ARTICLE 3

SUBSTANCE USE DISORDER SERVICES

Section 1. Minnesota Statutes 2022, section 151.065, subdivision 7, is amended to read:

Subd. 7. Deposit of fees. (a) The license fees collected under this section, with the exception of the fees identified in paragraphs (b) and (c), shall be deposited in the state government special revenue fund.

(b) $5,000 of each fee collected under subdivision 1, clauses (6) to (9), and (11) to (15), and subdivision 3, clauses (4) to (7), and (9) to (13), and $55,000 of each fee collected under subdivision 1, clause (16); and subdivision 3, clause (14), shall be deposited in the opiate epidemic response fund established in section 256.043.

(c) If the fees collected under subdivision 1, clause (16), or subdivision 3, clause (14), are reduced under section 256.043, $5,000 of the reduced fee shall be deposited in the opiate epidemic response fund in section 256.043.

Sec. 2. Minnesota Statutes 2023 Supplement, 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 as defined in section 254B.01, subdivision 11; peer recovery support services provided by a recovery community organization as defined in section 254B.01, subdivision 8; and an acute care inpatient facility that provides services or treatment for mental illness, developmental disability, substance use disorder, or emotional disturbance.

Sec. 3. Minnesota Statutes 2022, section 245F.08, subdivision 3, is amended to read:

Subd. 3. Peer recovery support services. (a) Peers in recovery serve as mentors or recovery-support partners for individuals in recovery, and may provide encouragement, self-disclosure of recovery experiences, transportation to appointments, assistance with finding resources that will help locate housing, job search resources, and assistance finding and participating in support groups.

(b) Peer recovery support services are provided by a recovery peer and must be supervised by the responsible staff person, must be provided in accordance with sections 254B.05, subdivision 5, and 254B.052.

EFFECTIVE DATE. This section is effective January 1, 2025.
Sec. 4. Minnesota Statutes 2023 Supplement, section 245G.07, subdivision 2, is amended to read:

Subd. 2. Additional treatment service. A license holder may provide or arrange the following additional treatment service as a part of the client's individual treatment plan:

1. relationship counseling provided by a qualified professional to help the client identify the impact of the client's substance use disorder on others and to help the client and persons in the client's support structure identify and change behaviors that contribute to the client's substance use disorder;

2. therapeutic recreation to allow the client to participate in recreational activities without the use of mood-altering chemicals and to plan and select leisure activities that do not involve the inappropriate use of chemicals;

3. stress management and physical well-being to help the client reach and maintain an appropriate level of health, physical fitness, and well-being;

4. living skills development to help the client learn basic skills necessary for independent living;

5. employment or educational services to help the client become financially independent;

6. socialization skills development to help the client live and interact with others in a positive and productive manner;

7. room, board, and supervision at the treatment site to provide the client with a safe and appropriate environment to gain and practice new skills; and

8. peer recovery support services must be provided by an individual in a recovery peer qualified according to section 245I.04, subdivision 18. Peer recovery support services include education; advocacy; mentoring through self-disclosure of personal recovery experiences; attending recovery and other support groups with a client; accompanying the client to appointments that support recovery; assistance accessing resources to obtain housing; employment, education, and advocacy services; and nonclinical recovery support to assist the transition from treatment into the recovery community must be provided according to sections 254B.05, subdivision 5, and 254B.052.

EFFECTIVE DATE. This section is effective January 1, 2025.

Sec. 5. Minnesota Statutes 2023 Supplement, section 245I.04, subdivision 19, is amended to read:

Subd. 19. Recovery peer scope of practice. (a) A recovery peer, under the supervision of a licensed alcohol and drug counselor or mental health professional who meets the qualifications under subdivision 2, must:

1. provide individualized peer support and individual recovery planning to each client;
(2) promote a client's recovery goals, self-sufficiency, self-advocacy, and development of natural supports; and

(3) support a client's maintenance of skills that the client has learned from other services.

(b) A licensed alcohol and drug counselor or mental health professional providing supervision to a recovery peer must meet with the recovery peer face-to-face, either remotely or in person, at least once per month in order to provide adequate supervision to the recovery peer. Supervision must include reviewing individual recovery plans, as defined in section 254B.01, subdivision 4e, and reviewing documentation of peer recovery support services provided for clients and may include client updates, discussion of ethical considerations, and any other questions or issues relevant to peer recovery support services.

Sec. 6. Minnesota Statutes 2022, section 254B.01, is amended by adding a subdivision to read:

Subd. 4e. Individual recovery plan. "Individual recovery plan" means a person-centered outline of supports that an eligible vendor of peer recovery support services under section 254B.05, subdivision 1, must develop to respond to an individual's peer recovery support services needs and goals.

Sec. 7. Minnesota Statutes 2022, section 254B.01, is amended by adding a subdivision to read:

Subd. 8a. Recovery peer. "Recovery peer" means a person who is qualified according to section 245I.04, subdivision 18, to provide peer recovery support services within the scope of practice provided under section 245I.04, subdivision 19.

Sec. 8. Minnesota Statutes 2023 Supplement, section 254B.05, subdivision 1, is amended to read:

Subdivision 1. Licensure or certification required. (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 the requirements of clauses (1) to

(12) and meets membership certification or accreditation requirements of the Association

of Recovery Community Organizations, the Alliance for Recovery Centered Organizations,

the Council on Accreditation of Peer Recovery Support Services, or a Minnesota statewide

recovery community organization identified by the commissioner is an eligible vendor of

two recovery services. A Minnesota statewide recovery organization identified by

the commissioner must update recovery community organization applicants for certification

or accreditation on the status of the application within 45 days of receipt. If the approved

statewide recovery organization denies an application, it must provide a written explanation

for the denial to the recovery community organization. Eligible vendors under this paragraph

must:

(1) be nonprofit organizations under section 501(c)(3) of the Internal Revenue Code, be

free from conflicting self-interests, and be autonomous in decision-making, program

development, peer recovery support services provided, and advocacy efforts for the purpose

of supporting the recovery community organization's mission;

(2) be led and governed by individuals in the recovery community, with more than 50

percent of the board of directors or advisory board members self-identifying as people in

personal recovery from substance use disorders;

(3) primarily focus on recovery from substance use disorders, with missions and visions

that support this primary focus have a mission statement and conduct corresponding activities

indicating that the organization's primary purpose is to support recovery from substance

use disorder;

(4) be grassroots and reflective of and engaged with the community served demonstrate

ongoing community engagement with the identified primary region and population served

by the organization, including individuals in recovery and their families, friends, and recovery

allies;

(5) be accountable to the recovery community through documented priority-setting and

participatory decision-making processes that promote the involvement and engagement of,

and consultation with, people in recovery and their families, friends, and recovery allies;

(6) provide nonclinical peer recovery support services, including but not limited to

recovery support groups, recovery coaching, telephone recovery support, skill-building

groups, and harm-reduction activities, and provide recovery public education and advocacy;

(7) have written policies that allow for and support opportunities for all paths toward

recovery and refrain from excluding anyone based on their chosen recovery path, which

PAGE R4A3
may include but is not limited to harm reduction paths, faith-based paths, and non-faith-based paths;

(8) be purposeful in meeting the diverse needs of Black, Indigenous, and people of color communities, including LGBTQIA+ communities, and other underrepresented or marginalized communities. Organizational practices may include board and staff development activities, organizational practices training, service offerings, advocacy efforts, and culturally informed outreach and service plans;

(9) be stewards of use recovery-friendly language in all media and written materials that is supportive of and promotes recovery across diverse geographical and cultural contexts and reduces stigma; and

(10) establish and maintain an employee and volunteer a publicly available recovery community organization code of ethics and easily accessible grievance policy and procedures posted in physical spaces, on websites, or as program policies or forms;

(11) provide an orientation for recovery peers that includes an overview of the consumer advocacy services provided by the Ombudsman for Mental Health and Developmental Disabilities and other relevant advocacy services; and

(12) provide notice to peer recovery support services participants that includes the following statement: "If you have a complaint about the provider or the person providing your peer recovery support services, you may contact the Minnesota Alliance of Recovery Community Organizations. You may also contact the Office of Ombudsman for Mental Health and Developmental Disabilities." The statement must also include:

(i) the telephone number, website address, email address, and mailing address of the Minnesota Alliance of Recovery Community Organizations and the Office of Ombudsman for Mental Health and Developmental Disabilities;

(ii) the recovery community organization's name, address, email, telephone number, and name or title of the person at the recovery community organization to whom problems or complaints may be directed; and

(iii) a statement that the recovery community organization will not retaliate against a peer recovery support services participant because of a complaint.

(e) A recovery community organization approved by the commissioner before June 30, 2023, shall retain their designation as recovery community organizations must have begun the application process as required by an approved certifying or accrediting entity and have begun the process to meet the requirements under paragraph (d) by September 1, 2024, in order to be considered as an eligible vendor of peer recovery support services.

(f) A recovery community organization that is aggrieved by an accreditation, certification, or membership determination and believes it meets the requirements under paragraph (d) may appeal the determination under section 256.045, subdivision 3; paragraph (a); clause
If the human services judge determines that the recovery community organization meets the requirements under paragraph (d), the recovery community organization is an eligible vendor of peer recovery support services.

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.

Hospitals, federally qualified health centers, and rural health clinics are eligible vendors of a comprehensive assessment when the comprehensive assessment is completed according to section 245G.05 and by an individual who meets the criteria of an alcohol and drug counselor according to section 245G.11; subdivision 5. The alcohol and drug counselor must be individually enrolled with the commissioner and reported on the claim as the individual who provided the service.

Any complaints about a recovery community organization or peer recovery support services may be made to and reviewed or investigated by the ombudsperson for behavioral health and developmental disabilities under sections 245.91 and 245.94.

EFFECTIVE DATE. This section is effective the day following final enactment, except the amendments adding paragraph (d), clauses (11) and (12), and paragraph (i) are effective July 1, 2025.
(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) 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) withdrawal management services provided according to chapter 245F;

(6) 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;

(7) 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;

(B) 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 ASAM level of care 3.5 according to section 254B.19, subdivision 1, clause (7), and are 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

(9) 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:

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

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

(B) is licensed under chapter 245A and sections 245G.01 to 245G.19; 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.
(e) Adolescent residential programs that meet the requirements of Minnesota Rules, parts 2960.0430 to 2960.0490 and 2960.0580 to 2960.0690, are exempt from the requirements in paragraph (c), clause (4), items (i) to (iv).

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

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

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

(i) 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.

(j) Eligible vendors of peer recovery support services must:

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

2. limit an individual client to 14 hours per week for peer recovery support services from an individual provider of peer recovery support services.

(k) Peer recovery support services not provided in accordance with section 254B.052 are subject to monetary recovery under section 256B.064 as money improperly paid.

EFFECTIVE DATE. This section is effective January 1, 2025.
provided to promote a client's recovery goals, self-sufficiency, self-advocacy, and development of natural supports and to support maintenance of a client's recovery.

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

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

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

Subd. 2. Individual recovery plan. (a) The individual recovery plan must be developed with the client and must be completed within the first three sessions with a recovery peer.

(b) The recovery peer must document how each session ties into the client's individual recovery plan. The individual recovery plan must be updated as needed. The individual recovery plan must include:

(1) the client's name;
(2) the recovery peer's name;
(3) the name of the recovery peer's supervisor;
(4) the client's recovery goals;
(5) the client's resources and assets to support recovery;
(6) activities that may support meeting identified goals; and
(7) the planned frequency of peer recovery support services sessions between the recovery peer and the client.

Subd. 3. Eligible vendor documentation requirements. An eligible vendor of peer recovery support services under section 254B.05, subdivision 1, must keep a secure file for each individual receiving medical assistance peer recovery support services. The file must include, at a minimum:

(1) the client's comprehensive assessment under section 245G.05 that led to the client's referral for peer recovery support services;
(2) the client's individual recovery plan; and
(3) documentation of each billed peer recovery support services interaction between the client and the recovery peer, including the date, start and end time with a.m. and p.m.
Section 1. Minnesota Statutes 2023 Supplement, section 256.042, subdivision 2, is amended to read:

Subd. 2. Membership. (a) The council shall consist of the following 20 voting members, appointed by the commissioner of human services except as otherwise specified, and three nonvoting members:

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

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

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

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

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

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

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

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

designations, the client's response, and the name of the recovery peer who provided the service.

EFFECTIVE DATE. This section is effective January 1, 2025.
(9) one member appointed by the Minnesota Ambulance Association who is serving with an ambulance service as an emergency medical technician, advanced emergency medical technician, or paramedic;

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

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

(12) two members representing Indian tribes, one representing the Ojibwe tribes and one representing the Dakota tribes;

(13) one member representing an urban American Indian community;

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

(15) one mental health advocate representing persons with mental illness;

(16) one member appointed by the Minnesota Hospital Association;

(17) one member representing a local health department; and

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

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

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

(d) The chair shall convene the council at least quarterly, and may convene other meetings as necessary. The chair shall convene meetings at different locations in the state to provide geographic access, and shall ensure that at least one-half of the meetings are held at locations outside of the seven-county metropolitan area.

(e) The commissioner of human services shall provide staff and administrative services for the advisory council.
(f) The council is subject to chapter 13D.

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

Sec. 2. Minnesota Statutes 2023 Supplement, section 256.043, subdivision 3, is amended to read:

Subd. 3. Appropriations from registration and license fee account. (a) The appropriations in paragraphs (b) to (n) shall be made from the registration and license fee account on a fiscal year basis in the order specified.

(b) The appropriations specified in Laws 2019, chapter 63, article 3, section 1, paragraphs (b), (f), (g), and (h), as amended by Laws 2020, chapter 115, article 3, section 35, shall be made accordingly.

(c) $100,000 is appropriated to the commissioner of human services for grants for opiate antagonist distribution. Grantees may utilize funds for opioid overdose prevention, community asset mapping, education, and opiate antagonist distribution.

(d) $2,000,000 is appropriated to the commissioner of human services for grants to Tribal nations and five urban Indian communities for traditional healing practices for American Indians and to increase the capacity of culturally specific providers in the behavioral health workforce.

(e) $400,000 is appropriated to the commissioner of human services for competitive grants for opioid-focused Project ECHO programs.

(f) $277,000 in fiscal year 2024 and $321,000 each year thereafter is appropriated to the commissioner of human services to administer the funding distribution and reporting requirements in paragraph (o).

(g) $3,000,000 in fiscal year 2025 and $3,000,000 each year thereafter is appropriated to the commissioner of human services for safe recovery sites start-up and capacity building grants under section 254B.18.

(h) $395,000 in fiscal year 2024 and $415,000 each year thereafter is appropriated to the commissioner of human services for the opioid overdose surge alert system under section 245.891.

(i) $300,000 is appropriated to the commissioner of management and budget for evaluation activities under section 256.042, subdivision 1, paragraph (c).

(j) $261,000 is appropriated to the commissioner of human services for the provision of administrative services to the Opiate Epidemic Response Advisory Council and for the administration of the grants awarded under paragraph (n).

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

Sec. 11. Minnesota Statutes 2023 Supplement, section 256.043, subdivision 3, is amended to read:

Subd. 3. Appropriations from registration and license fee account. (a) The appropriations in paragraphs (b) to (n) shall be made from the registration and license fee account on a fiscal year basis in the order specified.

(b) The appropriations specified in Laws 2019, chapter 63, article 3, section 1, paragraphs (b), (f), (g), and (h), as amended by Laws 2020, chapter 115, article 3, section 35, shall be made accordingly.

(c) $100,000 is appropriated to the commissioner of human services for grants for opiate antagonist distribution. Grantees may utilize funds for opioid overdose prevention, community asset mapping, education, and opiate antagonist distribution.

(d) $2,000,000 is appropriated to the commissioner of human services for grants to Tribal nations and five urban Indian communities for traditional healing practices for American Indians and to increase the capacity of culturally specific providers in the behavioral health workforce.

(e) $400,000 is appropriated to the commissioner of human services for competitive grants for opioid-focused Project ECHO programs.

(f) $277,000 in fiscal year 2024 and $321,000 each year thereafter is appropriated to the commissioner of human services to administer the funding distribution and reporting requirements in paragraph (o).

(g) $3,000,000 in fiscal year 2025 and $3,000,000 each year thereafter is appropriated to the commissioner of human services for safe recovery sites start-up and capacity building grants under section 254B.18.

(h) $395,000 in fiscal year 2024 and $415,000 each year thereafter is appropriated to the commissioner of human services for the opioid overdose surge alert system under section 245.891.

(i) $300,000 is appropriated to the commissioner of management and budget for evaluation activities under section 256.042, subdivision 1, paragraph (c).

(j) $261,000 is appropriated to the commissioner of human services for the provision of administrative services to the Opiate Epidemic Response Advisory Council and for the administration of the grants awarded under paragraph (n).

(k) $126,000 is appropriated to the Board of Pharmacy for the collection of the registration fees under section 151.066.
$672,000 is appropriated to the commissioner of public safety for the Bureau of Criminal Apprehension. Of this amount, $384,000 is for drug scientists and lab supplies and $288,000 is for special agent positions focused on drug interdiction and drug trafficking.

(m) After the appropriations in paragraphs (b) to (l) are made, 50 percent of the remaining amount is appropriated to the commissioner of human services for distribution to county social service agencies and Tribal social service agency initiative projects authorized under section 256.01, subdivision 14b, to provide prevention and child protection services to children and families who are affected by addiction. The commissioner shall distribute this money proportionally to county social service agencies and Tribal social service agency initiative projects through a formula based on intake data from the previous three calendar years related to substance use and out-of-home placement episodes where parental drug abuse is the primary reason for the out-of-home placement using data from the previous calendar year.

County social service agencies and Tribal social service agency initiative projects receiving funds from the opiate epidemic response fund must annually report to the commissioner on how the funds were used to provide prevention and child protection services, including measurable outcomes, as determined by the commissioner. County social service agencies and Tribal social service agency initiative projects must not use funds received under this paragraph to supplant current state or local funding received for child protection services for children and families who are affected by addiction.

(n) After the appropriations in paragraphs (b) to (m) are made, the remaining amount in the account is appropriated to the commissioner of human services to award grants as specified by the Opiate Epidemic Response Advisory Council in accordance with section 256.042, unless otherwise appropriated by the legislature.

(o) Beginning in fiscal year 2022 and each year thereafter, funds for county social service agencies and Tribal social service agency initiative projects under paragraph (m) and grant funds specified by the Opiate Epidemic Response Advisory Council under paragraph (n) may be distributed on a calendar year basis.

(p) Notwithstanding section 16A.28, subdivision 3, funds appropriated in paragraphs (c), (d), (e), (g), (m), and (n) are available for three years after the funds are appropriated.

(p) Notwithstanding section 16A.28, subdivision 3, funds appropriated in paragraphs (c), (d), (e), (g), (m), and (n) are available for three years after the funds are appropriated.

Subdivision 1. Establishment. The commissioner must submit a waiver application to the Centers for Medicare and Medicaid Services to implement a medical assistance demonstration project to provide health care and coordination services that bridge to community-based services for individuals confined in state, local, or Tribal correctional facilities, or facilities located outside of the seven-county metropolitan area that have an inmate census with a significant proportion of Tribal members or American Indians, prior to community reentry. The demonstration must be designed to:

(1) increase continuity of coverage;
(2) improve access to health care services, including mental health services, physical  
health services, and substance use disorder treatment services;
(3) enhance coordination between Medicaid systems, health and human services systems,  
correctional systems, and community-based providers;
(4) reduce overdoses and deaths following release;
(5) decrease disparities in overdoses and deaths following release; and  
(6) maximize health and overall community reentry outcomes.

Subd. 2. Eligible individuals. Notwithstanding section 256B.055, subdivision 14,  
individuals are eligible to receive services under this demonstration if they are eligible under  
section 256B.055, subdivision 3a, 6, 7, 7a, 9, 15, 16, or 17, as determined by the  
commissioner in collaboration with correctional facilities, local governments, and Tribal  
governments;

Subd. 3. Eligible correctional facilities. (a) The commissioner's waiver application is  
limited to:
(1) three state correctional facilities to be determined by the commissioner of corrections,  
one of which must be the Minnesota Correctional Facility-Shakopee;
(2) two facilities for delinquent children and youth licensed under section 241.021,  
subdivision 2, identified in coordination with the Minnesota Juvenile Detention Association  
and the Minnesota Sheriffs' Association;
(3) four correctional facilities for adults licensed under section 241.021, subdivision 1,  
identified in coordination with the Minnesota Sheriffs' Association and the Association of  
Minnesota Counties; and  
(4) one correctional facility owned and managed by a Tribal government or a facility  
located outside of the seven-county metropolitan area that has an inmate census with a  
significant proportion of Tribal members or American Indians.

(b) Additional facilities may be added to the waiver contingent on legislative authorization  
and appropriations;

Subd. 4. Services and duration. (a) Services must be provided 90 days prior to an  
individual's release date or, if an individual's confinement is less than 90 days, during the  
time period between a medical assistance eligibility determination and the release to the  
community;

(b) Facilities must offer the following services using either community-based or  
corrections-based providers:
(1) case management activities to address physical and behavioral health needs, including  
a comprehensive assessment of individual needs, development of a person-centered care
plan, referrals and other activities to address assessed needs, and monitoring and follow-up activities;

(2) drug coverage in accordance with section 256B.0625, subdivision 13, including up to a 30-day supply of drugs upon release;

(3) substance use disorder comprehensive assessments according section 254B.05, subdivision 5, paragraph (b), clause (2);

(4) treatment coordination services according to section 254B.05, subdivision 5, paragraph (b), clause (3);

(5) peer recovery support services according to sections 245I.04, subdivisions 18 and 19, and 254B.05, subdivision 5, paragraph (b), clause (4);

(6) substance use disorder individual and group counseling provided according to sections 245G.07, subdivision 1, paragraph (a), clause (1); 245G.11, subdivision 5; and 254B.05;

(7) mental health diagnostic assessments as required under section 245I.10;

(8) group and individual psychotherapy as required under section 256B.0671;

(9) peer specialist services as required under sections 245I.04 and 256B.0615;

(10) family planning and obstetrics and gynecology services; and

(11) physical health well-being and screenings and care for adults and youth.

Subd. 5. Provider requirements and standards. (a) Service providers must adhere to applicable licensing and provider requirements under chapters 245A, 245G, 245I, 254B, 256B, and 256I.

(b) Service providers must be enrolled to provide services under Minnesota health care programs.

(c) Services must be provided by eligible providers employed by the correctional facility or by eligible community providers under contract with the correctional facility.

(d) The commissioner must determine whether each facility is ready to participate in this demonstration based on a facility-submitted assessment of the facility's readiness to implement:

(1) prerelease medical assistance application and enrollment processes for inmates not enrolled in medical assistance coverage.
(2) the provision or facilitation of all required prerelease services for a period of up to
90 days prior to release;
(3) coordination among county and Tribal human services agencies and all other entities
with a role in furnishing health care and supports to address health related social needs;
(4) appropriate reentry planning, prerelease care management, and assistance with care
transitions to the community;
(5) operational approaches to implementing certain Medicaid and CHIP requirements
including applications, suspensions, notices, fair hearings, and reasonable promptness for
coverage of services;
(6) a data exchange process to support care coordination and transition activities; and
(7) reporting of all requested data to the commissioner of human services to support
program monitoring; evaluation, oversight, and all financial data to meet reinvestment
requirements.
(c) Participating facilities must detail reinvestment plans for all new federal Medicaid
money expended for reentry services that were previously the responsibility of each facility
and provide detailed financial reports to the commissioner.
Subd. 6. Payment rates. (a) Payment rates for services under this section that are
approved under Minnesota’s state plan agreement with the Centers for Medicare and Medicaid
Services are equal to current and applicable state law and federal requirements.
(b) Case management payment rates are equal to rates authorized by the commissioner
for relocation targeted case management under section 256B.0621, subdivision 10.
(c) Claims for covered drugs purchased through discount purchasing programs, such as
the Federal Supply Schedule of the United States General Services Administration or the
MMCAP Infuse program, must be no more than the actual acquisition cost plus the
professional dispensing fee in section 256B.0625, subdivision 13c. Drugs administered to
members must be billed on a professional claim in accordance with section 256B.0625,
subdivision 13c, paragraph (e), and submitted with the actual acquisition cost for the drug
on the claim line. Pharmacy claims must be submitted with the actual acquisition cost as
the ingredient cost field and the dispensing fee in section 256B.0625, subdivision 13c, as
the dispensing fee field on the claim with the basis of cost indicator of 08. Providers may
establish written protocols for establishing or calculating the facility’s actual acquisition
drug cost based on a monthly, quarterly, or other average of the facility’s actual acquisition
drug cost through the discount purchasing program. A written protocol must not include an
inflation, markup, spread, or margin to be added to the provider’s actual purchase price after
subtracting all discounts.
Subd. 7. Reentry services working group. (a) The commissioner of human services
in collaboration with the commissioner of corrections, must convene a reentry services
working group to consider ways to improve the demonstration under this section and related
policies for justice-involved individuals.

(b) The working group must be composed of balanced representation, including:

(1) people with lived experience; and

(2) representatives from:

(i) community health care providers;

(ii) the Minnesota Sheriffs’ Association;

(iii) the Minnesota Association for County Social Service Administrators;

(iv) the Association of Minnesota Counties;

(v) the Minnesota Juvenile Detention Association;

(vi) the Office of Addiction and Recovery;

(vii) NAMI Minnesota;

(viii) the Minnesota Association of Resources for Recovery and Chemical Health;

(ix) Tribal Nations; and

(x) the Minnesota Alliance of Recovery Community Organizations.

c) The working group must:

(1) advise on the waiver application, implementation, monitoring, evaluation, and
reinvestment plan;

(2) recommend strategies to improve processes that ensure notifications of the individual’s
release date, current location, postrelease location, and other relevant information are
provided to state, county, and Tribal eligibility systems and managed care organizations;

(3) consider the value of expanding, replicating, or adapting the components of the
demonstration authorized under this section to additional populations;

(4) consider information technology and other implementation needs for participating
correctional facilities; and

(5) recommend ideas to fund expanded reentry services.

EFFECTIVE DATE. This section is effective January 1, 2026, or upon federal approval,
whichever is later, except subdivision 7 is effective July 1, 2024. The commissioner of
human services must notify the revisor of statutes when federal approval is obtained.
Sec. 13.  Minnesota Statutes 2022, section 256B.69, subdivision 4, is amended to read:

Subd. 4. Limitation of choice. (a) The commissioner shall develop criteria to determine when limitation of choice may be implemented in the experimental counties. The criteria shall ensure that all eligible individuals in the county have continuing access to the full range of medical assistance services as specified in subdivision 6.

(b) The commissioner shall exempt the following persons from participation in the project, in addition to those who do not meet the criteria for limitation of choice:

1. persons eligible for medical assistance according to section 256B.055, subdivision 1;

2. persons eligible for medical assistance due to blindness or disability as determined by the Social Security Administration or the state medical review team, unless:

   (i) they are 65 years of age or older; or
   (ii) they reside in Itasca County or they reside in a county in which the commissioner conducts a pilot project under a waiver granted pursuant to section 1115 of the Social Security Act;

3. recipients who currently have private coverage through a health maintenance organization;

4. recipients who are eligible for medical assistance by spending down excess income for medical expenses other than the nursing facility per diem expense;

5. recipients who receive benefits under the Refugee Assistance Program, established under United States Code, title 8, section 1522(e);

6. children who are both determined to be severely emotionally disturbed and receiving case management services according to section 256B.0625, subdivision 20, except children who are eligible for and who decline enrollment in an approved preferred integrated network under section 245.4682;

7. adults who are both determined to be seriously and persistently mentally ill and received case management services according to section 256B.0625, subdivision 20;

8. persons eligible for medical assistance according to section 256B.057, subdivision 10;

9. persons with access to cost-effective employer-sponsored private health insurance or persons enrolled in a non-Medicare individual health plan determined to be cost-effective according to section 256B.0625, subdivision 15; and

10. [Blank]
(10) persons who are absent from the state for more than 30 consecutive days but still
deemed a resident of Minnesota, identified in accordance with section 256B.056, subdivision
1, paragraph (b); and
(11) persons who are enrolled in the reentry demonstration waiver under section
256B.0761.

Children under age 21 who are in foster placement may enroll in the project on an elective
basis. Individuals excluded under clauses (1), (6), and (7) may choose to enroll on an elective
basis. The commissioner may enroll recipients in the prepaid medical assistance program
for seniors who are (1) age 65 and over; and (2) eligible for medical assistance by spending
down excess income.

(c) The commissioner may allow persons with a one-month spenddown who are otherwise
eligible to enroll to voluntarily enroll or remain enrolled, if they elect to prepay their monthly
spenddown to the state.

(d) The commissioner may require those individuals to enroll in the prepaid medical
assistance program who otherwise would have been excluded under paragraph (b), clauses
(1), (3), and (8), and under Minnesota Rules, part 9500.1452, subpart 2, items H, K, and L.

(e) Before limitation of choice is implemented, eligible individuals shall be notified and
after notification, shall be allowed to choose only among demonstration providers. The
commissioner may assign an individual with private coverage through a health maintenance
organization, to the same health maintenance organization for medical assistance coverage,
if the health maintenance organization is under contract for medical assistance in the
individual’s county of residence. After initially choosing a provider, the recipient is allowed
to change that choice only at specified times as allowed by the commissioner. If a
demonstration provider ends participation in the project for any reason, a recipient enrolled
with that provider must select a new provider but may change providers without cause once
more within the first 60 days after enrollment with the second provider.

(f) An infant born to a woman who is eligible for and receiving medical assistance and
who is enrolled in the prepaid medical assistance program shall be retroactively enrolled to
the month of birth in the same managed care plan as the mother once the child is enrolled
in medical assistance unless the child is determined to be excluded from enrollment in a
prepaid plan under this section;

EFFECTIVE DATE. This section is effective January 1, 2026, or upon federal approval,
whichever is later. The commissioner of human services must notify the revisor of statutes
when federal approval is obtained.

Sec. 14. Minnesota Statutes 2023 Supplement, section 256B.761, is amended to read:

256B.761 REIMBURSEMENT FOR MENTAL HEALTH SERVICES.

(a) Effective for services rendered on or after July 1, 2001, payment for medication
management provided to psychiatric patients, outpatient mental health services, day treatment
services, home-based mental health services; and family community support services shall be paid at the lower of (1) submitted charges, or (2) 75.6 percent of the 50th percentile of 1999 charges.

(b) Effective July 1, 2001, the medical assistance rates for outpatient mental health services provided by an entity that operates: (1) a Medicare-certified comprehensive outpatient rehabilitation facility; and (2) a facility that was certified prior to January 1, 1993, with at least 33 percent of the clients receiving rehabilitation services in the most recent calendar year who are medical assistance recipients, will be increased by 38 percent, when those services are provided within the comprehensive outpatient rehabilitation facility and provided to residents of nursing facilities owned by the entity.

(c) In addition to rate increases otherwise provided, the commissioner may restructure coverage policy and rates to improve access to adult rehabilitative mental health services under section 256B.0623 and related mental health support services under section 256B.021, subdivision 4, paragraph (f), clause (2). For state fiscal years 2015 and 2016, the projected state share of increased costs due to this paragraph is transferred from adult mental health grants under sections 254.4661 and 256E.12. The transfer for fiscal year 2016 is a permanent base adjustment for subsequent fiscal years. Payments made to managed care plans and county-based purchasing plans under sections 256B.69, 256B.692, and 256L.12 shall reflect the rate changes described in this paragraph.

(d) Any ratables effective before July 1, 2015, do not apply to early intensive developmental and behavioral intervention (EIDBI) benefits described in section 256B.0949.

(e) Effective for services rendered on or after January 1, 2024, payment rates for behavioral health services included in the rate analysis required by Laws 2021, First Special Session chapter 7, article 17, section 18, except for adult day treatment services under section 256B.0671, subdivision 3; and early intensive developmental and behavioral intervention services under section 256B.0949, and substance use disorder services under chapter 254B, must be increased by three percent from the rates in effect on December 31, 2023. Effective for services rendered on or after January 1, 2025, payment rates for behavioral health services included in the rate analysis required by Laws 2021, First Special Session chapter 7, article 17, section 18, except for adult day treatment services under section 256B.0671, subdivision 3; and early intensive developmental and behavioral intervention services under section 256B.0949, and substance use disorder services under chapter 254B, must be annually adjusted according to the change from the midpoint of the previous rate year to the midpoint of the rate year for which the rate is being determined using the Centers for Medicare and Medicaid Services Medicare Economic Index as forecasted in the fourth quarter of the calendar year before the rate year. For payments made in accordance with this paragraph, if and to the extent that the commissioner identifies that the state has received federal financial participation for behavioral health services in excess of the amount allowed under United States Code, title 42, section 447.321, the state shall repay the excess amount to the Centers for Medicare and Medicaid Services with state money and maintain the full payment rate under this paragraph. This paragraph does not apply to federally qualified health centers.
(f) Effective January 1, 2024, the commissioner shall increase capitation payments made to managed care plans and county-based purchasing plans to reflect the behavioral health service rate increase provided in paragraph (e). Managed care and county-based purchasing plans must use the capitation rate increase provided under this paragraph to increase payment rates to behavioral health services providers. The commissioner must monitor the effect of this rate increase on enrollee access to behavioral health services. If for any contract year federal approval is not received for this paragraph, the commissioner must adjust the capitation rates paid to managed care plans and county-based purchasing plans for that contract year to reflect the removal of this provision. Contracts between managed care plans and county-based purchasing plans and providers to whom this paragraph applies must allow recovery of payments from those providers if capitation rates are adjusted in accordance with this paragraph. Payment recoveries must not exceed the amount equal to any increase in rates that results from this provision.

EFFECTIVE DATE: This section is effective July 1, 2024.

Subd. 18. Grant Programs; Chemical Dependency Treatment Support Grants

Appropriations by Fund

<table>
<thead>
<tr>
<th>Fund</th>
<th>2023</th>
<th>2024</th>
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<tbody>
<tr>
<td>General</td>
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<td>5,342,000</td>
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<tr>
<td>Lottery Prize</td>
<td>1,733,000</td>
<td>1,733,000</td>
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(a) Culturally Specific Recovery Community Organization Start-Up Grants: $4,000,000 in fiscal year 2024 is for culturally specific recovery community organization start-up grants. Notwithstanding Minnesota Statutes, section 16A.28, this appropriation is available until June 30, 2027. This is a onetime appropriation.

(b) Safe Recovery Sites: $14,537,000 in fiscal year 2024 is from the general fund for start-up and capacity-building grants for organizations to establish safe recovery sites.
63.28 Notwithstanding Minnesota Statutes; section 16A.28, this appropriation is onetime and is available until June 30, 2029.
63.31 (c) Technical Assistance for Culturally Specific Organizations; Culturally Specific Services Grants.
63.32 $4,000,000 in fiscal year 2024 is for grants to culturally specific providers for technical assistance navigating culturally specific and responsive substance use and recovery programs. Notwithstanding Minnesota Statutes; section 16A.28, this appropriation is available until June 30, 2029.
64.1 (d) Technical Assistance for Culturally Specific Grant Development Training.
64.2 $400,000 in fiscal year 2024 is for grants for up to four trainings for community members and culturally specific providers for grant writing training for substance use and recovery-related grants. Notwithstanding Minnesota Statutes; section 16A.28, this is a onetime appropriation and is available until June 30, 2027.
64.16 (e) Harm Reduction Supplies for Tribal and Culturally Specific Programs.
64.17 $7,597,000 in fiscal year 2024 is from the general fund to provide sole source grants to culturally specific communities to purchase syringes, testing supplies, and opiate antagonists. Notwithstanding Minnesota Statutes; section 16A.28, this appropriation is available until June 30, 2027. This is a onetime appropriation.
64.25 (f) Families and Family Treatment Capacity-Building and Start-Up Grants.
64.26 $10,000,000 in fiscal year 2024 is from the general fund for start-up and capacity-building grants for family substance use disorder treatment programs. Notwithstanding Minnesota Statutes; section 16A.28, this appropriation is available until June 30, 2029. This is a onetime appropriation.
Start-Up and Capacity Building Grants for Withdrawal Management. $500,000 in fiscal year 2024 and $1,000,000 in fiscal year 2025 are for start-up and capacity building grants for withdrawal management.

Recovery Community Organization Grants. $4,300,000 in fiscal year 2024 is from the general fund for grants to recovery community organizations, as defined in Minnesota Statutes, section 254B.01, subdivision 8, that are current grantees as of June 30, 2023. This is a onetime appropriation and is available until June 30, 2025.

Opioid Overdose Prevention Grants.

1) $125,000 in fiscal year 2024 and $125,000 in fiscal year 2025 are from the general fund for a grant to Ka Joog, a nonprofit organization in Minneapolis, Minnesota, to be used for collaborative outreach, education, and training on opioid use and overdose, and distribution of opiate antagonist kits in East African and Somali communities in Minnesota. This is a onetime appropriation.

2) $125,000 in fiscal year 2024 and $125,000 in fiscal year 2025 are from the general fund for a grant to the Steve Rummler Hope Network to be used for statewide outreach, education, and training on opioid use and overdose, and distribution of opiate antagonist kits. This is a onetime appropriation.

3) $250,000 in fiscal year 2024 and $250,000 in fiscal year 2025 are from the general fund for a grant to African Career Education and Resource, Inc. to be used for collaborative outreach, education, and training on opioid use and overdose, and distribution of opiate antagonist kits. This is a onetime appropriation.

Problem Gambling. $225,000 in fiscal year 2024 and $225,000 in fiscal year 2025
are from the lottery prize fund for a grant to a state affiliate recognized by the National Council on Problem Gambling. The affiliate must provide services to increase public awareness of problem gambling; education, training for individuals and organizations that provide effective treatment services to problem gamblers and their families; and research related to problem gambling.

(k) **Project ECHO. $1,310,000 in fiscal year 2024 and $1,295,000 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 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 one-time appropriation and is available until June 30, 2027.**

(l) **White Earth Nation Substance Use Disorder Digital Therapy Tool. $3,000,000 in fiscal year 2024 is from the general fund for a grant to the White Earth Nation to develop an individualized Native American centric digital therapy tool with Pathfinder Solutions. This is a one-time appropriation.**

The grant must be used to:
(1) develop a mobile application that is culturally tailored to connecting substance use disorder resources with White Earth Nation members;

(2) convene a planning circle with White Earth Nation members to design the tool;

(3) provide and expand White Earth Nation-specific substance use disorder services; and

(4) partner with an academic research institution to evaluate the efficacy of the program.

Wellness in the Woods.

Wellness in the Woods: $300,000 in fiscal year 2024 and $300,000 in fiscal year 2025 are from the general fund for a grant to Wellness in the Woods for daily peer support and special sessions for individuals who are in substance use disorder recovery, are transitioning out of incarceration, or who have experienced trauma. These are onetime appropriations.

Base Level Adjustment.

The general fund base is $3,247,000 in fiscal year 2026 and $3,247,000 in fiscal year 2027.

Sec. 16. DIRECTION TO OMBUDSMAN FOR MENTAL HEALTH AND DEVELOPMENTAL DISABILITIES.

By September 30, 2025, the ombudsman for mental health and developmental disabilities must provide a report to the governor and the chairs and ranking minority members of the legislative committees with jurisdiction over human services that contains summary information on complaints received regarding peer recovery support services provided by a recovery community organization as defined in Minnesota Statutes, section 254B.01; and any recommendations to the legislature to improve the quality of peer recovery support services, recovery peer worker misclassification, and peer recovery support services billing codes and procedures.
Subdivision 1. Establishment; duties. The commissioner of human services must convene a working group to develop recommendations on:

1. peer recovery support services billing rates and practices, including a billing model for providing services to groups of up to four clients and groups larger than four clients at one time;

2. acceptable activities to bill for peer recovery services, including group activities and transportation related to individual recovery plans;

3. ways to address authorization for additional service hours and a review of the amount of peer recovery support services clients may need;

4. improving recovery peer supervision and reimbursement for the costs of providing recovery peer supervision for provider organizations;

5. certification or other regulation of recovery community organizations and recovery peers; and

6. policy and statutory changes to improve access to peer recovery support services and increase oversight of provider organizations.

Subd. 2. Membership; meetings. (a) Members of the working group must include but not be limited to:

1. a representative of the Minnesota Alliance of Recovery Community Organizations;

2. a representative of the Minnesota Association of Resources for Recovery and Chemical Health;

3. representatives from at least three recovery community organizations who are eligible vendors of peer recovery support services under Minnesota Statutes, section 254B.05, subdivision 1;

4. at least two currently practicing recovery peers qualified under Minnesota Statutes, section 245I.04, subdivision 18;

5. at least two individuals currently providing supervision for recovery peers according to Minnesota Statutes, section 245I.04, subdivision 19;

6. the commissioner of human services or a designee;

7. a representative of county social services agencies; and

8. a representative of a Tribal social services agency.
Members of the working group may include a representative of the Alliance for Peer Recovery Support Services and a representative of the Council on Accreditation of Peer Recovery Support Services.

The commissioner of human services must make appointments to the working group by October 1, 2024, and convene the first meeting of the working group by December 1, 2024.

The commissioner of human services must provide administrative support and meeting space for the working group. The working group may conduct meetings remotely.

Subd. 3. Report. The commissioner must complete and submit a report on the recommendations in this section to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services policy and finance on or before August 1, 2025.

Subd. 4. Expiration. The working group expires upon submission of the report to the legislature under subdivision 3.

Subd. 3. Report. The commissioner must complete and submit a report on the recommendations in this section to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services policy and finance on or before August 1, 2025.

Subd. 4. Expiration. The working group expires upon submission of the report to the legislature under subdivision 3.

The commissioner of human services must establish capacity-building grants for eligible local correctional facilities as they prepare to implement reentry demonstration services under Minnesota Statutes, section 256B.0761. Allowable expenditures under this grant include:

1. developing, in coordination with incarcerated individuals and community members with lived experience, processes and protocols listed under Minnesota Statutes, section 256B.0761, subdivision 5, paragraph (d);
2. establishing or modifying information technology systems to support implementation of the reentry demonstration waiver;
3. personnel costs; and
4. other expenses as determined by the commissioner.

The commissioner of human services must submit an application to the United States Secretary of Health and Human Services to implement a medical assistance reentry demonstration that covers services for incarcerated individuals as described under Minnesota Statutes, section 256B.0761. Coverage of prerelease services is contingent on federal approval of the demonstration and the required implementation and reinvestment plans.
Sec. 20. REPEALER.

Minnesota Statutes 2022, section 256.043, subdivision 4, is repealed.

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