) the client's current medications;

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

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

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

(9) the client's history of mental health and substance use disorder treatment; ~~and~~

(10) cultural influences on the client~~.~~; and

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

(i) amounts and types of substances, frequency and duration, route of administration, periods of abstinence, and circumstances of relapse; and

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

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

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

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

client and a written evaluation of the client. The assessor must complete a client's standard diagnostic assessment within the client's cultural context. An alcohol and drug counselor may gather and document the information in paragraphs (b) and (c) when completing a comprehensive assessment according to section 245G.05.

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

(1) the client's age;

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

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

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

(5) the client's current medications;

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

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

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

(9) the client's history of mental health and substance use disorder treatment; ~~and~~

(10) cultural influences on the client~~.~~; and

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

(i) amounts and types of substances, frequency and duration, route of administration, periods of abstinence, and circumstances of relapse; and

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

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

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

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

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

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

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

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

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

(1) When completing a standard diagnostic assessment of a client who is five years of age or younger, the assessor must use the current edition of the DC: 0-5 Diagnostic Classification of Mental Health and Development Disorders of Infancy and Early Childhood published by Zero to Three.

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

(3) When completing a standard diagnostic assessment of a client who is five years of age or younger, an assessor must administer the Early Childhood Service Intensity Instrument (ECSII) to the client and include the results in the client's assessment.

(4) When completing a standard diagnostic assessment of a client who is six to 17 years of age, an assessor must administer the Child and Adolescent Service Intensity Instrument (CASII) to the client and include the results in the client's assessment.

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

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

(1) the client's mental status examination;

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

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

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

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

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

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

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

(1) When completing a standard diagnostic assessment of a client who is five years of age or younger, the assessor must use the current edition of the DC: 0-5 Diagnostic Classification of Mental Health and Development Disorders of Infancy and Early Childhood published by Zero to Three.

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

(3) When completing a standard diagnostic assessment of a client who is five years of age or younger, an assessor must administer the Early Childhood Service Intensity Instrument (ECSII) to the client and include the results in the client's assessment.

(4) When completing a standard diagnostic assessment of a client who is six to 17 years of age, an assessor must administer the Child and Adolescent Service Intensity Instrument (CASII) to the client and include the results in the client's assessment.

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

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

(1) the client's mental status examination;

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

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

Senate Language S2934-3

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

House Language UES2934-2

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

Sec. 17. Minnesota Statutes 2022, section 253B.10, subdivision 1, is amended to read:

Subdivision 1. **Administrative requirements.** (a) When a person is committed, the court shall issue a warrant or an order committing the patient to the custody of the head of the treatment facility, state-operated treatment program, or community-based treatment program. The warrant or order shall state that the patient meets the statutory criteria for civil commitment.

(b) The commissioner shall prioritize civilly committed patients who are determined by the Office of Medical Director or a designee to require emergency admission to a state-operated treatment program, as well as patients being admitted from jail or a correctional institution who are:

(1) ordered confined in a state-operated treatment program for an examination under Minnesota Rules of Criminal Procedure, rules 20.01, subdivision 4, paragraph (a), and 20.02, subdivision 2;

(2) under civil commitment for competency treatment and continuing supervision under Minnesota Rules of Criminal Procedure, rule 20.01, subdivision 7;

(3) found not guilty by reason of mental illness under Minnesota Rules of Criminal Procedure, rule 20.02, subdivision 8, and under civil commitment or are ordered to be detained in a state-operated treatment program pending completion of the civil commitment proceedings; or

(4) committed under this chapter to the commissioner after dismissal of the patient's criminal charges.

Patients described in this paragraph must be admitted to a state-operated treatment program within 48 hours of the Office of Medical Director or a designee determining that a medically appropriate bed is available. The commitment must be ordered by the court as provided in section 253B.09, subdivision 1, paragraph (d).

(c) Upon the arrival of a patient at the designated treatment facility, state-operated treatment program, or community-based treatment program, the head of the facility or program shall retain the duplicate of the warrant and endorse receipt upon the original warrant or acknowledge receipt of the order. The endorsed receipt or acknowledgment must be filed in the court of commitment. After arrival, the patient shall be under the control and custody of the head of the facility or program.

(d) Copies of the petition for commitment, the court's findings of fact and conclusions of law, the court order committing the patient, the report of the court examiners, and the prepetition report, and any medical and behavioral information available shall be provided

Senate Language S2934-3

House Language UES2934-2

at the time of admission of a patient to the designated treatment facility or program to which the patient is committed. Upon a patient's referral to the commissioner of human services for admission pursuant to subdivision 1, paragraph (b), any inpatient hospital, treatment facility, jail, or correctional facility that has provided care or supervision to the patient in the previous two years shall, when requested by the treatment facility or commissioner, provide copies of the patient's medical and behavioral records to the Department of Human Services for purposes of preadmission planning. This information shall be provided by the head of the treatment facility to treatment facility staff in a consistent and timely manner and pursuant to all applicable laws.

Sec. 17. Minnesota Statutes 2022, section 254B.01, is amended by adding a subdivision to read:

Subd. 2a. **American Society of Addiction Medicine criteria or ASAM criteria.** "American Society of Addiction Medicine criteria" or "ASAM" means the clinical guidelines for purposes of the assessment, treatment, placement, and transfer or discharge of individuals with substance use disorders. The ASAM criteria are contained in the current edition of the *ASAM Criteria: Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions*.

Sec. 18. Minnesota Statutes 2022, section 254B.01, is amended by adding a subdivision to read:

Subd. 2a. **American Society of Addiction Medicine criteria or ASAM criteria.** "American Society of Addiction Medicine criteria" or "ASAM" means the clinical guidelines for purposes of assessment, treatment, placement, and transfer or discharge of individuals with substance use disorders. The ASAM criteria are contained in the current edition of the *ASAM Criteria: Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions*.

Sec. 18. Minnesota Statutes 2022, section 254B.01, subdivision 8, is amended to read:

Subd. 8. **Recovery community organization.** "Recovery community organization" means an independent organization led and governed by representatives of local communities of recovery. A recovery community organization mobilizes resources within and outside of the recovery community to increase the prevalence and quality of long-term recovery from ~~alcohol and other drug addiction~~ substance use disorder. Recovery community organizations provide peer-based recovery support activities such as training of recovery peers. Recovery community organizations provide mentorship and ongoing support to individuals dealing with a substance use disorder and connect them with the resources that can support each person's recovery. A recovery community organization also promotes a recovery-focused orientation in community education and outreach programming, and organize recovery-focused policy advocacy activities to foster healthy communities and reduce the stigma of substance use disorder.

Sec. 19. Minnesota Statutes 2022, section 254B.01, is amended by adding a subdivision to read:

Subd. 9. **Skilled treatment services.** "Skilled treatment services" has the meaning given for the "treatment services" described in section 245G.07, subdivisions 1, paragraph (a), clauses (1) to (4), and 2, clauses (1) to (6). Skilled treatment services must be provided by qualified professionals as identified in section 245G.07, subdivision 3.

Sec. 19. Minnesota Statutes 2022, section 254B.01, is amended by adding a subdivision to read:

Subd. 9. **Skilled treatment services.** "Skilled treatment services" has the meaning given for the "treatment services" described in section 245G.07, subdivisions 1, paragraph (a), clauses (1) to (4), and 2, clauses (1) to (6). Skilled treatment services must be provided by qualified professionals as identified in section 245G.07, subdivision 3.

Sec. 20. Minnesota Statutes 2022, section 254B.01, is amended by adding a subdivision to read:

Subd. 10. **Comprehensive assessment.** "Comprehensive assessment" means a person-centered, trauma-informed assessment that:

(1) is completed for a substance use disorder diagnosis, treatment planning, and determination of client eligibility for substance use disorder treatment services;

(2) meets the requirements in section 245G.05; and

(3) is completed by an alcohol and drug counselor qualified according to section 245G.11, subdivision 5.

Sec. 21. Minnesota Statutes 2022, section 254B.04, is amended by adding a subdivision to read:

Subd. 4. **Assessment criteria and risk descriptions.** (a) A level of care determination must use the following criteria to assess risk:

(b) Dimension 1: Acute intoxication and withdrawal potential. A vendor must use the following scoring and criteria in Dimension 1 to determine a client's acute intoxication and withdrawal potential, the client's ability to cope with withdrawal symptoms, and the client's current state of intoxication.

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

"1" The client can tolerate and cope with withdrawal discomfort. The client displays mild-to-moderate intoxication or signs and symptoms interfering with daily functioning but

Sec. 20. Minnesota Statutes 2022, section 254B.01, is amended by adding a subdivision to read:

Subd. 10. **Sober home.** A sober home is a cooperative living residence, a room and board residence, an apartment, or any other living accommodation that:

(1) provides temporary housing to persons with substance use disorders;

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

(3) charges a fee for living there;

(4) does not provide counseling or treatment services to residents; and

(5) promotes sustained recovery from substance use disorders.

Sec. 21. Minnesota Statutes 2022, section 254B.01, is amended by adding a subdivision to read:

Subd. 11. **Comprehensive assessment.** "Comprehensive assessment" means a person-centered, trauma-informed assessment that:

(1) is completed for a substance use disorder diagnosis, treatment planning, and determination of client eligibility for substance use disorder treatment services;

(2) meets the requirements in section 245G.05; and

(3) is completed by an alcohol and drug counselor qualified according to section 245G.11, subdivision 5.

Sec. 22. Minnesota Statutes 2022, section 254B.04, is amended by adding a subdivision to read:

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

(b) Dimension 1: Acute intoxication and withdrawal potential. A vendor must use the following criteria in Dimension 1 to determine a client's acute intoxication and withdrawal potential, the client's ability to cope with withdrawal symptoms, and the client's current state of intoxication.

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

"1" The client can tolerate and cope with withdrawal discomfort. The client displays mild-to-moderate intoxication or signs and symptoms interfering with daily functioning but

does not immediately endanger self or others. The client poses a minimal risk of severe withdrawal.

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

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

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

(c) Dimension 2: biomedical conditions and complications. The vendor must use the following scoring and criteria in Dimension 2 to determine a client's biomedical conditions and complications, the degree to which any physical disorder of the client would interfere with treatment for substance use, and the client's ability to tolerate any related discomfort. If the client is pregnant, the provider must determine the impact of continued substance use on the unborn child.

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

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

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

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

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

(d) Dimension 3: Emotional, behavioral, and cognitive conditions and complications. The vendor must use the following scoring and criteria in Dimension 3 to determine a client's emotional, behavioral, and cognitive conditions and complications; the degree to which any condition or complication is likely to interfere with treatment for substance use or with functioning in significant life areas; and the likelihood of harm to self or others.

does not immediately endanger self or others. The client poses a minimal risk of severe withdrawal.

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

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

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

(c) Dimension 2: biomedical conditions and complications. The vendor must use the following criteria in Dimension 2 to determine a client's biomedical conditions and complications, the degree to which any physical disorder of the client would interfere with treatment for substance use, and the client's ability to tolerate any related discomfort. If the client is pregnant, the provider must determine the impact of continued substance use on the unborn child.

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

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

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

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

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

(d) Dimension 3: Emotional, behavioral, and cognitive conditions and complications. The vendor must use the following criteria in Dimension 3 to determine a client's emotional, behavioral, and cognitive conditions and complications; the degree to which any condition or complication is likely to interfere with treatment for substance use or with functioning in significant life areas; and the likelihood of harm to self or others.

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

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

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

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

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

(e) Dimension 4: Readiness for change. The vendor must use the following scoring and criteria in Dimension 4 to determine a client's readiness for change and the support necessary to keep the client involved in treatment services.

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

"1" The client is motivated with active reinforcement to explore treatment and strategies for change but ambivalent about illness or need for change.

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

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

"4" The client is:

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

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

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

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

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

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

(e) Dimension 4: Readiness for change. The vendor must use the following criteria in Dimension 4 to determine a client's readiness for change and the support necessary to keep the client involved in treatment services.

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

"1" The client is motivated with active reinforcement to explore treatment and strategies for change but ambivalent about illness or need for change.

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

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

"4" The client is:

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

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

(f) Dimension 5: Relapse, continued use, and continued problem potential. The vendor must use the following scoring and criteria in Dimension 5 to determine a client's relapse, continued use, and continued problem potential and the degree to which the client recognizes relapse issues and has the skills to prevent relapse of either substance use or mental health problems.

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

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

"2" The client has:

(i) minimal recognition and understanding of relapse and recidivism issues and displays moderate vulnerability for further substance use or mental health problems; or

(ii) some coping skills inconsistently applied.

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

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

(g) Dimension 6: Recovery environment. The vendor must use the following scoring and criteria in Dimension 6 to determine a client's recovery environment, whether the areas of the client's life are supportive of or antagonistic to treatment participation and recovery.

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

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

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

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

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

(f) Dimension 5: Relapse, continued use, and continued problem potential. The vendor must use the following criteria in Dimension 5 to determine a client's relapse, continued use, and continued problem potential and the degree to which the client recognizes relapse issues and has the skills to prevent relapse of either substance use or mental health problems.

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

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

"2" The client has:

(i) minimal recognition and understanding of relapse and recidivism issues and displays moderate vulnerability for further substance use or mental health problems; or

(ii) some coping skills inconsistently applied.

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

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

(g) Dimension 6: Recovery environment. The vendor must use the following criteria in Dimension 6 to determine a client's recovery environment, whether the areas of the client's life are supportive of or antagonistic to treatment participation and recovery.

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

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

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

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

"4" The client has:

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

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

Sec. 22. Minnesota Statutes 2022, section 254B.05, subdivision 1, is amended to read:

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

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

(c) A county is an eligible vendor for a comprehensive assessment and assessment summary when provided by an individual who meets the staffing credentials of section 245G.11, subdivisions 1 and 5, and completed according to the requirements of section 245G.05. A county is an eligible vendor of care coordination services when provided by an individual who meets the staffing credentials of section 245G.11, subdivisions 1 and 7, and provided according to the requirements of section 245G.07, subdivision 1, paragraph (a), clause (5). A county is an eligible vendor of peer recovery services when the services are provided by an individual who meets the requirements of section 245G.11, subdivision 8.

(d) A recovery community organization ~~that meets certification requirements identified by the commissioner~~ certified by the Board of Recovery Services under sections 254B.20 to 254B.24 is an eligible vendor of peer support services.

(e) Recovery community organizations directly approved by the commissioner of human services before June 30, 2023, will retain their designation as a recovery community organization.

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

"4" The client has:

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

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

Sec. 23. Minnesota Statutes 2022, section 254B.05, subdivision 5, is amended to read:

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

(b) Eligible substance use disorder treatment services include:

(1) ~~outpatient treatment services that are licensed according to sections 245G.01 to 245G.17, or applicable tribal license;~~ those licensed, as applicable, according to chapter 245G or applicable Tribal license and provided by the following ASAM levels of care:

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

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

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

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

(v) ASAM level 3.1 clinically managed low-intensity residential services provided according to section 254B.19, subdivision 1, clause (5);

(vi) ASAM level 3.3 clinically managed population-specific high-intensity residential services provided according to section 254B.19, subdivision 1, clause (6); and

(vii) ASAM level 3.5 clinically managed high-intensity residential services provided according to section 254B.19, subdivision 1, clause (7);

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

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

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

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

(6) substance use disorder treatment services with medications for opioid use disorder ~~that are~~ provided in an opioid treatment program licensed according to sections 245G.01 to 245G.17 and 245G.22, or applicable tribal license;

Sec. 23. Minnesota Statutes 2022, section 254B.05, subdivision 5, is amended to read:

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

(b) Eligible substance use disorder treatment services include:

(1) ~~outpatient treatment services that are licensed according to sections 245G.01 to 245G.17, or applicable tribal license;~~ those licensed, as applicable, according to chapter 245G or applicable Tribal license and provided according to the following ASAM levels of care:

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

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

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

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

(v) ASAM level 3.1 clinically managed low-intensity residential services provided according to section 254B.19, subdivision 1, clause (5);

(vi) ASAM level 3.3 clinically managed population-specific high-intensity residential services provided according to section 254B.19, subdivision 1, clause (6); and

(vii) ASAM level 3.5 clinically managed high-intensity residential services provided according to section 254B.19, subdivision 1, clause (7);

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

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

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

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

(6) substance use disorder treatment services with medications for opioid use disorder ~~that are~~ provided in an opioid treatment program licensed according to sections 245G.01 to 245G.17 and 245G.22, or applicable tribal license;

~~(7) substance use disorder treatment with medications for opioid use disorder plus enhanced treatment services that meet the requirements of clause (6) and provide nine hours of clinical services each week;~~

~~(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)~~ (7) hospital-based treatment services that are licensed according to sections 245G.01 to 245G.17 or applicable tribal license and licensed as a hospital under sections 144.50 to 144.56;

~~(10)~~ (8) adolescent treatment programs that are licensed as outpatient treatment programs according to sections 245G.01 to 245G.18 or as residential treatment programs according to Minnesota Rules, parts 2960.0010 to 2960.0220, and 2960.0430 to 2960.0490, or applicable tribal license;

~~(11) high-intensity residential treatment~~ (9) ASAM 3.5 clinically managed high-intensity residential 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~~ ASAM level of care 3.5 according to section 254B.19, subdivision 1, clause (7), and is 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

~~(12)~~ (10) room and board facilities that meet the requirements of subdivision 1a.

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

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

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

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

(B) meets the licensure exclusion criteria of section 245A.03, subdivision 2, paragraph (a), clause (6), and meets the requirements under section 245G.19, subdivision 4; or

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

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

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

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

~~(7) substance use disorder treatment with medications for opioid use disorder plus enhanced treatment services that meet the requirements of clause (6) and provide nine hours of clinical services each week;~~

~~(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)~~ (7) hospital-based treatment services that are licensed according to sections 245G.01 to 245G.17 or applicable tribal license and licensed as a hospital under sections 144.50 to 144.56;

~~(10)~~ (8) adolescent treatment programs that are licensed as outpatient treatment programs according to sections 245G.01 to 245G.18 or as residential treatment programs according to Minnesota Rules, parts 2960.0010 to 2960.0220, and 2960.0430 to 2960.0490, or applicable tribal license;

~~(11) high-intensity residential treatment~~ (9) ASAM 3.5 clinically managed high-intensity residential 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~~ ASAM level of care 3.5 according to section 254B.19, subdivision 1, clause (7), and is 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

~~(12)~~ (10) room and board facilities that meet the requirements of subdivision 1a.

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

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

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

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

(B) meets the licensure exclusion criteria of section 245A.03, subdivision 2, paragraph (a), clause (6), and meets the requirements under section 245G.19, subdivision 4; or

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

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

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

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

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

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

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

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

(ii) 25 percent of the counseling staff are licensed mental health professionals under section 245I.04, subdivision 2, or are students or licensing candidates under the supervision of a licensed alcohol and drug counselor supervisor and mental health professional under section 245I.04, subdivision 2, except that no more than 50 percent of the mental health staff may be students or licensing candidates with time documented to be directly related to provisions of co-occurring services;

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

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

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

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

(d) In order to be eligible for a higher rate under paragraph (c), clause (1), a program that provides arrangements for off-site child care must maintain current documentation at the substance use disorder facility of the child care provider's current licensure to provide child care services. Programs that provide child care according to paragraph (c), clause (1), must be deemed in compliance with the licensing requirements in section 245G.19.

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

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

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

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

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

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

(ii) 25 percent of the counseling staff are licensed mental health professionals under section 245I.04, subdivision 2, or are students or licensing candidates under the supervision of a licensed alcohol and drug counselor supervisor and mental health professional under section 245I.04, subdivision 2, except that no more than 50 percent of the mental health staff may be students or licensing candidates with time documented to be directly related to provisions of co-occurring services;

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

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

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

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

(d) In order to be eligible for a higher rate under paragraph (c), clause (1), a program that provides arrangements for off-site child care must maintain current documentation at the substance use disorder facility of the child care provider's current licensure to provide child care services. Programs that provide child care according to paragraph (c), clause (1), must be deemed in compliance with the licensing requirements in section 245G.19.

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

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

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

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

EFFECTIVE DATE. The amendments to paragraph (b), clause (1), items (i) to (iv), are effective January 1, 2025, or upon federal approval, whichever is later. The amendments to paragraph (b), clause (1), items (v) to (vii), are effective January 1, 2024, or upon federal approval, whichever is later. The amendments to paragraph (b), clauses (2) to (10), are effective January 1, 2024.

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

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

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

EFFECTIVE DATE. Paragraph (b), clause (1), items (i) to (iv), are effective January 1, 2025, or upon federal approval, whichever is later. Paragraph (b), clause (1), items (v) to (vii), are effective January 1, 2024, or upon federal approval, whichever is later. Paragraph (b), clauses (2) to (10), are effective January 1, 2024.

Sec. 25. **[254B.18] SOBER HOMES.**

Subdivision 1. **Requirements.** All sober homes must comply with applicable state laws and regulations and local ordinances related to maximum occupancy, fire safety, and sanitation. All sober homes must register with the Department of Human Services. In addition, all sober homes must:

(1) maintain a supply of an opiate antagonist in the home;

(2) have trained staff that can administer an opiate antagonist;

(3) have written policies regarding access to all prescribed medications;

(4) have written policies regarding evictions;

(5) have staff training and policies regarding co-occurring mental illnesses;

(6) not prohibit prescribed medications taken as directed by a licensed prescriber, such as pharmacotherapies specifically approved by the Food and Drug Administration (FDA) for treatment of opioid use disorder and other medications with FDA-approved indications for the treatment of co-occurring disorders; and

(7) return all property and medications to a person discharged from the home and retain the items for a minimum of 60 days if the person did not collect them upon discharge. The owner must make every effort to contact persons listed as emergency contacts for the discharged person so that the items are returned.

Subd. 2. **Certification.** (a) The commissioner shall establish a certification program for sober homes. Certification is mandatory for sober homes receiving any federal, state, or local funding. The certification requirements must include:

(1) health and safety standards, including separate sleeping and bathroom facilities for people who identify as men and people who identify as women, written policies on how to accommodate residents who do not identify as a man or woman, and verification that the home meets fire and sanitation ordinances;

(2) intake admission procedures, including documentation of names and contact information for persons to contact in case of an emergency or upon discharge and notification of a family member, or other emergency contact designated by the resident under certain circumstances, including but not limited to death due to an overdose;

(3) an assessment of potential resident needs and appropriateness of the residence to meet these needs;

(4) a resident bill of rights, including a right to a refund if discharged;

(5) policies to address mental health and health emergencies, to prevent a person from hurting themselves or others, including contact information for emergency resources in the community;

(6) policies on staff qualifications and prohibition against fraternization;

(7) drug-testing procedures and requirements;

(8) policies to mitigate medication misuse, including policies for:

(i) securing medication;

(ii) house staff providing medication at specified times to residents;

(iii) medication counts with staff and residents;

(iv) storing and providing prescribed medications and documenting when a person accesses their prescribed medications; and

(v) ensuring that medications cannot be accessed by other residents;

(9) a policy on medications for opioid use disorder;

(10) having an opiate antagonist on site and in a conspicuous location;

(11) prohibiting charging exorbitant fees above standard costs for lab tests;

(12) discharge procedures, including involuntary discharge procedures that ensure at least a 24-hours notice prior to filing an eviction action. The notice must include the reasons for the involuntary discharge and a warning that an eviction action may become public as soon as it is filed, making finding future housing more difficult;

(13) a policy on referrals to substance use disorder treatment services, mental health services, peer support services, and support groups;

(14) training for staff on opiate antagonists, mental health crises, de-escalation, person-centered planning, creating a crisis plan, and becoming a culturally informed and responsive sober home;

(15) a fee schedule and refund policy;

(16) copies of all forms provided to residents;

(17) rules for residents;

(18) background checks of staff and administrators;

(19) policies that promote recovery by requiring resident participation in treatment, self-help groups or other recovery supports; and

(20) policies requiring abstinence from alcohol and illicit drugs.

(b) Certifications must be renewed every three years.

Subd. 3. **Registry.** The commissioner shall create a registry containing a listing of sober homes that have met the certification requirements. The registry must include each sober home city and zip code, maximum resident capacity, and whether the setting serves a specific population based on race, ethnicity, national origin, sexual orientation, gender identity, or physical ability.

Subd. 4. **Bill of rights.** An individual living in a sober home has the right to:

(1) access to an environment that supports recovery;

(2) access to an environment that is safe and free from alcohol and other illicit drugs or substances;

(3) be free from physical and verbal abuse, neglect, financial exploitation, and all forms of maltreatment covered under the Vulnerable Adults Act, sections 626.557 to 626.5572;

(4) be treated with dignity and respect and to have personal property treated with respect;

(5) have personal, financial, and medical information kept private and to be advised of the sober home's policies and procedures regarding disclosure of such information;

(6) access, while living in the residence, to other community-based support services as needed;

(7) be referred to appropriate services upon leaving the residence, if necessary;

(8) retain personal property that does not jeopardize safety or health;

(9) assert these rights personally or have them asserted by the individual's representative or by anyone on behalf of the individual without retaliation;

(10) be provided with the name, address, and telephone number of the ombudsman for mental health, substance use disorder, and developmental disabilities and information about the right to file a complaint;

(11) be fully informed of these rights and responsibilities, as well as program policies and procedures; and

(12) not be required to perform services for the residence that are not included in the usual expectations for all residents.

Subd. 5. **Private right of action.** In addition to pursuing other remedies, an individual may bring an action to recover damages caused by a violation of this section. The court shall award a resident who prevails in an action under this section double damages, costs, disbursements, reasonable attorney fees, and any equitable relief the court deems appropriate.

Subd. 6. **Complaints; ombudsman for mental health and developmental disabilities.** Any complaints about a sober home may be made to and reviewed or investigated by the ombudsman for mental health and developmental disabilities, pursuant to sections 245.91 and 245.94.

Sec. 24. **[254B.19] AMERICAN SOCIETY OF ADDICTION MEDICINE STANDARDS OF CARE.**

Subdivision 1. **Level of care requirements.** For each client assigned an ASAM level of care, eligible vendors must implement the standards set by the ASAM for the respective level of care. Additionally, vendors must meet the following requirements.

(1) For ASAM level 0.5 early intervention targeting individuals who are at risk of developing a substance-related problem but may not have a diagnosed substance use disorder, early intervention services may include individual or group counseling, treatment coordination, peer recovery support, screening brief intervention, and referral to treatment provided according to section 254A.03, subdivision 3, paragraph (c).

(2) For ASAM level 1.0 outpatient clients, adults must receive up to eight hours per week of skilled treatment services and adolescents must receive up to five hours per week. Services must be licensed according to section 245G.20 and meet requirements under section 256B.0759. Peer recovery and treatment coordination may be provided beyond the hourly skilled treatment service hours allowable per week.

(3) For ASAM level 2.1 intensive outpatient clients, adults must receive nine to 19 hours per week of skilled treatment services and adolescents must receive six or more hours per week. Vendors must be licensed according to section 245G.20 and must meet requirements under section 256B.0759. Peer recovery and treatment coordination may be provided beyond the hourly skilled treatment service hours allowable per week. If clinically indicated on the

Sec. 26. **[254B.19] AMERICAN SOCIETY OF ADDICTION MEDICINE STANDARDS OF CARE.**

Subdivision 1. **Level of care requirements.** For each client assigned an ASAM level of care, eligible vendors must implement the standards set by the ASAM for the respective level of care. Additionally, vendors must meet the following requirements:

(1) for ASAM level 0.5 early intervention targeting individuals who are at risk of developing a substance-related problem but may not have a diagnosed substance use disorder, early intervention services may include individual or group counseling, treatment coordination, peer recovery support, screening brief intervention, and referral to treatment provided according to section 254A.03, subdivision 3, paragraph (c).

(2) for ASAM level 1.0 outpatient clients, adults must receive up to eight hours per week of skilled treatment services and adolescents must receive up to five hours per week. Services must be licensed according to section 245G.20 and meet requirements under section 256B.0759. Peer recovery and treatment coordination may be provided beyond the hourly skilled treatment service hours allowable per week.

(3) for ASAM level 2.1 intensive outpatient clients, adults must receive nine to 19 hours per week of skilled treatment services and adolescents must receive six or more hours per week. Vendors must be licensed according to section 245G.20 and must meet requirements under section 256B.0759. Peer recovery services and treatment coordination may be provided beyond the hourly skilled treatment service hours allowable per week. If clinically indicated

client's treatment plan, this service may be provided in conjunction with room and board according to section 254B.05, subdivision 1a.

(4) For ASAM level 2.5 partial hospitalization clients, adults must receive 20 hours or more of skilled treatment services. Services must be licensed according to section 245G.20 and must meet requirements under section 256B.0759. Level 2.5 is for clients who need daily monitoring in a structured setting as directed by the individual treatment plan and in accordance with the limitations in section 254B.05, subdivision 5, paragraph (h). If clinically indicated on the client's treatment plan, this service may be provided in conjunction with room and board according to section 254B.05, subdivision 1a.

(5) For ASAM level 3.1 clinically managed low-intensity residential clients, programs must provide at least 5 hours of skilled treatment services per week according to each client's specific treatment schedule as directed by the individual treatment plan. Programs must be licensed according to section 245G.20 and must meet requirements under section 256B.0759.

(6) For ASAM level 3.3 clinically managed population-specific high-intensity residential clients, programs must be licensed according to section 245G.20 and must meet requirements under section 256B.0759. Programs must have 24-hour-a-day staffing coverage. Programs must be enrolled as a disability responsive program as described in section 254B.01, subdivision 4b, and must specialize in serving persons with a traumatic brain injury or a cognitive impairment so significant, and the resulting level of impairment so great, that outpatient or other levels of residential care would not be feasible or effective. Programs must provide, at minimum, daily skilled treatment services seven days a week according to each client's specific treatment schedule as directed by the individual treatment plan.

(7) For ASAM level 3.5 clinically managed high-intensity residential clients, services must be licensed according to section 245G.20 and must meet requirements under section 256B.0759. Programs must have 24-hour-a-day staffing coverage and provide, at minimum, daily skilled treatment services seven days a week according to each client's specific treatment schedule as directed by the individual treatment plan.

(8) For ASAM level withdrawal management 3.2 clinically managed clients, withdrawal management must be provided according to chapter 245F.

(9) For ASAM level withdrawal management 3.7 medically monitored clients, withdrawal management must be provided according to chapter 245F.

Subd. 2. **Patient referral arrangement agreement.** The license holder must maintain documentation of a formal patient referral arrangement agreement for each of the following levels of care not provided by the license holder:

(1) level 1.0 outpatient;

(2) level 2.1 intensive outpatient;

(3) level 2.5 partial hospitalization;

on the client's treatment plan, this service may be provided in conjunction with room and board according to section 254B.05, subdivision 1a.

(4) for ASAM level 2.5 partial hospitalization clients, adults must receive 20 hours or more of skilled treatment services. Services must be licensed according to section 245G.20 and must meet requirements under section 256B.0759. Level 2.5 is for clients who need daily monitoring in a structured setting, as directed by the individual treatment plan and in accordance with the limitations in section 254B.05, subdivision 5, paragraph (h). If clinically indicated on the client's treatment plan, this service may be provided in conjunction with room and board according to section 254B.05, subdivision 1a.

(5) for ASAM level 3.1 clinically managed low-intensity residential clients, programs must provide at least 5 hours of skilled treatment services per week according to each client's specific treatment schedule, as directed by the individual treatment plan. Programs must be licensed according to section 245G.20 and must meet requirements under section 256B.0759.

(6) for ASAM level 3.3 clinically managed population-specific high-intensity residential clients, programs must be licensed according to section 245G.20 and must meet requirements under section 256B.0759. Programs must have 24-hour staffing coverage. Programs must be enrolled as a disability responsive program as described in section 254B.01, subdivision 4b, and must specialize in serving persons with a traumatic brain injury or a cognitive impairment so significant, and the resulting level of impairment so great, that outpatient or other levels of residential care would not be feasible or effective. Programs must provide, at minimum, daily skilled treatment services seven days a week according to each client's specific treatment schedule, as directed by the individual treatment plan.

(7) for ASAM level 3.5 clinically managed high-intensity residential clients, services must be licensed according to section 245G.20 and must meet requirements under section 256B.0759. Programs must have 24-hour staffing coverage and provide, at minimum, daily skilled treatment services seven days a week according to each client's specific treatment schedule, as directed by the individual treatment plan.

(8) for ASAM level withdrawal management 3.2 clinically managed clients, withdrawal management must be provided according to chapter 245F.

(9) for ASAM level withdrawal management 3.7 medically monitored clients, withdrawal management must be provided according to chapter 245F.

Subd. 2. **Patient referral arrangement agreement.** The license holder must maintain documentation of a formal patient referral arrangement agreement for each of the following ASAM levels of care not provided by the license holder:

(1) level 1.0 outpatient;

(2) level 2.1 intensive outpatient;

(3) level 2.5 partial hospitalization;

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(4) level 3.1 clinically managed low-intensity residential;

(5) level 3.3 clinically managed population-specific high-intensity residential;

(6) level 3.5 clinically managed high-intensity residential;

(7) level withdrawal management 3.2 clinically managed residential withdrawal management; and

(8) level withdrawal management 3.7 medically monitored inpatient withdrawal management.

Subd. 3. **Evidence-based practices.** All services delivered within the ASAM levels of care referenced in subdivision 1, clauses (1) to (7), must have documentation of the evidence-based practices being utilized as referenced in the most current edition of the ASAM criteria.

Subd. 4. **Program outreach plan.** Eligible vendors providing services under ASAM levels of care referenced in subdivision 1, clauses (2) to (7), must have a program outreach plan. The treatment director must document a review and update the plan annually. The program outreach plan must include treatment coordination strategies and processes to ensure seamless transitions across the continuum of care. The plan must include how the provider will:

(1) increase the awareness of early intervention treatment services, including but not limited to the services defined in section 254A.03, subdivision 3, paragraph (c);

(2) coordinate, as necessary, with certified community behavioral health clinics when a license holder is located in a geographic region served by a certified community behavioral health clinic;

(3) establish a referral arrangement agreement with a withdrawal management program licensed under chapter 245F when a license holder is located in a geographic region in which a withdrawal management program is licensed under chapter 245F. If a withdrawal management program licensed under chapter 245F is not geographically accessible, the plan must include how the provider will address the client's need for this level of care;

(4) coordinate with inpatient acute-care hospitals, including emergency departments, hospital outpatient clinics, urgent care centers, residential crisis settings, medical detoxification inpatient facilities and ambulatory detoxification providers in the area served by the provider to help transition individuals from emergency department or hospital settings and minimize the time between assessment and treatment;

(5) develop and maintain collaboration with local county and Tribal human services agencies; and

(6) collaborate with primary care and mental health settings.

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(4) level 3.1 clinically managed low-intensity residential;

(5) level 3.3 clinically managed population-specific high-intensity residential;

(6) level 3.5 clinically managed high-intensity residential;

(7) level withdrawal management 3.2 clinically managed residential withdrawal management; and

(8) level withdrawal management 3.7 medically monitored inpatient withdrawal management.

Subd. 3. **Evidence-based practices.** All services delivered within the ASAM levels of care referenced in subdivision 1, clauses (1) to (7), must have documentation of the evidence-based practices being utilized as referenced in the most current edition of the ASAM criteria.

Subd. 4. **Program outreach plan.** Eligible vendors providing services under ASAM levels of care referenced in subdivision 1, clauses (2) to (7), must have a program outreach plan. The treatment director must document a review and update the plan annually. The program outreach plan must include treatment coordination strategies and processes to ensure seamless transitions across the continuum of care. The plan must include how the provider will:

(1) increase the awareness of early intervention treatment services, including but not limited to the services defined in section 254A.03, subdivision 3, paragraph (c);

(2) coordinate, as necessary, with certified community behavioral health clinics when a license holder is located in a geographic region served by a certified community behavioral health clinic;

(3) establish a referral arrangement agreement with a withdrawal management program licensed under chapter 245F when a license holder is located in a geographic region in which a withdrawal management program is licensed under chapter 245F. If a withdrawal management program licensed under chapter 245F is not geographically accessible, the plan must include how the provider will address the client's need for this level of care;

(4) coordinate with inpatient acute-care hospitals, including emergency departments, hospital outpatient clinics, urgent care centers, residential crisis settings, medical detoxification inpatient facilities and ambulatory detoxification providers in the area served by the provider to help transition individuals from emergency department or hospital settings and minimize the time between assessment and treatment;

(5) develop and maintain collaboration with local county and Tribal human services agencies; and

(6) collaborate with primary care and mental health settings.

Sec. 25. **[254B.191] EVIDENCE-BASED TRAINING.**

The commissioner must establish ongoing training opportunities for substance use disorder treatment providers under chapter 245F to increase knowledge and develop skills to adopt evidence-based and promising practices in substance use disorder treatment programs. Training opportunities must support the transition to ASAM standards. Training formats may include self or organizational assessments, virtual modules, one-to-one coaching, self-paced courses, interactive hybrid courses, and in-person courses. Foundational and skill-building training topics may include:

(1) ASAM criteria;

(2) person-centered and culturally responsive services;

(3) medical and clinical decision making;

(4) conducting assessments and appropriate level of care;

(5) treatment and service planning;

(6) identifying and overcoming systems challenges;

(7) conducting clinical case reviews; and

(8) appropriate and effective transfer and discharge.

Sec. 26. **[254B.20] DEFINITIONS.**

Subdivision 1. **Applicability.** For the purposes of sections 254B.20 to 254B.24, the following terms have the meanings given.

Subd. 2. **Board.** "Board" means the Board of Recovery Services established by section 254B.21.

Subd. 3. **Credential or credentialing.** "Credential" or "credentialing" means the standardized process of formally reviewing and designating a recovery organization as qualified to employ peer recovery specialists based on criteria established by the board.

Subd. 4. **Minnesota Certification Board.** "Minnesota Certification Board" means the nonprofit agency member board of the International Certification and Reciprocity Consortium that sets the policies and procedures for alcohol and other drug professional certifications in Minnesota, including peer recovery specialists.

Subd. 5. **Peer recovery specialist.** "Peer recovery specialist" has the meaning given to "recovery peer" in section 245F.02, subdivision 21. A peer recovery specialist must meet the qualifications of a recovery peer in section 245G.11, subdivision 8.

EFFECTIVE DATE. This section is effective January 1, 2024.

Sec. 28. **EVIDENCE-BASED TRAINING.**

The commissioner of human services must establish training opportunities for substance use disorder treatment providers under Minnesota Statutes, chapters 245F and 245G, and applicable Tribal licenses, to increase knowledge and develop skills to adopt evidence-based and promising practices in substance use disorder treatment programs. Training opportunities must support the transition to American Society of Addiction Medicine (ASAM) standards. Training formats may include self or organizational assessments, virtual modules, one-to-one coaching, self-paced courses, interactive hybrid courses, and in-person courses. Foundational and skill-building training topics may include:

(1) ASAM criteria;

(2) person-centered and culturally responsive services;

(3) medical and clinical decision making;

(4) conducting assessments and appropriate level of care;

(5) treatment and service planning;

(6) identifying and overcoming systems challenges;

(7) conducting clinical case reviews; and

(8) appropriate and effective transfer and discharge.

Subd. 6. **Peer recovery services.** "Peer recovery services" has the meaning given to "peer recovery support services" in section 245F.02, subdivision 17.

Sec. 27. **[254B.21] MINNESOTA BOARD OF RECOVERY SERVICES.**

Subdivision 1. **Creation.** (a) The Minnesota Board of Recovery Services is established and consists of 13 members appointed by the governor as follows:

(1) five of the members must be certified peer recovery specialists certified under the Minnesota Certification Board with an active credential;

(2) two of the members must be certified peer recovery specialist supervisors certified under the Minnesota Certification Board with an active credential;

(3) four of the members must be currently employed by a Minnesota-based recovery community organization recognized by the commissioner of human services; and

(4) two of the members must be public members as defined in section 214.02, and be either a family member of a person currently using substances or a person in recovery from a substance use disorder.

(b) At the time of their appointments, at least three members must reside outside of the seven-county metropolitan area.

(c) At the time of their appointments, at least three members must be members of:

(1) a community of color; or

(2) an underrepresented community, defined as a group that is not represented in the majority with respect to race, ethnicity, national origin, sexual orientation, gender identity, or physical ability.

Subd. 2. **Officers.** The board must annually elect a chair and vice-chair from among its members and may elect other officers as necessary. The board must meet at least twice a year but may meet more frequently at the call of the chair.

Subd. 3. **Membership terms; compensation.** Membership terms, compensation of members, removal of members, the filling of membership vacancies, and fiscal year and reporting requirements are as provided in section 15.058.

Subd. 4. **Expiration.** The board does not expire.

Sec. 28. **[254B.22] DUTIES OF THE BOARD.**

The Minnesota Board of Recovery Services shall:

(1) develop and define by rule criteria for credentialing recovery organizations using nationally recognized best practices and standards;

(2) determine the renewal cycle and renewal period for eligible vendors of peer recovery services;

(3) receive, review, approve, or disapprove initial applications, renewals, and reinstatement requests for credentialing from recovery organizations;

(4) establish administrative procedures for processing applications submitted under clause (3) and hire or appoint such agents as are appropriate for processing applications;

(5) retain records of board actions and proceedings in accordance with public records laws; and

(6) establish, maintain, and publish annually a register of current credentialed recovery organizations.

Sec. 29. **[254B.23] REQUIREMENTS FOR CREDENTIALING.**

Subdivision 1. **Application requirements.** An application submitted to the board for credentialing must include:

(1) evidence that the applicant is a nonprofit organization based in Minnesota or meets the eligibility criteria defined by the board;

(2) a description of the applicant's activities and services that support recovery from substance use disorder; and

(3) any other requirements as specified by the board.

Subd. 2. **Fee.** Each applicant must pay a nonrefundable application fee as established by the board. The revenue from the fee must be deposited in the state government special revenue fund.

Sec. 30. **[254B.24] APPEAL AND HEARING.**

A recovery organization aggrieved by the board's failure to issue, renew, or reinstate credentialing under sections 254B.20 to 254B.24 may appeal by requesting a hearing under the procedures of chapter 14.

Sec. 31. **[254B.30] PROJECT ECHO GRANTS.**

Subdivision 1. **Establishment.** The commissioner must establish a grant program to support new or existing Project ECHO programs in the state.

Subd. 2. **Project ECHO at Hennepin Healthcare.** The commissioner must use appropriations under this subdivision to award grants to Hennepin Healthcare to establish

THE FOLLOWING PARAGRAPH WAS COPIED FROM HOUSE ARTICLE 8, SECTION 2, SUBDIVISION 17.

(k) **Project ECHO.** $1,500,000 in fiscal year 2024 and $1,500,000 in fiscal year 2025 are from the general fund for a grant to Hennepin Healthcare to expand the Project ECHO program. The grant must be used to establish at least four substance use disorder-focused Project ECHO programs at Hennepin

at least four substance use disorder-focused Project ECHO programs, expanding the grantee's capacity to improve health and substance use disorder outcomes for diverse populations of individuals enrolled in medical assistance, including but not limited to immigrants, individuals who are homeless, individuals seeking maternal and perinatal care, and other underserved populations. The Project ECHO programs funded under this subdivision must be culturally responsive, and the grantee must contract with culturally and linguistically appropriate substance use disorder service providers who have expertise in focus areas, based on the populations served. Grant funds may be used for program administration, equipment, provider reimbursement, and staffing hours.

Sec. 32. Minnesota Statutes 2022, section 256B.0759, subdivision 2, is amended to read:

Subd. 2. **Provider participation.** (a) ~~Outpatient~~ Programs licensed by the Department of Human Services as nonresidential substance use disorder treatment ~~providers may elect to participate in the demonstration project and meet the requirements of subdivision 3. To participate, a provider must notify the commissioner of the provider's intent to participate in a format required by the commissioner and enroll as a demonstration project provider~~ programs that receive payment under this chapter must enroll as demonstration project providers and meet the requirements of subdivision 3 by January 1, 2025. Programs that do not meet the requirements of this paragraph are ineligible for payment for services provided under section 256B.0625.

(b) Programs licensed by the Department of Human Services as residential treatment programs according to section 245G.21 that receive payment under this chapter must enroll as demonstration project providers and meet the requirements of subdivision 3 by January 1, 2024. Programs that do not meet the requirements of this paragraph are ineligible for payment for services provided under section 256B.0625.

(c) Programs licensed by the Department of Human Services as residential treatment programs according to section 245G.21 that receive payment under this chapter and are licensed as a hospital under sections 144.50 to 144.581 must enroll as demonstration project providers and meet the requirements of subdivision 3 by January 1, 2025.

~~(c)~~ (d) Programs licensed by the Department of Human Services as withdrawal management programs according to chapter 245F that receive payment under this chapter must enroll as demonstration project providers and meet the requirements of subdivision 3 by January 1, 2024. Programs that do not meet the requirements of this paragraph are ineligible for payment for services provided under section 256B.0625.

Healthcare, expanding the grantee's capacity to improve health and substance use disorder outcomes for diverse populations of individuals enrolled in medical assistance, including but not limited to immigrants, individuals who are homeless, individuals seeking maternal and perinatal care, and other underserved populations. The Project ECHO programs funded under this section must be culturally responsive, and the grantee must contract with culturally and linguistically appropriate substance use disorder service providers who have expertise in focus areas, based on the populations served. Grant funds may be used for program administration, equipment, provider reimbursement, and staffing hours. This is a onetime appropriation.

Sec. 27. Minnesota Statutes 2022, section 256B.0759, subdivision 2, is amended to read:

Subd. 2. **Provider participation.** (a) ~~Outpatient~~ Programs licensed by the Department of Human Services as nonresidential substance use disorder treatment ~~providers may elect to participate in the demonstration project and meet the requirements of subdivision 3. To participate, a provider must notify the commissioner of the provider's intent to participate in a format required by the commissioner and enroll as a demonstration project provider~~ programs that receive payment under this chapter must enroll as demonstration project providers and meet the requirements of subdivision 3 by January 1, 2025. Programs that do not meet the requirements of this paragraph are ineligible for payment for services provided under section 256B.0625.

(b) Programs licensed by the Department of Human Services as residential treatment programs according to section 245G.21 that receive payment under this chapter must enroll as demonstration project providers and meet the requirements of subdivision 3 by January 1, 2024. Programs that do not meet the requirements of this paragraph are ineligible for payment for services provided under section 256B.0625.

(c) Programs licensed by the Department of Human Services as residential treatment programs according to section 245G.21 that receive payment under this chapter and are licensed as a hospital under sections 144.50 to 144.581 must enroll as demonstration project providers and meet the requirements of subdivision 3 by January 1, 2025.

~~(c)~~ (d) Programs licensed by the Department of Human Services as withdrawal management programs according to chapter 245F that receive payment under this chapter must enroll as demonstration project providers and meet the requirements of subdivision 3 by January 1, 2024. Programs that do not meet the requirements of this paragraph are ineligible for payment for services provided under section 256B.0625.

~~(d)~~ (e) Out-of-state residential substance use disorder treatment programs that receive payment under this chapter must enroll as demonstration project providers and meet the requirements of subdivision 3 by January 1, 2024. Programs that do not meet the requirements of this paragraph are ineligible for payment for services provided under section 256B.0625.

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

~~(f)~~ (g) The commissioner shall allow providers enrolled in the demonstration project before July 1, 2021, to receive applicable rate enhancements authorized under subdivision 4 for all services provided on or after the date of enrollment, except that the commissioner shall allow a provider to receive applicable rate enhancements authorized under subdivision 4 for services provided on or after July 22, 2020, to fee-for-service enrollees, and on or after January 1, 2021, to managed care enrollees, if the provider meets all of the following requirements:

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

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

~~(g)~~ (h) The commissioner may recoup any rate enhancements paid under paragraph ~~(f)~~ (g) to a provider that does not meet the requirements of subdivision 3 by July 1, 2021.

Sec. 33. Minnesota Statutes 2022, section 256I.05, is amended by adding a subdivision to read:

Subd. 1s. **Supplemental rate; Douglas County.** Notwithstanding the provisions of subdivisions 1a and 1c, beginning July 1, 2023, a county agency shall negotiate a supplementary rate in addition to the rate specified in subdivision 1, not to exceed $750 per month, including any legislatively authorized inflationary adjustments, for a housing support provider located in Douglas County that operates a long-term residential facility with a total of 74 beds that serve chemically dependent men and provide 24-hour-a-day supervision and other support services.

Sec. 34. Minnesota Statutes 2022, section 256I.05, is amended by adding a subdivision to read:

Subd. 1t. **Supplemental rate; Crow Wing County.** Notwithstanding the provisions of subdivisions 1a and 1c, beginning July 1, 2023, a county agency shall negotiate a supplementary rate in addition to the rate specified in subdivision 1, not to exceed $750 per month, including any legislatively authorized inflationary adjustments, for a housing support

~~(d)~~ (e) Out-of-state residential substance use disorder treatment programs that receive payment under this chapter must enroll as demonstration project providers and meet the requirements of subdivision 3 by January 1, 2024. Programs that do not meet the requirements of this paragraph are ineligible for payment for services provided under section 256B.0625.

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

~~(f)~~ (g) The commissioner shall allow providers enrolled in the demonstration project before July 1, 2021, to receive applicable rate enhancements authorized under subdivision 4 for all services provided on or after the date of enrollment, except that the commissioner shall allow a provider to receive applicable rate enhancements authorized under subdivision 4 for services provided on or after July 22, 2020, to fee-for-service enrollees, and on or after January 1, 2021, to managed care enrollees, if the provider meets all of the following requirements:

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

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

~~(g)~~ (h) The commissioner may recoup any rate enhancements paid under paragraph ~~(f)~~ (g) to a provider that does not meet the requirements of subdivision 3 by July 1, 2021.

provider located in Crow Wing County that operates a long-term residential facility with a total of 90 beds that serves chemically dependent men and women and provides 24-hour-a-day supervision and other support services.

Sec. 35. Minnesota Statutes 2022, section 256I.05, is amended by adding a subdivision to read:

Subd. 1u. **Supplemental rate; Douglas County.** Notwithstanding the provisions in this section, beginning July 1, 2023, a county agency shall negotiate a supplemental rate for up to 20 beds in addition to the rate specified in subdivision 1, not to exceed the maximum rate allowed under subdivision 1a, including any legislatively authorized inflationary adjustments, for a housing support provider located in Douglas County that operates two facilities and provides room and board and supplementary services to adult males recovering from substance use disorder, mental illness, or housing instability.

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

Sec. 36. **[325F.725] SOBER HOME TITLE PROTECTION.**

No person or entity may use the phrase "sober home," whether alone or in combination with other words and whether orally or in writing, to advertise, market, or otherwise describe, offer, or promote itself, or any housing, service, service package, or program that it provides within this state, unless the person or entity is a cooperative living residence, a room and board residence, an apartment, or any other living accommodation that provides temporary housing to persons with a substance use disorder, does not provide counseling or treatment services to residents, promotes sustained recovery from substance use disorders, and follows the sober living guidelines published by the federal Substance Abuse and Mental Health Services Administration.

Sec. 37. **CULTURALLY RESPONSIVE RECOVERY COMMUNITY GRANTS.**

The commissioner must establish start-up and capacity-building grants for prospective or new recovery community organizations serving or intending to serve culturally specific or population-specific recovery communities. Grants may be used for expenses that are not reimbursable under Minnesota health care programs, including but not limited to:

(1) costs associated with hiring and retaining staff;

(2) staff training, purchasing office equipment and supplies;

(3) purchasing software and website services;

(4) costs associated with establishing nonprofit status;

(5) rental and lease costs and community outreach; and

(6) education and recovery events.

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

Sec. 38. **WITHDRAWAL MANAGEMENT START-UP AND CAPACITY-BUILDING GRANTS.**

The commissioner must establish start-up and capacity-building grants for prospective or new withdrawal management programs that will meet medically monitored or clinically monitored levels of care. Grants may be used for expenses that are not reimbursable under Minnesota health care programs, including but not limited to:

(1) costs associated with hiring staff;

(2) costs associated with staff retention;

(3) the purchase of office equipment and supplies;

(4) the purchase of software;

(5) costs associated with obtaining applicable and required licenses;

(6) business formation costs;

(7) costs associated with staff training; and

(8) the purchase of medical equipment and supplies necessary to meet health and safety requirements.

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

Sec. 39. **FAMILY TREATMENT START-UP AND CAPACITY-BUILDING GRANTS.**

The commissioner must establish start-up and capacity-building grants for prospective or new substance use disorder treatment programs that serve parents with their children. Grants must be used for expenses that are not reimbursable under Minnesota health care programs, including but not limited to:

(1) physical plant upgrades to support larger family units;

(2) supporting the expansion or development of programs that provide holistic services, including trauma supports, conflict resolution, and parenting skills;

(3) increasing awareness, education, and outreach utilizing culturally responsive approaches to develop relationships between culturally specific communities and clinical treatment provider programs; and

(4) expanding culturally specific family programs and accommodating diverse family units.

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Sec. 24. **[254B.17] WITHDRAWAL MANAGEMENT START-UP AND CAPACITY-BUILDING GRANTS.**

The commissioner must establish start-up and capacity-building grants for prospective or new withdrawal management programs licensed under chapter 245F that will meet medically monitored or clinically monitored levels of care. Grants may be used for expenses that are not reimbursable under Minnesota health care programs, including but not limited to:

(1) costs associated with hiring staff;

(2) costs associated with staff retention;

(3) the purchase of office equipment and supplies;

(4) the purchase of software;

(5) costs associated with obtaining applicable and required licenses;

(6) business formation costs;

(7) costs associated with staff training; and

(8) the purchase of medical equipment and supplies necessary to meet health and safety requirements.

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

Sec. 29. **FAMILY TREATMENT START-UP AND CAPACITY-BUILDING GRANTS.**

The commissioner of human services must establish start-up and capacity-building grants for prospective or new substance use disorder treatment programs that serve parents with their children. Grants must be used for expenses that are not reimbursable under Minnesota health care programs, including but not limited to:

(1) physical plant upgrades to support larger family units;

(2) supporting the expansion or development of programs that provide holistic services, including trauma supports, conflict resolution, and parenting skills;

(3) increasing awareness, education, and outreach utilizing culturally responsive approaches to develop relationships between culturally specific communities and clinical treatment provider programs; and

(4) expanding culturally specific family programs and accommodating diverse family units.

Senate Language S2934-3

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

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Sec. 30. **SAFE RECOVERY SITES START-UP AND CAPACITY-BUILDING GRANTS.**

(a) The commissioner of human services must establish start-up and capacity-building grants for current or prospective harm reduction organizations to promote health, wellness, safety, and recovery to people who are in active stages of substance use disorder. Grants must be used to establish safe recovery sites that offer harm reduction services and supplies, including but not limited to:

(1) safe injection spaces;

(2) sterile needle exchange;

(3) opiate antagonist rescue kits;

(4) fentanyl and other drug testing;

(5) street outreach;

(6) educational and referral services;

(7) health, safety, and wellness services; and

(8) access to hygiene and sanitation.

(b) The commissioner must conduct local community outreach and engagement in collaboration with newly established safe recovery sites. The commissioner must evaluate the efficacy of safe recovery sites and collect data to measure health-related and public safety outcomes.

(c) The commissioner must prioritize grant applications for organizations that are culturally specific or culturally responsive and that commit to serving individuals from communities that are disproportionately impacted by the opioid epidemic, including:

(1) Native American, American Indian, and Indigenous communities; and

(2) Black, African American, and African-born communities.

(d) For purposes of this section, a "culturally specific" or "culturally responsive" organization is an organization that is designed to address the unique needs of individuals who share a common language, racial, ethnic, or social background, and is governed with significant input from individuals of that specific background.

HOUSE ARTICLE 3, SECTION 31 WAS REMOVED TO MATCH WITH SENATE ARTICLE 5, SECTION 5.

Sec. 40. **MEDICAL ASSISTANCE BEHAVIORAL HEALTH SYSTEM TRANSFORMATION STUDY.**

The commissioner, in consultation with stakeholders, must evaluate the feasibility, potential design, and federal authorities needed to cover traditional healing, behavioral health services in correctional facilities, and contingency management under the medical assistance program.

Sec. 41. **REVISOR INSTRUCTION.**

The revisor of statutes shall renumber Minnesota Statutes, section 245G.01, subdivision 20b, as Minnesota Statutes, section 245G.01, subdivision 20d, and make any necessary changes to cross-references.

Sec. 32. **REVISED PAYMENT METHODOLOGY FOR OPIOID TREATMENT PROGRAMS.**

The commissioner of human services must revise the payment methodology for substance use services with medications for opioid use disorder under Minnesota Statutes, section 254B.05, subdivision 5, paragraph (b), clause (6). Payment must occur only if the provider renders the service or services billed on that date of service or, in the case of drugs and drug-related services, within a week as defined by the commissioner. The revised payment methodology must include a weekly bundled rate that includes the costs of drugs, drug administration and observation, drug packaging and preparation, and nursing time. The bundled weekly rate must be based on the Medicare rate. The commissioner must seek all necessary waivers, state plan amendments, and federal authorities required to implement the revised payment methodology.

EFFECTIVE DATE. This section is effective January 1, 2024, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 33. **MEDICAL ASSISTANCE BEHAVIORAL HEALTH SYSTEM TRANSFORMATION STUDY.**

The commissioner of human services, in consultation with stakeholders, must evaluate the feasibility, potential design, and federal authorities needed to cover traditional healing, behavioral health services in correctional facilities, and contingency management under the medical assistance program.

Sec. 34. **OPIOID TREATMENT PROGRAM WORK GROUP.**

The commissioner of human services must convene a work group of community partners to evaluate the opioid treatment program model under Minnesota Statutes, section 245G.22, and to make recommendations on overall service design; simplification or improvement of regulatory oversight; increasing access to opioid treatment programs and improving the quality of care; addressing geographic, racial, and justice-related disparities for individuals who utilize or may benefit from medications for opioid use disorder; and other related topics, as determined by the work group. The commissioner must report the work group's recommendations to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services by January 15, 2024.

Sec. 35. **REVISOR INSTRUCTION.**

The revisor of statutes shall renumber Minnesota Statutes, section 245G.01, subdivision 20b, as Minnesota Statutes, section 245G.01, subdivision 20d, and make any other necessary changes to subdivision numbers or cross-references.

Senate Language S2934-3

Sec. 42. **REPEALER.**

(a) Minnesota Statutes 2022, sections 245G.05, subdivision 2; and 256B.0759, subdivision 6, are repealed.

(b) Minnesota Statutes 2022, section 246.18, subdivisions 2 and 2a, are repealed.

EFFECTIVE DATE. Paragraph (a) is effective January 1, 2024. Paragraph (b) is effective July 1, 2023.

House Language UES2934-2

Sec. 36. **REPEALER.**

(a) Minnesota Statutes 2022, sections 245G.06, subdivision 2; and 256B.0759, subdivision 6, are repealed.

(b) Minnesota Statutes 2022, section 246.18, subdivisions 2 and 2a, are repealed.

EFFECTIVE DATE. Paragraph (a) is effective January 1, 2024. Paragraph (b) is effective July 1, 2023.