CHAPTER 254B

SUBSTANCE USE DISORDER TREATMENT

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254B.01 DEFINITIONS.

Subdivision 1. MS 2012 [Repealed, 2014 c 262 art 3 s 18]

Subd. 2. **American Indian.** For purposes of services provided under section 254B.09, subdivision 8, "American Indian" means a person who is a member of an Indian Tribe, and the commissioner shall use the definitions of "Indian" and "Indian Tribe" and "Indian organization" provided in Public Law 93-638. For purposes of services provided under section 254B.09, subdivision 6, "American Indian" means a resident of federally recognized Tribal lands who is recognized as an Indian person by the federally recognized Tribal governing body.

Subd. 2a. **American Society of Addiction Medicine criteria or ASAM criteria.** "American Society of Addiction Medicine criteria" or "ASAM criteria" 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 most current edition of the ASAM Criteria: Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions.

Subd. 2b. **Behavioral health fund.** "Behavioral health fund" means money allocated for payment of treatment services under chapter 254B.

Subd. 2c. **Client.** "Client" means an individual who has requested substance use disorder services or for whom substance use disorder services have been requested.

Subd. 2d. **Commissioner.** Unless otherwise indicated, "commissioner" means the commissioner of human services.

Subd. 2e. **Co-payment.** "Co-payment" means:

(1) the amount an insured person is obligated to pay before the person's third-party payment source is obligated to make a payment; or

(2) the amount an insured person is obligated to pay in addition to the amount the person's third-party payment source is obligated to pay.

Subd. 3. [Renumbered subd 12]

Subd. 4. [Renumbered subd 2d]

Subd. 4a. **Culturally specific or culturally responsive program.** (a) "Culturally specific or culturally responsive program" means a substance use disorder treatment service program or subprogram that is culturally responsive or culturally specific when the program attests that it:

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

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

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

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

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

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

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

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

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

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

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

Subd. 4c. **Department.** "Department" means the Department of Human Services.

Subd. 4d. **Drug and Alcohol Abuse Normative Evaluation System or DAANES.** "Drug and Alcohol Abuse Normative Evaluation System" or "DAANES" means the reporting system used to collect all substance use disorder treatment data across all levels of care and providers.

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.0501 must develop to respond to an individual's peer recovery support services needs and goals.

Subd. 5. MS 2024 [Repealed, 1Sp2025 c 9 a 4 s 57]

Subd. 6. **Local money.** "Local money" means county levies, federal social services money, or other money that may be spent at county discretion to provide substance use disorder services eligible for payment according to Laws 1986, chapter 394, sections 8 to 20.

Subd. 6a. **Minor child.** "Minor child" means an individual under the age of 18 years.

Subd. 6b. **Policyholder.** "Policyholder" means a person who has a third-party payment policy under which a third-party payment source has an obligation to pay all or part of a client's treatment costs.

Subd. 7. MS 2010 [Repealed, 2011 c 86 s 23]

Subd. 8. **Recovery community organization.** "Recovery community organization" means an independent, nonprofit 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 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.

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.

Subd. 9. **Responsible relative.** "Responsible relative" means a person who is a member of the client's household and is the client's spouse or the parent of a minor child who is a client.

Subd. 10. **Psychosocial treatment services.** "Psychosocial treatment services" includes the treatment services described in section 245G.07, subdivision 1a. Psychosocial treatment services must be provided by qualified professionals as identified in section 245G.07, subdivision 3, paragraph (b).

[See Note.]

Subd. 11. **Recovery residence.** A "recovery residence" 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;

(3) charges a fee for living there;

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

(5) promotes sustained recovery from substance use disorders; and

(6) follows the sober living guidelines published by the federal Substance Abuse and Mental Health Services Administration.

Subd. 12. **Substance use disorder treatment services.** "Substance use disorder treatment services" means a planned program of care for the treatment of substance misuse or substance use disorder to minimize or prevent further substance misuse by the person. Diagnostic, evaluation, prevention, referral, detoxification, and aftercare services that are not part of a program of care licensable as a residential or nonresidential substance use disorder treatment program are not substance use disorder services for purposes of this section. For pregnant and postpartum women, substance use disorder services include halfway house services, aftercare services, psychological services, and case management.

Subd. 13. **Third-party payment source.** "Third-party payment source" means a person, entity, or public or private agency other than medical assistance or general assistance medical care that has a probable obligation to pay all or part of the costs of a client's substance use disorder treatment.

Subd. 14. **Vendor.** "Vendor" means a provider of substance use disorder treatment services that meets the criteria established in sections 254B.0501 to 254B.0507, and that has applied to participate as a provider in the medical assistance program according to Minnesota Rules, part 9505.0195.

Subd. 15. **Executive board.** "Executive board" has the meaning given in section 246C.015.

History: *1986 c 394 s 8; 1987 c 299 s 3; 1994 c 631 s 31; 1997 c 203 art 4 s 5; 1999 c 245 art 5 s 16; 2005 c 98 art 3 s 24; 1Sp2010 c 1 art 19 s 8; 2014 c 291 art 3 s 6; 2016 c 189 art 16 s 4; 1Sp2017 c 6 art 8 s 53,54; 1Sp2021 c 7 art 11 s 9,10; 2022 c 98 art 4 s 51; 2023 c 50 art 2 s 28-40,62; art 3 s 5; 2023 c 61 art 4 s 8; 2024 c 79 art 4 s 11; 2024 c 125 art 3 s 5,6; 2024 c 127 art 48 s 5,6; 1Sp2025 c 9 art 4 s 22,23,55*

NOTE: The amendment to subdivision 10 by Laws 2025, First Special Session chapter 9, article 4, section 22, is effective upon federal approval. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained. Laws 2025, First Special Session chapter 9, article 4, section 22, the effective date.

254B.02 SUBSTANCE USE DISORDER ALLOCATION PROCESS.

Subdivision 1. **Substance use disorder treatment allocation.** The substance use disorder treatment appropriation shall be placed in a special revenue account. The money in the special revenue account must be used according to the requirements in this chapter.

Subd. 2. MS 2008 [Repealed, 1Sp2010 c 1 art 19 s 24]

Subd. 3. MS 2008 [Repealed, 1Sp2010 c 1 art 19 s 24]

Subd. 4. MS 2008 [Repealed, 1Sp2010 c 1 art 19 s 24]

Subd. 5. **Tribal allocation.** The commissioner may make direct payments to Tribal Nation servicing agencies from money allocated under this section to support individuals with substance use disorders and determine eligibility for behavioral health fund payments. The payment must not be less than 133 percent of the Tribal Nations payment for the fiscal year ending June 30, 2009, adjusted in proportion to the statewide change in the appropriation for this chapter.

History: *1986 c 394 s 9; 1987 c 299 s 4-7; 1989 c 282 art 2 s 103; 1995 c 207 art 3 s 13; 1997 c 85 art 4 s 7; 1997 c 203 art 4 s 6; art 7 s 16; 1999 c 159 s 32; 1Sp2001 c 9 art 3 s 4; 2002 c 379 art 1 s 113; 2007 c 147 art 11 s 12,13; 1Sp2010 c 1 art 19 s 9,10; 1Sp2019 c 9 art 6 s 42; 2022 c 98 art 4 s 51; 2023 c 70 art 9 s 23; 1Sp2025 c 9 art 4 s 24; 2026 c 121 art 6 s 7*

254B.03 RESPONSIBILITY TO PROVIDE SUBSTANCE USE DISORDER TREATMENT.

Subdivision 1. **Financial eligibility determinations.** (a) The commissioner of human services or Tribal Nation servicing agencies must determine financial eligibility for substance use disorder services and provide substance use disorder services to persons residing within its jurisdiction who meet criteria established by the commissioner. Substance use disorder money must be administered by the local agencies according to law and rules adopted by the commissioner under sections 14.001 to 14.69.

(b) In order to contain costs, the commissioner of human services shall select eligible vendors of substance use disorder services who can provide economical and appropriate treatment. The commissioner may approve proposals from county boards to provide services in an economical manner or to control utilization, with safeguards to ensure that necessary services are provided. If a county implements a demonstration or experimental medical services funding plan, the commissioner shall transfer the money as appropriate.

(c) An individual may choose to obtain a comprehensive assessment as provided in section 245G.05. Individuals obtaining a comprehensive assessment may access any enrolled provider that is licensed to provide the level of service authorized pursuant to section 254A.19, subdivision 3. If the individual is enrolled in a prepaid health plan, the individual must comply with any provider network requirements or limitations.

Subd. 2. **Behavioral health fund payment.** (a) Payment from the behavioral health fund is limited to payments for services identified in sections 254B.0501 to 254B.0507, other than detoxification licensed under Minnesota Rules, parts 9530.6510 to 9530.6590, and detoxification provided in another state that would be required to be licensed as a substance use disorder program if the program were in the state. Out of state vendors must also provide the commissioner with assurances that the program complies substantially with state licensing requirements and possesses all licenses and certifications required by the host state to provide substance use disorder treatment. Vendors receiving payments from the behavioral health fund must not require co-payment from a recipient of benefits for services provided under this subdivision. The vendor is prohibited from using the client's public benefits to offset the cost of services paid under this section. The vendor shall not require the client to use public benefits for room or board costs. This includes but is not limited to cash assistance benefits under chapters 142E, 142G, and 256D, or SNAP benefits. Retention of SNAP benefits is a right of a client receiving services through the behavioral health fund or through state contracted managed care entities. Payment from the behavioral health fund shall be made for necessary room and board costs provided by vendors meeting the criteria under section 254B.0503 or in a community hospital licensed by the commissioner of health according to sections 144.50 to 144.56 to a client who is:

(1) determined to meet the criteria for placement in a residential substance use disorder treatment program according to rules adopted under section 254A.03, subdivision 3; and

(2) concurrently receiving a substance use disorder treatment service in a program licensed by the commissioner and reimbursed by the behavioral health fund.

(b) The commissioner shall coordinate substance use disorder services and determine whether there is a need for any proposed expansion of substance use disorder treatment services. The commissioner shall deny vendor certification to any provider that has not received prior approval from the commissioner for the creation of new programs or the expansion of existing program capacity. The commissioner shall consider the provider's capacity to obtain clients from outside the state based on plans, agreements, and previous utilization history, when determining the need for new treatment services.

(c) At least 60 days prior to submitting an application for new licensure under chapter 245G, the applicant must notify the county human services director in writing of the applicant's intent to open a new treatment program. The written notification must include, at a minimum:

(1) a description of the proposed treatment program; and

(2) a description of the target population to be served by the treatment program.

(d) The county human services director may submit a written statement to the commissioner, within 60 days of receiving notice from the applicant, regarding the county's support of or opposition to the opening of the new treatment program. The written statement must include documentation of the rationale for the county's determination. The commissioner shall consider the county's written statement when determining whether there is a need for the treatment program as required by paragraph (c).

Subd. 3. **Counties to pay state for county share.** Counties shall pay the state for the county share of the services authorized by the commissioner, except when the payment is made according to section 254B.09, subdivision 8.

Subd. 4. **Division of costs.** (a) Except for services provided by a county under section 254B.09, subdivision 1, or services provided under section 256B.69, the county shall, out of local money, pay the state for 22.95 percent of the cost of substance use disorder services, except for those services provided to persons enrolled in medical assistance under chapter 256B and room and board services under section 254B.0505, subdivision 1. Counties may use the indigent hospitalization levy for treatment and hospital payments made under this section.

(b) 22.95 percent of any state collections from private or third-party pay, less 15 percent for the cost of payment and collections, must be distributed to the county that paid for a portion of the treatment under this section.

Subd. 4a. MS 2018 [Repealed, 1Sp2019 c 9 art 6 s 81; 2020 c 74 art 3 s 13]

Subd. 5. **Rules; appeal.** The commissioner shall adopt rules as necessary to implement this chapter.

Subd. 6. MS 1988 [Repealed, 1989 c 155 s 5]

Subd. 7. **Commissioner review; complaints.** The commissioner shall:

(1) provide training and assistance to counties on procedures for processing placements and making payments;

(2) visit facilities and review records as necessary to determine compliance with procedures established by law and rule;

(3) take complaints from vendors and recipients and investigate county placement activities as needed to determine compliance with law and rule.

Counties and vendors shall make regular reports as required by the commissioner to facilitate commissioner review.

Subd. 8. MS 1996 [Repealed, 1997 c 7 art 2 s 67]

Subd. 9. **Commissioner to select vendors and set rates.** (a) Effective July 1, 2011, the commissioner shall:

(1) enter into agreements with eligible vendors that:

(i) meet the standards in section 254B.0501;

(ii) have good standing in all applicable licensure; and

(iii) have a current approved provider agreement as a Minnesota health care program provider that contains program standards for each rate and rate enhancement defined by the commissioner; and

(2) set rates for services reimbursed under this chapter.

(b) When setting rates, the commissioner shall consider the complexity and the acuity of the problems presented by the client.

(c) When rates set under this section and rates set under section 254B.09, subdivision 8, apply to the same treatment placement, section 254B.09, subdivision 8, supersedes.

History: *1986 c 394 s 10; 1Sp1986 c 3 art 2 s 2; 1987 c 299 s 8-12; 1987 c 333 s 22; 1989 c 209 art 2 s 1; 1989 c 282 art 2 s 104,105; 1990 c 422 s 10; 1990 c 568 art 2 s 58; 1997 c 203 art 7 s 17; 1Sp1997 c 5 s 21; 1999 c 245 art 5 s 17; 1Sp2001 c 9 art 3 s 5; 2002 c 379 art 1 s 113; 2007 c 147 art 11 s 14,15; 2009 c 79 art 7 s 7-9; 1Sp2010 c 1 art 19 s 11,12; 2011 c 86 s 6,7; 1Sp2011 c 9 art 8 s 3; 2016 c 158 art 2 s 51; 2016 c 189 art 16 s 5; 1Sp2017 c 6 art 8 s 55; 1Sp2019 c 9 art 6 s 43,44; 2020 c 74 art 3 s 4; 2020 c 74 art 3 s 12; 2021 c 30 art 2 s 4; art 13 s 48,83; 2022 c 98 art 4 s 51; 2023 c 50 art 2 s 41-43; 2024 c 80 art 4 s 26; art 5 s 7; art 7 s 12; 2024 c 108 art 4 s 17; 2024 c 115 art 16 s 42; 1Sp2025 c 9 art 4 s 25,26,55*

254B.04 ELIGIBILITY FOR BEHAVIORAL HEALTH FUND SERVICES.

Subdivision 1. **Scope and applicability.** This section governs the administration of the behavioral health fund, establishes the criteria to be applied by local agencies to determine a client's financial eligibility under the behavioral health fund, and determines a client's obligation to pay for substance use disorder treatment services.

Subd. 1a. **Client eligibility.** (a) Persons eligible for benefits under Code of Federal Regulations, title 25, part 20, who meet the income standards of section 256B.056, subdivision 4, and are not enrolled in medical assistance, are entitled to behavioral health fund services. State money appropriated for this paragraph must be placed in a separate account established for this purpose.

(b) Persons with dependent children who are determined to be in need of substance use disorder treatment pursuant to an assessment under section 260E.20, subdivision 1, or in need of chemical dependency treatment pursuant to a case plan under section 260C.201, subdivision 6, or 260C.212, shall be assisted by the commissioner to access needed treatment services. Treatment services must be appropriate for the individual or family, which may include long-term care treatment or treatment in a facility that allows the dependent children to stay in the treatment facility. The county shall pay for out-of-home placement costs, if applicable.

(c) Notwithstanding paragraph (a), any person enrolled in medical assistance or MinnesotaCare is eligible for room and board services under section 254B.0505, subdivision 1, clause (9).

(d) A client is eligible to have substance use disorder treatment paid for with funds from the behavioral health fund when the client:

(1) is eligible for MFIP as determined under chapter 142G;

(2) is eligible for medical assistance as determined under Minnesota Rules, parts 9505.0010 to 9505.0140;

(3) is eligible for general assistance, general assistance medical care, or work readiness as determined under Minnesota Rules, parts 9500.1200 to 9500.1272; or

(4) has income that is within current household size and income guidelines for entitled persons, as defined in this subdivision and subdivision 7.

(e) Clients who meet the financial eligibility requirement in paragraph (a) and who have a third-party payment source are eligible for the behavioral health fund if the third-party payment source pays less than 100 percent of the cost of treatment services for eligible clients.

(f) A client is ineligible to have substance use disorder treatment services paid for with behavioral health fund money if the client:

(1) has an income that exceeds current household size and income guidelines for entitled persons as defined in this subdivision and subdivision 7; or

(2) has an available third-party payment source that will pay the total cost of the client's treatment.

(g) A client who is disenrolled from a state prepaid health plan during a treatment episode is eligible for continued treatment service that is paid for by the behavioral health fund until the treatment episode is completed or the client is re-enrolled in a state prepaid health plan if the client:

(1) continues to be enrolled in MinnesotaCare, medical assistance, or general assistance medical care; or

(2) is eligible according to paragraphs (a) and (b) and is determined eligible by the commissioner under section 254B.04.

(h) When a county commits a client under chapter 253B to a regional treatment center for substance use disorder services and the client is ineligible for the behavioral health fund, the county is responsible for the payment to the regional treatment center according to section 254B.0501, subdivision 3.

(i) Notwithstanding any laws to the contrary, persons enrolled in MinnesotaCare or medical assistance are eligible for room and board services when provided through intensive residential treatment services and residential crisis services under section 256B.0632 and chapter 245I.

(j) A person is eligible for one 60-consecutive-calendar-day period per year. A person may submit a request for additional eligibility to the commissioner. A person denied additional eligibility under this paragraph may request a state agency hearing under section 256.045.

Subd. 2. MS 1988 [Repealed, 1989 c 155 s 5]

Subd. 2a. MS 2025 Supp [Repealed, 1Sp2025 c 9 a 4 s 57]

Subd. 2b. MS 2022 [Repealed, 2023 c 50 art 2 s 63]

Subd. 2c. MS 2022 [Repealed, 2023 c 50 art 2 s 63]

Subd. 3. MS 2012 [Repealed, 2014 c 262 art 3 s 18]

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.

(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.

(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.

(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.

(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.

(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.

Subd. 5. **Commissioner responsibility to provide administrative services.** The commissioner of human services may employ individuals to conduct administrative activities and facilitate access to substance use disorder treatment services.

Subd. 6. **Commissioner to determine client financial eligibility.** (a) The commissioner shall determine a client's financial eligibility for the behavioral health fund according to section 254B.04, subdivision 1a, with the income calculated prospectively for one year from the date of request. The commissioner shall pay for eligible clients according to chapter 256G. Client eligibility must be determined using only forms prescribed by the commissioner. To determine a client's eligibility, the commissioner must determine the client's income, the size of the client's household, the availability of a third-party payment source, and a responsible relative's ability to pay for the client's substance use disorder treatment.

(b) A client who is a minor child must not be deemed to have income available to pay for substance use disorder treatment, unless the minor child is responsible for payment under section 144.347 for substance use disorder treatment services sought under section 144.343, subdivision 1.

(c) The commissioner must determine the client's household size as follows:

(1) if the client is a minor child, the household size includes the following persons living in the same dwelling unit:

(i) the client;

(ii) the client's birth or adoptive parents; and

(iii) the client's siblings who are minors; and

(2) if the client is an adult, the household size includes the following persons living in the same dwelling unit:

(i) the client;

(ii) the client's spouse;

(iii) the client's minor children; and

(iv) the client's spouse's minor children.

For purposes of this paragraph, household size includes a person listed in clauses (1) and (2) who is in an out-of-home placement if a person listed in clause (1) or (2) is contributing to the cost of care of the person in out-of-home placement.

(d) The commissioner must determine the client's current prepaid health plan enrollment, the availability of a third-party payment source, including the availability of total payment, partial payment, and amount of co-payment.

(e) The commissioner shall require the client and policyholder to conditionally assign to the department the client and policyholder's rights and the rights of minor children to benefits or services provided to the client if the department is required to collect from a third-party pay source.

(f) The commissioner must determine a client's eligibility for the behavioral health fund for a 60-consecutive-calendar-day period per calendar year.

(g) A client, responsible relative, and policyholder must provide income or wage verification, household size verification, and must make an assignment of third-party payment rights under paragraph (e). If a client, responsible relative, or policyholder does not comply with the provisions of this subdivision, the client is ineligible for behavioral health fund payment for substance use disorder treatment, and the client and responsible relative must be obligated to pay for the full cost of substance use disorder treatment services provided to the client.

Subd. 6a. **Span of eligibility.** The commissioner must enter the financial eligibility span within five business days of a request. If the comprehensive assessment is completed within the timelines required under chapter 245G, then the span of eligibility must begin on the date services were initiated. If the comprehensive assessment is not completed within the timelines required under chapter 245G, then the span of eligibility must begin on the date the comprehensive assessment was completed.

Subd. 7. **Client fees.** A client whose household income is within current household size and income guidelines for entitled persons as defined in section 254B.04, subdivision 1a, must pay no fee for care related to substance use disorder, including drug screens.

Subd. 8. **Vendor must participate in DAANES system.** To be eligible for payment under the behavioral health fund, a vendor must participate in the Drug and Alcohol Abuse Normative Evaluation System (DAANES) or submit to the commissioner the information required in the DAANES in the format specified by the commissioner.

History: *1986 c 394 s 11; 1987 c 299 s 13; 1988 c 689 art 2 s 268; 1989 c 282 art 2 s 106; 1990 c 568 art 2 s 59; 1991 c 292 art 4 s 14; 1992 c 513 art 9 s 24; 1994 c 529 s 5; 1997 c 203 art 4 s 7; 1999 c 139 art 4 s 2; 1999 c 245 art 8 s 4; 1Sp2001 c 9 art 3 s 6; 2002 c 379 art 1 s 113; 1Sp2011 c 9 art 8 s 4; 2012 c 216 art 12 s 7; 2013 c 108 art 1 s 2; 2013 c 113 art 2 s 1; 2014 c 312 art 28 s 1; 2016 c 158 art 2 s 52; 2016 c 189 art 16 s 6; 1Sp2017 c 6 art 8 s 56,57; 2019 c 50 art 1 s 69; 1Sp2019 c 9 art 6 s 45,46; 1Sp2020 c 2 art 8 s 83; 2021 c 30 art 13 s 83; 2023 c 25 s 132; 2023 c 50 art 2 s 44-51; 2024 c 80 s art 7 s 12; 2024 c 108 art 4 s 18-21; 2024 c 127 art 61 s 13; 2025 c 38 art 7 s 4; 1Sp2025 c 9 art 4 s 27-30,55; 2026 c 95 art 5 s 17*

254B.041 Subdivision 1. MS 1994 [Repealed, 1996 c 305 art 2 s 67]

Subd. 2. MS 2022 [Repealed, 2023 c 50 art 2 s 63]

254B.05 Subdivision 1. (a) [Renumbered 254B.0501, subdivision 1]

(b) [Renumbered 254B.0501, subd 4]

(c) [Renumbered 254B.0501, subd 5]

(d) [Renumbered 254B.0501, subd 6, para (a)]

(e) [Renumbered 254B.0501, subd 6, para (b)]

(f) [Renumbered 254B.0501, subd 6, para (c)]

(g) [Renumbered 254B.0501, subd 6, para (d)]

(h) [Renumbered 254B.0501, subd 7]

(i) [Renumbered 254B.0501, subd 2]

(j) [Renumbered 254B.052, subd 5]

Subd. 1a. (a) [Renumbered 254B.0503, subdivision 1, para (a)]

(b) [Renumbered 254B.0503, subd 2, para (a)]

(c) [Renumbered 254B.0503, subdivision 1, para (b)]

(d) [Renumbered 254B.0503, subdivision 1, para (c)]

(e) [Renumbered 254B.0503, subd 2, para (b)]

(f) [Renumbered 254B.0503, subdivision 1, para (d)]

(g) [Renumbered 254B.0503, subdivision 1, para (e)]

Subd. 1b. [Renumbered 254B.0501, subd 8]

Subd. 2. [Renumbered 254B.0501, subd 9]

Subd. 3. [Renumbered 254B.0501, subd 10]

Subd. 4. [Renumbered 254B.0501, subd 3]

Subd. 5. (a) [Renumbered 254B.0505, subdivision 1]

(b) [Renumbered 254B.0505, subdivision 1]

(c) [Renumbered 254B.0507]

(1) [Renumbered 254B.0507, subd 2, para (a)]

(2) [Renumbered 254B.0507, subd 3]

(3) [Renumbered 254B.0507, subd 4]

(4) [Renumbered 254B.0507, subd 5]

(5) [Renumbered 254B.0507, subd 6, para (a)]

(d) [Renumbered 245B.0507, subd 2, para (b)]

(e) [Renumbered 254B.0507, subd 6, para (b)]

(f) [Renumbered 254B.0505, subd 2]

(g) [Renumbered 254B.0505, subd 3]

(h) [Renumbered 254B.0505, subd 4]

(i) [Renumbered 254B.0505, subd 5]

(j) [Renumbered 254B.0505, subd 6]

(k) [Renumbered 254B.0505, subd 7]

(l) [Renumbered 254B.0505, subd 8]

(m) [Renumbered 254B.052, subd 6]

254B.0501 VENDOR ELIGIBILITY.

Subdivision 1. **Licensed programs and hospitals.** 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.

Subd. 2. **Health care providers; comprehensive assessments.** 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 254A.19, subdivision 3, 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.

Subd. 3. **Regional treatment centers.** Regional treatment center substance use disorder treatment units are eligible vendors. The executive board may expand the capacity of substance use disorder treatment units beyond the capacity funded by direct legislative appropriation to serve individuals who are referred for treatment by counties and whose treatment will be paid for by funding under this chapter or other funding sources. Notwithstanding the provisions of sections 254B.03 to 254B.04, payment for any person committed at county request to a regional treatment center under chapter 253B for chemical dependency treatment and determined to be ineligible under the behavioral health fund, shall become the responsibility of the county.

Subd. 4. **Licensed private practitioners.** 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 provided according to section 254A.19, subdivision 3, and treatment services provided according to sections 245G.06 and 245G.07, subdivisions 1, 1a, and 1b.

Subd. 5. **Counties.** A county is an eligible vendor for a comprehensive assessment 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 254A.19, subdivision 3. A county is an eligible vendor of treatment 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 1b. 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, and according to section 254B.052.

Subd. 6. **Recovery community organizations.** (a) A recovery community organization that meets the requirements of clauses (1) to (15), complies with the training requirements in section 254B.052, subdivision 4, and meets certification requirements of the Minnesota Alliance of Recovery Community Organizations or another Minnesota statewide recovery organization identified by the commissioner is an eligible vendor of peer recovery support services. If the commissioner does not identify another statewide recovery organization, or the Minnesota Alliance of Recovery Community Organizations or the statewide recovery organization identified by the commissioner is not reasonably positioned to certify vendors, the commissioner must determine the eligibility of a vendor of peer recovery support services. A Minnesota statewide recovery organization identified by the commissioner must update recovery community organization applicants for certification 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) have a mission statement and conduct corresponding activities indicating that the organization's primary purpose is to support recovery from substance use disorder;

(4) 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 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, 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 may include but is not limited to harm reduction paths, faith-based paths, and nonfaith-based paths;

(8) maintain organizational practices to meet the needs of Black, Indigenous, and people of color communities, LGBTQ+ communities, and other underrepresented or marginalized communities. Organizational practices may include board and staff training, service offerings, advocacy efforts, and culturally informed outreach and services;

(9) 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;

(10) establish and maintain a publicly available recovery community organization code of ethics and grievance policy and procedures;

(11) not classify or treat any recovery peer hired on or after July 1, 2024, as an independent contractor;

(12) not classify or treat any recovery peer as an independent contractor on or after January 1, 2025;

(13) 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;

(14) 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; and

(15) comply with the requirements of section 245A.04, subdivision 15a.

(b) A recovery community organization approved by the commissioner before June 30, 2023, 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 (a) by September 1, 2024, in order to be considered as an eligible vendor of peer recovery support services.

(c) A recovery community organization that is aggrieved by a certification determination and believes it meets the requirements under paragraph (a) may appeal the determination under section 256.045, subdivision 3, paragraph (a), clause (14), for reconsideration as an eligible vendor. If the human services judge determines that the recovery community organization meets the requirements under paragraph (a), the recovery community organization is an eligible vendor of peer recovery support services for up to two years from the date of the determination. After two years, the recovery community organization must apply for certification under paragraph (a) to continue to be an eligible vendor of peer recovery support services.

(d) All recovery community organizations must be certified by an entity listed in paragraph (a) by June 30, 2026.

[See Note.]

Subd. 7. **Detoxification and unlicensed programs ineligible.** 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 subdivision 8 and section 254B.0503, subdivisions 1 and 2, are not eligible vendors.

[See Note.]

Subd. 8. **Additional vendor requirements.** Vendors must comply with the following duties:

(1) maintain a provider agreement with the department;

(2) continually comply with the standards in the agreement;

(3) participate in the Drug Alcohol Normative Evaluation System;

(4) submit an annual financial statement which reports functional expenses of substance use disorder treatment costs in a form approved by the commissioner;

(5) report information about the vendor's current capacity in a manner prescribed by the commissioner; and

(6) maintain adequate and appropriate insurance coverage necessary to provide substance use disorder treatment services, and at a minimum:

(i) employee dishonesty in the amount of $10,000 if the vendor has or had custody or control of money or property belonging to clients; and

(ii) bodily injury and property damage in the amount of $2,000,000 for each occurrence, except that a county or a county joint powers entity who is otherwise an eligible vendor shall be subject to the limits on liability under section 466.04.

Subd. 9. **Regulatory methods.** (a) Where appropriate and feasible, the commissioner shall identify and implement alternative methods of regulation and enforcement to the extent authorized in this subdivision. These methods shall include:

(1) expansion of the types and categories of licenses that may be granted;

(2) when the standards of an independent accreditation body have been shown to predict compliance with the rules, the commissioner shall consider compliance with the accreditation standards to be equivalent to partial compliance with the rules; and

(3) use of an abbreviated inspection that employs key standards that have been shown to predict full compliance with the rules.

(b) The commissioner shall work with the commissioners of health, public safety, administration, and education in consolidating duplicative licensing and certification rules and standards if the commissioner determines that consolidation is administratively feasible, would significantly reduce the cost of licensing, and would not reduce the protection given to persons receiving services in licensed programs. Where administratively feasible and appropriate, the commissioner shall work with the commissioners of health, public safety, administration, and education in conducting joint agency inspections of programs.

(c) The commissioner shall work with the commissioners of health, public safety, administration, and education in establishing a single point of application for applicants who are required to obtain concurrent licensure from more than one of the commissioners listed in this paragraph.

Subd. 10. **Fee reductions.** If the commissioner determines that the methods in subdivision 9, paragraph (a), clause (2) or (3), can be used in licensing a program, the commissioner shall reduce licensure fees by up to 50 percent. The commissioner may adopt rules to provide for the reduction of fees when a license holder substantially exceeds the basic standards for licensure.

History: *1986 c 394 s 12; 1987 c 299 s 14; 1987 c 333 s 22; 1988 c 532 s 11; 1991 c 292 art 4 s 15; 1994 c 529 s 6; 1995 c 207 art 3 s 14; art 8 s 32; 1999 c 245 art 5 s 18; 2009 c 79 art 7 s 10; 2010 c 303 s 3; 1Sp2010 c 1 art 19 s 13; 2011 c 86 s 8; 2014 c 262 art 3 s 10; 1Sp2017 c 6 art 8 s 58; 1Sp2019 c 9 art 2 s 104,105; art 6 s 47; 1Sp2020 c 2 art 5 s 34; 2021 c 30 art 13 s 83; 2022 c 98 art 4 s 51; 2023 c 50 art 3 s 6; 2023 c 61 art 4 s 9; 2023 c 70 art 9 s 24; 2024 c 79 art 4 s 12; 2024 c 108 art 4 s 22; 2024 c 125 art 3 s 7; 2024 c 127 art 48 s 7; 2025 c 38 art 4 s 31; 1Sp2025 c 9 art 4 s 31,55; 2026 c 95 art 5 s 18*

NOTE: The amendment to subdivision 6 by Laws 2025, First Special Session chapter 9, article 4, section 31, is effective upon federal approval. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained. Laws 2025, First Special Session chapter 9, article 4, section 31, the effective date.

NOTE: Subdivision 7 is effective upon federal approval. The commissioner shall notify the revisor of statutes when federal approval is obtained. Laws 2023, chapter 70, article 9, section 24, the effective date.

254B.0503 ROOM AND BOARD PROVIDER REQUIREMENTS.

Subdivision 1. **Eligible vendor requirements.** (a) Vendors of room and board are eligible for behavioral health fund payment if the vendor:

(1) has rules prohibiting residents bringing chemicals into the facility or using chemicals while residing in the facility and provide consequences for infractions of those rules;

(2) is determined to meet applicable health and safety requirements;

(3) is not a jail or prison;

(4) is not concurrently receiving funds under chapter 256I for the recipient;

(5) admits individuals who are 18 years of age or older;

(6) is registered as a board and lodging or lodging establishment according to section 157.17;

(7) has awake staff on site whenever a client is present;

(8) has staff who are at least 18 years of age and meet the requirements of section 245G.11, subdivision 1, paragraph (b);

(9) has emergency behavioral procedures that meet the requirements of section 245G.16;

(10) meets the requirements of section 245G.08, subdivision 5, if administering medications to clients;

(11) meets the abuse prevention requirements of section 245A.65, including a policy on fraternization and the mandatory reporting requirements of section 626.557;

(12) documents coordination with the treatment provider to ensure compliance with section 254B.03, subdivision 2;

(13) protects client funds and ensures freedom from exploitation by meeting the provisions of section 245A.04, subdivision 13;

(14) has a grievance procedure that meets the requirements of section 245G.15, subdivision 2; and

(15) has sleeping and bathroom facilities for men and women separated by a door that is locked, has an alarm, or is supervised by awake staff.

(b) Programs providing children's mental health crisis admissions and stabilization under section 245.4882, subdivision 6, are eligible vendors of room and board.

(c) Programs providing children's residential services under section 245.4882, except services for individuals who have a placement under chapter 260C or 260D, are eligible vendors of room and board.

(d) A vendor that is not licensed as a residential treatment program must have a policy to address staffing coverage when a client may unexpectedly need to be present at the room and board site.

(e) No new vendors for room and board services may be approved after June 30, 2025, to receive payments from the behavioral health fund, under the provisions of section 254B.04, subdivision 2a. Room and board vendors that were approved and operating prior to July 1, 2025, may continue to receive payments from the behavioral health fund for services provided until December 31, 2026. Room and board vendors providing services in accordance with section 254B.04, subdivision 2a, will no longer be eligible to claim reimbursement for room and board services provided on or after January 1, 2027.

Subd. 2. **Exemptions.** (a) Programs licensed according to Minnesota Rules, chapter 2960, are exempt from subdivision 1, paragraph (a), clauses (5) to (15).

(b) Licensed programs providing intensive residential treatment services or residential crisis stabilization services pursuant to section 256B.0624 or 256B.0632 are eligible vendors of room and board and are exempt from subdivision 1, paragraph (a), clauses (6) to (15).

History: *2011 c 86 s 8; 1Sp2017 c 6 art 8 s 59; 2018 c 182 art 2 s 17; 1Sp2019 c 9 art 6 s 48; 2021 c 30 art 13 s 83; 2022 c 99 art 1 s 15; 2023 c 50 art 1 s 21; 2023 c 70 art 9 s 25; 2025 c 38 art 7 s 5; 1Sp2025 c 9 art 4 s 32,55; 2026 c 121 art 6 s 8*

254B.0505 RATE REQUIREMENTS.

Subdivision 1. **Services rates.** Subject to the requirements of section 254B.0509, the commissioner shall establish rates for the following substance use disorder treatment services funded under this chapter:

(1) 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 3.1 clinically managed low-intensity residential services provided according to section 254B.19, subdivision 1, clause (5), at 15 or more hours of skilled treatment services each week;

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

(viii) 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 section 254A.19, subdivision 3;

(3) treatment coordination services provided according to section 245G.07, subdivision 1b;

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

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

(8) medium-intensity residential treatment services that provide 15 hours of skilled treatment services each week and are licensed according to sections 245G.01 to 245G.17 and 245G.21 or applicable Tribal license;

(9) 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;

(10) 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

(11) room and board facilities that meet the requirements of section 254B.0503.

[See Note.]

Subd. 2. **Services via telehealth.** 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.

Subd. 3. **Group setting staff ratio.** 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.

Subd. 4. **Outpatient services.** 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.

Subd. 5. **Payment start date.** 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.

Subd. 6. **Payment for missed services.** A license holder that is unable to provide all residential treatment services because a client missed services remains eligible to bill for the client's intensity level of services under this subdivision if the license holder can document the reason the client missed services and the interventions done to address the client's absence.

Subd. 7. **Holidays.** Hours in a treatment week may be reduced in observance of federally recognized holidays.

Subd. 8. **Utilization review requirements.** Eligible vendors of services in subdivision 1, clauses (1) to (10), must 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.

Subd. 9. **Withdrawal management services.** For withdrawal management services provided by an eligible vendor that is licensed under chapter 245F as a clinically managed withdrawal management program or as a medically monitored withdrawal management program, utilization review, as defined in section 62M.02, may occur but may not be initiated until five calendar days after the date of service initiation.

[See Note.]

Subd. 10. **Monetary recovery.** Reimbursement for services authorized under this chapter that are not provided in accordance with this chapter are subject to monetary recovery under section 256B.064 as money improperly paid.

Subd. 11. **Billing limits.** Treatment coordination must not exceed five hours per week per recipient.

History: *2011 c 86 s 8; 2014 c 228 art 4 s 1; 2014 c 291 art 3 s 7; 2015 c 21 art 1 s 52; 2015 c 78 art 2 s 3; 2016 c 189 art 16 s 7; 1Sp2017 c 6 art 8 s 60; 1Sp2019 c 9 art 6 s 49; 1Sp2021 c 7 art 6 s 8; art 11 s 11; 2022 c 98 art 4 s 30,51; 2023 c 50 art 1 s 22; art 2 s 52; 2024 c 85 s 59; 2024 c 108 art 4 s 23; 2024 c 125 art 3 s 8; 2024 c 127 art 48 s 8; 1Sp2025 c 9 art 4 s 33,55; 2026 c 95 art 5 s 19-21; 2026 c 121 art 6 s 9*

NOTE: The amendment to subdivision 1, clause (1), by Laws 2023, chapter 50, article 2, section 52, is effective upon federal approval. Laws 2023, chapter 50, article 2, section 52, the effective date.

NOTE: The amendment to subdivision 1 by Laws 2023, chapter 61, article 4, section 10, is effective upon federal approval. The commissioner shall notify the revisor of statutes when federal approval is obtained. Laws 2023, chapter 61, article 4, section 10, the effective date.

NOTE: The amendments to subdivision 1, clauses (1) and (8), by Laws 2024, chapter 108, article 4, section 23, are effective retroactively from January 1, 2024, with federal approval or retroactively from a later federally approved date. The commissioner of human services shall notify the revisor of statutes of the effective date upon federal approval. Laws 2024, chapter 108, article 4, section 23, the effective date.

NOTE: The amendment to subdivision 1, clause (4), by Laws 2025, First Special Session chapter 9, article 4, section 33, is effective upon federal approval. The commissioner of human services must notify the revisor of statutes when federal approval is obtained. Laws 2025, First Special Session chapter 9, article 4, section 33, the effective date.

NOTE: Subdivision 9, as added by Laws 2026, chapter 95, article 5, section 20, is effective upon federal approval. Laws 2026, chapter 95, article 5, section 20, the effective date.

254B.0507 ENHANCED RATE REQUIREMENTS.

Subdivision 1. **Enhanced rates.** The commissioner shall establish higher rates for programs that meet the requirements of section 254B.0505, subdivision 1, and the requirements of subdivision 2, 3, 4, 5, or 6.

Subd. 2. **Child care.** (a) Programs that serve parents with their children are eligible for an enhanced payment rate if the program:

(1) 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; or

(ii) is licensed under chapter 245A and sections 245G.01 to 245G.19; or

(2) arranges for off-site child care during hours of treatment activity at a facility that is licensed under chapter 142B as:

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

(ii) a family child care home under Minnesota Rules, chapter 9502.

(b) In order to be eligible for a higher rate under this subdivision, 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.

Subd. 3. **Culturally specific or culturally responsive programs.** Culturally specific or culturally responsive programs as defined in section 254B.01, subdivision 4a, are eligible for an enhanced payment rate.

[See Note.]

Subd. 4. **Disability responsive programs.** Disability responsive programs as defined in section 254B.01, subdivision 4b, are eligible for an enhanced payment rate.

[See Note.]

Subd. 5. **Medical services.** Programs that offer medical services delivered by appropriately credentialed health care staff in an amount equal to one hour per client per week are eligible for an enhanced payment rate if the medical needs of the client and the nature and provision of any medical services provided are documented in the client file.

Subd. 6. **Services for individuals with co-occurring disorders.** (a) Programs that offer services to individuals with co-occurring mental health and substance use disorder problems are eligible for an enhanced payment rate if:

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

(2) the program employs a mental health professional as defined in section 245I.04, subdivision 2;

(3) clients scoring positive on a standardized mental health screen receive a mental health diagnostic assessment within ten days of admission, excluding weekends and holidays;

(4) 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;

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

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

(b) 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 clauses (1) to (4).

[See Note.]

History: *2011 c 86 s 8; 2014 c 228 art 4 s 1; 2015 c 21 art 1 s 52; 2015 c 71 art 2 s 20; 1Sp2017 c 6 art 8 s 60; 2018 c 182 art 2 s 18; 2019 c 50 art 1 s 70; 1Sp2019 c 9 art 6 s 49; 2022 c 98 art 4 s 30,51; art 6 s 25; 2023 c 50 art 2 s 52; 2023 c 61 art 4 s 10; 2024 c 108 art 4 s 23; 2025 c 38 art 4 s 32; 1Sp2025 c 9 art 4 s 33,55; 2026 c 88 art 1 s 111*

NOTE: The amendments to subdivisions 3 and 4 by Laws 2021, First Special Session chapter 7, article 11, section 11, are effective upon federal approval. Laws 2021, First Special Session chapter 7, article 11, section 11, the effective date.

NOTE: The amendment to subdivision 6, paragraph (a), clause (2), by Laws 2022, chapter 98, article 4, section 30, is effective upon federal approval. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained. Laws 2022, chapter 98, article 4, section 30, the effective date.

254B.0509 RATE ADJUSTMENTS.

Subdivision 1. **Base payment rates.** Effective for services provided on or after January 1, 2026, the commissioner must implement the following base payment rates for substance use disorder treatment services under section 254B.0505, subdivision 1:

(1) for low-intensity residential services, 100 percent of the modeled rate included in the final report required by Laws 2021, First Special Session chapter 7, article 17, section 18;

(2) for high-intensity residential services, 83 percent of the modeled rate included in the final report required by Laws 2021, First Special Session chapter 7, article 17, section 18; and

(3) for treatment coordination services, 100 percent of the modeled rate included in the final report required by Laws 2021, First Special Session chapter 7, article 17, section 18.

Subd. 2. **Annual adjustments.** Effective January 1, 2027, and annually thereafter, the commissioner of human services must adjust the payment rates under section 254B.0505, subdivision 1, clauses (1) to (9), 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. Notwithstanding this subdivision, rates must not be adjusted lower than those established on January 1, 2026.

History: *1Sp2025 c 9 art 4 s 34,55; 2026 c 121 art 6 s 10*

NOTE: This section is effective upon federal approval. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained. Laws 2025, First Special Session chapter 9, article 4, section 34, the effective date.

254B.051 SUBSTANCE USE DISORDER TREATMENT EFFECTIVENESS.

In addition to the substance use disorder treatment program performance outcome measures that the commissioner of human services collects annually from treatment providers, the commissioner shall request additional data from programs that receive appropriations from the behavioral health fund. This data shall include number of client readmissions six months after release from inpatient treatment, and the cost of treatment per person for each program receiving behavioral health funds. The commissioner may post this data on the department website.

History: *2008 c 234 s 6; 1Sp2017 c 6 art 8 s 61; 2021 c 30 art 13 s 83*

254B.052 PEER RECOVERY SUPPORT SERVICES REQUIREMENTS.

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

(b) Peer recovery support services must be provided according to (1) an individual recovery plan if provided by a recovery community organization or county, (2) a treatment plan if provided in either a substance use disorder treatment program under chapter 245G or a Tribally licensed substance use disorder treatment program, or (3) 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 the client receives 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.0501 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. designations, the client's response, and the name of the recovery peer who provided the service.

Subd. 4. **Recovery community organization vendor compliance training.** (a) Effective January 1, 2027, in order to enroll as an eligible vendor of peer recovery support services, a recovery community organization must require all owners active in day-to-day management and operations of the organization and managerial and supervisory employees to complete compliance training before applying for enrollment and every three years thereafter. Mandatory compliance training format and content must be determined by the commissioner, and must include the following topics:

(1) state and federal program billing, documentation, and service delivery requirements;

(2) eligible vendor enrollment requirements;

(3) provider program integrity, including fraud prevention, fraud detection, and penalties;

(4) fair labor standards;

(5) workplace safety requirements; and

(6) recent changes in service requirements.

(b) Any new owners active in day-to-day management and operations of the organization and managerial and supervisory employees must complete the training under this subdivision in order to be employed by or conduct management and operations activities for the organization. If the individual moves to another recovery community organization and serves in a similar ownership or employment capacity, the individual is not required to repeat the training required under this subdivision if the individual documents completion of the training within the past three years.

(c) By July 1, 2026, the commissioner must make the training required under this subdivision available in person, online, or by electronic remote connection.

(d) A recovery community organization enrolled as an eligible vendor before January 1, 2027, must document completion of the compliance training as required under this subdivision by January 1, 2028, and every three years thereafter.

Subd. 5. **Complaints.** 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.

Subd. 6. MS 2025 Supp [Repealed, 2026 c 95 art 5 s 40]

Subd. 7. **Billing limits.** Peer recovery support services must not exceed 14 hours per week per recipient, of which no more than two hours per day per recipient may be provided by telehealth. Peer recovery support services must not exceed 520 hours annually per recipient.

History: *2024 c 125 art 3 s 9; 2024 c 127 art 48 s 9; 1Sp2025 c 9 art 4 s 35,55; 2026 c 95 art 5 s 22,23; 2026 c 121 art 6 s 34*

254B.06 REIMBURSEMENT; PAYMENT; DENIAL.

Subdivision 1. **State collections.** The commissioner is responsible for all collections from persons determined to be partially responsible for the cost of care of an eligible person receiving services under Laws 1986, chapter 394, sections 8 to 20. The commissioner may initiate, or request the attorney general to initiate, necessary civil action to recover the unpaid cost of care. The commissioner may collect all third-party payments for substance use disorder services provided under Laws 1986, chapter 394, sections 8 to 20, including private insurance and federal Medicaid and Medicare financial participation. The remaining receipts must be deposited in the behavioral health fund.

Subd. 2. **Allocation of collections.** The commissioner shall allocate 77.05 percent of patient payments and third-party payments to the special revenue account and 22.95 percent to the county financially responsible for the patient.

Subd. 3. **Payment; denial.** The commissioner shall pay eligible vendors for placements made by local agencies under section 254B.03, subdivision 1, and placements by Tribal designated agencies according to section 254B.09. The commissioner may reduce or deny payment of the state share when services are not provided according to the placement criteria established by the commissioner. The commissioner may pay for all or a portion of improper county substance use disorder placements and bill the county for the entire payment made when the placement did not comply with criteria established by the commissioner. The commissioner may make payments to vendors and charge the county 100 percent of the payments if documentation of a county approved placement is received more than 30 working days, exclusive of weekends and holidays, after the date services began. The commissioner shall not pay vendors until private insurance company claims have been settled.

Subd. 4. **Reimbursement for institutions for mental diseases.** The commissioner shall not deny reimbursement to a program designated as an institution for mental diseases under United States Code, title 42, section 1396d, due to a reduction in federal financial participation and the addition of new residential beds.

Subd. 5. **Prohibition of duplicative claim submission.** (a) For time-based claims, submissions must follow the guidelines in the Centers for Medicare and Medicaid Services' Healthcare Common Procedure Coding System and the American Medical Association's Current Procedural Terminology to determine the appropriate units of time to report.

(b) More than half the duration of a time-based code must be spent performing the service to be eligible under this section. Any other claim submission for service provided during the remaining balance of the unit of time is duplicative and ineligible.

(c) A provider may only round up to the next whole number of service units on a submitted claim when more than one and one-half times the defined value of the code has occurred and no additional time increment code exists.

History: *1986 c 394 s 13; 1987 c 299 s 15; 1989 c 282 art 2 s 107; 1992 c 513 art 7 s 13; 1Sp1993 c 1 art 3 s 21; 2007 c 147 art 11 s 16; 1Sp2010 c 1 art 19 s 14; 1Sp2011 c 9 art 8 s 5; 2016 c 189 art 16 s 8,9; 1Sp2019 c 9 art 6 s 50,51; 2021 c 30 art 13 s 83; 2022 c 98 art 4 s 51; 2025 c 38 art 4 s 33*

254B.07 THIRD-PARTY LIABILITY.

The state agency provision and payment of, or liability for, substance use disorder medical care is the same as in section 256B.042.

History: *1986 c 394 s 14; 1Sp2017 c 6 art 8 s 62*

254B.08 FEDERAL WAIVERS.

The commissioner shall apply for any federal waivers necessary to secure, to the extent allowed by law, federal financial participation for the provision of services to persons who need substance use disorder services. The commissioner may seek amendments to the waivers or apply for additional waivers to contain costs. The commissioner shall ensure that payment for the cost of providing substance use disorder services under the federal waiver plan does not exceed the cost of substance use disorder services that would have been provided without the waivered services.

History: *1986 c 394 s 15; 1987 c 299 s 16; 1988 c 689 art 2 s 268; 1990 c 568 art 2 s 60; 1Sp2017 c 6 art 8 s 63*

254B.09 INDIAN RESERVATION ALLOCATION OF BEHAVIORAL HEALTH FUND.

Subdivision 1. **Vendor payments.** The commissioner shall pay eligible vendors for substance use disorder services to American Indians on the same basis as other payments, except that no local match is required when an invoice is submitted by the governing authority of a federally recognized American Indian Tribal body or a county if the Tribal governing body has not entered into an agreement under subdivision 2 on behalf of a current resident of the reservation under this section.

Subd. 2. **American Indian agreements.** The commissioner may enter into agreements with federally recognized Tribal units to pay for substance use disorder treatment services provided under Laws 1986, chapter 394, sections 8 to 20. The agreements must clarify how the governing body of the Tribal unit fulfills the Tribal unit's responsibilities regarding the form and manner of invoicing.

Subd. 3. MS 1988 [Repealed, 1989 c 282 art 2 s 219]

Subd. 4. MS 2008 [Repealed, 1Sp2010 c 1 art 19 s 24]

Subd. 5. MS 2008 [Repealed, 1Sp2010 c 1 art 19 s 24]

Subd. 6. **American Indian Tribal placements.** After entering into an agreement under subdivision 2, the governing authority of each reservation may submit invoices to the state for the cost of providing substance use disorder services to residents of the reservation according to the placement rules governing county placements, except that local match requirements are waived. The governing body may designate an agency to act on its behalf to provide placement services and manage invoices by written notice to the commissioner and evidence of agreement by the agency designated.

Subd. 7. MS 2008 [Repealed, 1Sp2010 c 1 art 19 s 24]

Subd. 8. **Payments to improve services to American Indians.** The commissioner may set rates for substance use disorder services to American Indians according to the American Indian Health Improvement Act, Public Law 94-437, for eligible vendors. These rates shall supersede rates set in county purchase of service agreements when payments are made on behalf of clients eligible according to Public Law 94-437.

History: *1985 c 248 s 70; 1986 c 394 s 16; 1987 c 299 s 17-19; 1988 c 532 s 12; 1989 c 282 art 2 s 108-110; 1997 c 203 art 4 s 8-10; 1Sp2001 c 9 art 3 s 7; 2002 c 275 s 1; 2002 c 379 art 1 s 113; 2009 c 79 art 7 s 11; 1Sp2010 c 1 art 19 s 15; 1Sp2017 c 6 art 8 s 64; 2023 c 25 s 133; 1Sp2025 c 9 art 4 s 36*

254B.10 MS 1988 [Repealed, 1989 c 282 art 2 s 219]

254B.11 [Never effective, 2009 c 173 art 1 s 49]

254B.12 RATE METHODOLOGY.

Subdivision 1. **Behavioral health fund rate methodology established.** The commissioner shall establish a new rate methodology for the behavioral health fund. The new methodology must replace county-negotiated rates with a uniform statewide methodology that must include a graduated reimbursement scale based on the patients' level of acuity and complexity. At least biennially, the commissioner shall review the financial information provided by vendors to determine the need for rate adjustments.

Subd. 2. **Payment methodology for highly specialized vendors.** Notwithstanding subdivision 1, the commissioner shall seek federal authority to develop separate payment methodologies for substance use disorder treatment services provided under the behavioral health fund: (1) by a state-operated vendor; or (2) for persons who have been civilly committed to the executive board, present the most complex and difficult care needs, and are a potential threat to the community. A payment methodology under this subdivision is effective for services provided on or after October 1, 2015, or on or after the receipt of federal approval, whichever is later.

Subd. 3. **Substance use disorder provider rate increase.** For the substance use disorder services listed in section 254B.05, subdivision 5, and provided on or after July 1, 2017, payment rates shall be increased by one percent over the rates in effect on January 1, 2017, for vendors who meet the requirements of sections 254B.0501 to 254B.0507.

Subd. 4. **Culturally specific or culturally responsive program and disability responsive program provider rate increase.** For the substance use disorder services listed in section 254B.0505 provided by programs that meet the requirements of section 254B.0507, subdivisions 2, 3, and 4, on or after January 1, 2022, payment rates shall increase by five percent over the rates in effect on January 1, 2021. The commissioner shall increase prepaid medical assistance capitation rates as appropriate to reflect this increase.

History: *2009 c 79 art 7 s 13; 2011 c 86 s 9; 2014 c 312 art 29 s 4; 2015 c 71 art 2 s 21; 1Sp2017 c 6 art 8 s 65,66; 2021 c 30 art 13 s 83; 1Sp2021 c 7 art 11 s 12; 2022 c 98 art 4 s 51; 2024 c 79 art 10 s 3; 1Sp2025 c 9 art 4 s 55*

254B.121 RATE METHODOLOGY; SUBSTANCE USE DISORDER TREATMENT SERVICES WITH MEDICATIONS FOR OPIOID USE DISORDER.

Subdivision 1. **Rates established.** Notwithstanding sections 254B.03, subdivision 9, paragraph (a), clause (2); 254B.0505, subdivision 1; and 254B.12, subdivision 1, the commissioner shall use the rates in this section for substance use disorder treatment services with medications for opioid use disorder.

Subd. 2. **Rate updates.** Effective each January 1, the commissioner must update the rates for substance use disorder treatment services with medications for opioid use disorder that are licensed according to sections 245G.01 to 245G.17 and 245G.22, or applicable Tribal license, to equal the corresponding Minnesota-specific, locality-adjusted Medicare rates for the same or comparable services in the calendar year in which the services are provided. This rate does not apply to federally qualified health centers, rural health centers, Indian health services, and certified community behavioral health centers.

Subd. 3. **Nondrug weekly bundle annual limit.** No more than 30 weekly nondrug bundle charges are eligible for coverage in the first calendar year that an enrollee is being treated by an opioid treatment provider and no more than 15 weekly nondrug bundle charges are eligible for coverage in subsequent calendar years. The commissioner may override the coverage limitation on the number of weekly nondrug bundle charges for an enrollee if the provider obtains authorization to exceed the limit and documents the medical necessity, services to be provided, and rationale for requiring the enrollee to report to the provider's facility for a face-to-face encounter more frequently.

History: *2023 c 61 art 4 s 11; 2024 c 125 art 8 s 11; 2024 c 127 art 53 s 11; 1Sp2025 c 9 art 4 s 55*

NOTE: This section, as added by Laws 2023, chapter 61, article 4, section 11, is effective upon federal approval. The commissioner shall notify the revisor of statutes when federal approval is obtained. Laws 2023, chapter 61, article 4, section 11, the effective date, as amended by Laws 2024, chapter 125, article 8, section 11, and Laws 2024, chapter 127, article 53, section 11.

254B.13 Subdivision 1. MS 2022 [Repealed, 2023 c 50 art 1 s 38]

Subd. 2. MS 2022 [Repealed, 2023 c 50 art 1 s 38]

Subd. 2a. MS 2022 [Repealed, 2023 c 50 art 1 s 38]

Subd. 3. MS 2013 Supp [Repealed, 2014 c 262 art 3 s 18]

Subd. 4. MS 2022 [Repealed, 2023 c 50 art 1 s 38]

Subd. 5. MS 2022 [Repealed, 2023 c 50 art 1 s 38]

Subd. 6. MS 2022 [Repealed, 2023 c 50 art 1 s 38]

Subd. 7. MS 2022 [Repealed, 2023 c 50 art 1 s 38]

Subd. 8. MS 2022 [Repealed, 2023 c 50 art 1 s 38]

254B.14 Subdivision 1. [Repealed, 2022 c 98 art 4 s 52]

Subd. 2. [Repealed, 2022 c 98 art 4 s 52]

Subd. 3. [Repealed, 2022 c 98 art 4 s 52]

Subd. 4. [Repealed, 2022 c 98 art 4 s 52]

Subd. 5. [Repealed, 2022 c 98 art 4 s 52]

Subd. 6. [Repealed, 2022 c 98 art 4 s 52]

254B.15 SUBSTANCE USE DISORDER SYSTEM REFORM.

Subdivision 1. **Authorization of substance use disorder treatment system reform.** The commissioner shall design a reform of Minnesota's substance use disorder treatment system to ensure a full continuum of care is available for individuals with substance use disorders.

Subd. 2. **Goals.** The reform proposal in subdivision 3 shall support the following goals:

(1) improve and promote strategies to identify individuals with substance use issues and disorders;

(2) ensure timely access to treatment and improve access to treatment;

(3) enhance clinical practices and promote clinical guidelines and decision-making tools for serving people with substance use disorders;

(4) build aftercare and recovery support services;

(5) coordinate and consolidate funding streams, including local, state, and federal funds, to maximize efficiency;

(6) increase the use of quality and outcome measures to inform benefit design and payment models; and

(7) coordinate treatment of substance use disorder primary care, long-term care, and the mental health delivery system when appropriate.

Subd. 3. **Reform proposal.** (a) A reform proposal shall include systemic and practice reforms to develop a robust continuum of care to effectively treat the physical, behavioral, and mental dimensions of substance use disorders. Elements of the reform proposal shall include, but are not limited to:

(1) an assessment and access process that permits clients to present directly to a service provider for a substance use disorder assessment and authorization of services;

(2) mechanisms for direct reimbursement of credentialed professionals;

(3) care coordination models to link individuals with substance use disorders to appropriate providers;

(4) peer support services to assist people with substance use disorders who are in recovery;

(5) implementation of withdrawal management services pursuant to chapter 245F;

(6) primary prevention services to delay the onset of substance use and avoid the development of addiction;

(7) development of new services and supports that are responsive to the chronic nature of substance use disorders; and

(8) exploration and implementation of available options to allow for exceptions to the federal Institution for Mental Diseases (IMD) exclusion for medically necessary, rehabilitative, substance use disorder treatment provided in the most integrated and least restrictive setting.

(b) The commissioner shall develop a proposal consistent with the criteria outlined in paragraph (a) and seek all federal authority necessary to implement the proposal. The commissioner shall seek any federal waivers, state plan amendments, requests for new funding, realignment of existing funding, and other authority necessary to implement elements of the reform proposal outlined in this section.

(c) Implementation is contingent upon legislative approval of the proposal under this subdivision.

Subd. 4. **Legislative update.** No later than February 1, 2017, the commissioner shall present an update on the progress of the proposal to members of the legislative committees in the house of representatives and senate with jurisdiction over health and human services policy and finance on the progress of the proposal and shall make recommendations on any legislative changes and state appropriations necessary to implement the proposal.

Subd. 5. **Stakeholder input.** In developing the proposal, the commissioner shall consult with consumers, providers, counties, Tribes, health plans, and other stakeholders.

History: *2016 c 170 s 1*

254B.151 SUBSTANCE USE DISORDER COMMUNITY OF PRACTICE.

Subdivision 1. **Establishment; purpose.** The commissioner of human services, in consultation with substance use disorder subject matter experts, shall establish a substance use disorder community of practice. The purposes of the community of practice are to improve treatment outcomes for individuals with substance use disorders and reduce disparities by using evidence-based and best practices through peer-to-peer and person-to-provider sharing.

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

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

(2) substance use disorder treatment providers;

(3) representatives from recovery community organizations;

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

(5) a representative from the Department of Health;

(6) a representative from the Department of Corrections;

(7) representatives from county social services agencies;

(8) representatives from Tribal Nations or Tribal social services providers;

(9) representatives from managed care organizations; and

(10) a representative from Direct Care and Treatment.

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

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

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

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

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

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

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

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

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

(6) develop capacity for community advocacy.

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

History: *1Sp2021 c 7 art 11 s 13; 2024 c 79 art 4 s 13; 2024 c 125 art 5 s 43; 2024 c 127 art 50 s 43*

254B.16 MS 2022 [Repealed, 2023 c 50 art 1 s 38]

254B.17 WITHDRAWAL MANAGEMENT START-UP AND CAPACITY-BUILDING GRANTS.

The commissioner must establish start-up and capacity-building grants for prospective, new, or existing substance use disorder treatment or withdrawal management programs that will meet ASAM criteria for medically managed or clinically monitored levels of care by integrating withdrawal management services into outpatient, intensive outpatient, or residential treatment services. Grants must be used to measurably increase client capacity or expand available services and must align services with ASAM criteria. Grants may be used to add medications for opioid use disorder to a grantee's available services and for capacity-building expenses that are not reimbursable under Minnesota health care programs, including but not limited to:

(1) costs associated with hiring staff or contracting with medical services providers;

(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;

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

(9) costs associated with adding or improving physical space;

(10) start-up costs associated with adding new locations; and

(11) costs associated with becoming ASAM certified for medically managed levels of care.

History: *2023 c 61 art 4 s 12; 2026 c 121 art 6 s 11*

254B.18 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.

History: *2023 c 61 art 4 s 13*

254B.181 MS 2024 [Repealed, 1Sp2025 c 9 art 4 s 57; 2026 c 121 art 6 s 33]

254B.19 AMERICAN SOCIETY OF ADDICTION MEDICINE STANDARDS OF CARE.

Subdivision 1. **Level of care requirements.** (a) 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 (b).

(2) For ASAM level 1.0 outpatient clients, adults must receive up to eight hours per week of psychosocial 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. Ancillary services and treatment coordination may be provided beyond the hourly psychosocial 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 psychosocial 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. Ancillary services and treatment coordination may be provided beyond the hourly psychosocial treatment service hours allowable per week. If clinically indicated on the client's treatment plan, this service may be provided in conjunction with room and board according to section 254B.0503.

(4) For ASAM level 2.5 partial hospitalization clients, adults must receive 20 hours or more of psychosocial treatment services. Services must be licensed according to section 245G.20. 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.0505, subdivision 4. If clinically indicated on the client's treatment plan, this service may be provided in conjunction with room and board according to section 254B.0503.

(5) For ASAM level 3.1 clinically managed low-intensity residential clients, programs must provide at least 5 hours of psychosocial 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 a minimum, daily psychosocial 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 a minimum, daily psychosocial 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.

(b) Notwithstanding the minimum daily psychosocial treatment service requirements under paragraph (a), clauses (6) and (7), ASAM level 3.3 and 3.5 vendors must provide each client at least 30 hours of treatment services per week for the period between January 1, 2024, through June 30, 2024.

[See Note.]

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;

(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: Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions.

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 (b);

(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.

History: *2023 c 50 art 2 s 53; 2024 c 125 art 3 s 10; 2024 c 127 art 48 s 10; 1Sp2025 c 9 art 4 s 37,55*

NOTE: The amendment to subdivision 1 by Laws 2025, First Special Session chapter 9, article 4, section 37, is effective upon federal approval. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained. Laws 2025, First Special Session chapter 9, article 4, section 37, the effective date.

254B.191 EVIDENCE-BASED TRAINING.

The commissioner of human services must establish training opportunities for substance use disorder treatment providers under 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.

History: *2023 c 61 art 4 s 15*

254B.21 DEFINITIONS.

Subdivision 1. **Scope.** For the purposes of sections 254B.21 to 254B.216, the following terms have the meanings given.

Subd. 2. **Applicant.** "Applicant" means any individual, organization, or entity who has applied for certification of a recovery residence.

Subd. 3. **Certified recovery residence.** "Certified recovery residence" means a recovery residence that has completed the application process and been approved for certification by the commissioner.

Subd. 4. **Co-occurring disorders.** "Co-occurring disorders" means a diagnosis of both a substance use disorder and a mental health disorder.

Subd. 5. **Operator.** "Operator" means the lawful owner or lessee of a recovery residence or a person employed and designated by the owner or lessee of the recovery residence to have primary responsibility for oversight of the recovery residence, including but not limited to hiring and termination of recovery residence staff, recovery residence maintenance, and responding to complaints being investigated by the commissioner.

Subd. 6. **Recovery residence.** "Recovery residence" means a type of community residence that provides a safe, healthy, family-like, substance-free living environment that supports individuals in recovery from substance use disorder.

Subd. 7. **Recovery residence registry.** "Recovery residence registry" means the list of certified recovery residences maintained by the commissioner.

Subd. 8. **Resident.** "Resident" means an individual who resides in a recovery residence.

Subd. 9. **Staff.** "Staff" means employees, contractors, or volunteers who provide monitoring, assistance, or other services for the use and benefit of a recovery residence and the residence's residents.

Subd. 10. **Substance free.** "Substance free" means being free from the use of alcohol, illicit drugs, and the illicit use of prescribed drugs. This term does not prohibit medications prescribed, dispensed, or administered by a licensed health care professional, such as pharmacotherapies specifically approved by the United States Food and Drug Administration (FDA) for treatment of a substance use disorder as well as other medications approved by the FDA for the treatment of co-occurring disorders when taken as directed.

Subd. 11. **Substance use disorder.** "Substance use disorder" has the meaning given in the most recent edition of the Diagnostic and Statistical Manual of Disorders of the American Psychiatric Association.

History: *1Sp2025 c 9 art 4 s 38*

254B.211 RECOVERY RESIDENCE REQUIREMENTS AND RESIDENT RIGHTS.

Subdivision 1. **Applicability.** This section is applicable to all recovery residences regardless of certification status.

Subd. 2. **Residence requirements.** All recovery residences must:

(1) comply with applicable state laws and regulations and local ordinances related to maximum occupancy, fire safety, and sanitation;

(2) have safety policies and procedures that, at a minimum, address:

(i) safety inspections requiring periodic verification of smoke detectors, carbon monoxide detectors, fire extinguishers, and emergency evacuation drills;

(ii) exposure to bodily fluids and contagious disease; and

(iii) emergency procedures posted in conspicuous locations in the residence;

(3) maintain a supply of an opiate antagonist in the home, post information on proper use, and train staff in opiate antagonist use;

(4) have written policies regarding access to all prescribed medications and storage of medications when requested by the resident;

(5) have written policies regarding residency termination, including how length of stay is determined and procedures in case of evictions;

(6) 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 the items upon discharge. The owner must make an effort to contact persons listed as emergency contacts for the discharged person so that the items are returned;

(7) ensure separation of money of persons served by the program from money of the program or program staff. The program and staff must not:

(i) borrow money from a person served by the program;

(ii) purchase personal items from a person served by the program;

(iii) sell merchandise or personal services to a person served by the program;

(iv) require a person served by the program to purchase items for which the program is eligible for reimbursement; or

(v) use money of persons served by the program to purchase items for which the program is already receiving public or private payments;

(8) document the names and contact information for persons to contact in case of an emergency, upon discharge, or other circumstances designated by the resident, including but not limited to death due to an overdose;

(9) maintain contact information for emergency resources in the community, including but not limited to local mental health crisis services and the 988 Lifeline, to address mental health and health emergencies;

(10) have policies on staff qualifications and a prohibition against relationships between operators and residents;

(11) permit residents to use, as directed by a licensed prescriber, legally prescribed and dispensed or administered pharmacotherapies approved by the FDA for the treatment of opioid use disorder, co-occurring substance use disorders, and mental health conditions;

(12) have a fee schedule and refund policy;

(13) have rules for residents, including on prohibited items;

(14) have policies that promote resident participation in treatment, self-help groups, or other recovery supports;

(15) have policies requiring abstinence from alcohol and illicit drugs on the property. If the program utilizes drug screening or toxicology, the procedures must be included in the program's policies;

(16) distribute the recovery resident bill of rights in subdivision 3, resident rules, certification, and grievance process and post the documents in this clause in common areas;

(17) have policies and procedures on person and room searches;

(18) have code of ethics policies and procedures they are aligned with the NARR code of ethics and document that the policies and procedures are read and signed by all those associated with the operation of the recovery residence, including owners, operators, staff, and volunteers;

(19) have a description of how residents are involved with the governance of the residence, including decision-making procedures, how residents are involved in setting and implementing rules, and the role of peer leaders, if any; and

(20) have procedures to maintain a respectful environment, including appropriate action to stop intimidation, bullying, sexual harassment, or threatening behavior of residents, staff, and visitors within the

residence. Programs should consider trauma-informed and resilience-promoting practices when determining action.

Subd. 3. **Resident bill of rights.** An individual living in a recovery residence has the right to:

(1) have access to an environment that supports recovery;

(2) have 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 recovery residence's policies and procedures regarding disclosure of the 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 the safety or health of the resident or others;

(9) assert the rights in this subdivision personally or have the rights 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 and developmental disabilities and the commissioner and be provided with information about the right to file a complaint;

(11) be fully informed of the rights and responsibilities in this section and 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.

History: *1Sp2025 c 9 art 4 s 39*

254B.212 COMPLAINTS AGAINST RECOVERY RESIDENCES.

Subdivision 1. **In general.** Any complaints about a recovery residence may be made to and reviewed or investigated by the commissioner.

Subd. 2. **Types of complaints.** The commissioner must receive and review complaints that concern:

(1) the health and safety of residents;

(2) management of the recovery residence, including but not limited to house environment, financial procedures, staffing, house rules and regulations, improper handling of resident terminations, and recovery support environment; or

(3) illegal activities or threats.

Subd. 3. **Investigation.** (a) Complaints regarding illegal activities or threats must be immediately referred to law enforcement in the jurisdiction where the recovery residence is located. The commissioner must

continue to investigate complaints under subdivision 2, clause (3), that have been referred to law enforcement unless law enforcement requests the commissioner to stay the investigation.

(b) The commissioner must investigate all other types of complaints under this section and may take any action necessary to conduct an investigation, including but not limited to interviewing the recovery residence operator, staff, and residents and inspecting the premises.

Subd. 4. **Anonymity.** When making a complaint pursuant to this section, an individual must disclose the individual's identity to the commissioner. Unless ordered by a court or authorized by the complainant, the commissioner must not disclose the complainant's identity.

Subd. 5. **Prohibition against retaliation.** A recovery residence owner, operator, director, staff member, or resident must not be subject to retaliation, including but not limited to interference, threats, coercion, harassment, or discrimination, for making any complaint against a recovery residence or against a recovery residence owner, operator, or chief financial officer.

History: *1Sp2025 c 9 art 4 s 40*

254B.213 CERTIFICATION.

Subdivision 1. **Voluntary certification.** The commissioner must establish and provide for the administration of a voluntary certification program based on best practices as outlined by the American Society for Addiction Medicine and the Substance Abuse and Mental Health Services Administration for recovery residences seeking certification under this section.

Subd. 2. **Application requirements.** An applicant for certification must, at a minimum, submit the following documents on forms approved by the commissioner:

(1) if the premises for the recovery residence is leased, documentation from the owner that the applicant has permission from the owner to operate a recovery residence on the premises;

(2) all policies and procedures required under this chapter;

(3) copies of all forms provided to residents, including but not limited to the recovery residence's medication, drug-testing, return-to-use, refund, and eviction or transfer policies;

(4) proof of insurance coverage necessary and, at a minimum:

(i) employee dishonesty insurance in the amount of $10,000 if the vendor has or had custody or control of money or property belonging to clients; and

(ii) bodily injury and property damage insurance in the amount of $2,000,000 for each occurrence; and

(5) proof of completed background checks for the operator and residence staff.

Subd. 3. **Inspection pursuant to application.** Upon receiving a completed application, the commissioner must conduct an initial on-site inspection of the recovery residence to ensure the residence is in compliance with the requirements of sections 254B.21 to 254B.216.

Subd. 4. **Certification.** The commissioner must certify a recovery residence upon approval of the application and after the initial on-site inspection. The certification automatically terminates three years after issuance of the certification if the commissioner does not renew the certification. Upon certification, the commissioner must issue the recovery residence a proof of certification.

Subd. 5. **Display of proof of certification.** A certified recovery residence must publicly display a proof of certification in the recovery residence.

Subd. 6. **Nontransferability.** Certifications issued pursuant to this section cannot be transferred to an address other than the address in the application or to another certification holder without prior approval from the commissioner.

History: *1Sp2025 c 9 art 4 s 41*

254B.214 MONITORING AND OVERSIGHT OF CERTIFIED RECOVERY RESIDENCES.

Subdivision 1. **Monitoring and inspections.** (a) The commissioner must conduct an on-site certification review of the certified recovery residence every three years to determine the certification holder's compliance with applicable rules and statutes.

(b) The commissioner must offer the certification holder a choice of dates for an announced certification review. A certification review must occur during regular business hours.

(c) The commissioner must make the results of certification reviews and the results of investigations that result in a correction order publicly available on the department's website.

Subd. 2. **Commissioner's right of access.** (a) When the commissioner is exercising the powers conferred to the commissioner under this section, if the recovery residence is in operation and the information is relevant to the commissioner's inspection or investigation, the certification holder must provide the commissioner access to:

(1) the physical facility and grounds where the residence is located;

(2) documentation and records, including electronically maintained records;

(3) residents served by the recovery residence;

(4) staff persons of the recovery residence; and

(5) personnel records of current and former staff of the recovery residence.

(b) The applicant or certification holder must provide the commissioner with access to the facility and grounds, documentation and records, residents, and staff without prior notice and as often as the commissioner considers necessary if the commissioner is conducting an inspection or investigating alleged maltreatment or a violation of a law or rule. When conducting an inspection, the commissioner may request assistance from other state, county, and municipal governmental agencies and departments. The applicant or certification holder must allow the commissioner, at the commissioner's expense, to photocopy, photograph, and make audio and video recordings during an inspection.

Subd. 3. **Correction orders.** (a) If the applicant or certification holder fails to comply with a law or rule, the commissioner may issue a correction order. The correction order must state:

(1) the condition that constitutes a violation of the law or rule;

(2) the specific law or rule that the applicant or certification holder has violated; and

(3) the time that the applicant or certification holder is allowed to correct each violation.

(b) If the applicant or certification holder believes that the commissioner's correction order is erroneous, the applicant or certification holder may ask the commissioner to reconsider the correction order. An applicant

or certification holder must make a request for reconsideration in writing. The request must be sent via electronic communication to the commissioner within 20 calendar days after the applicant or certification holder received the correction order and must:

(1) specify the part of the correction order that is allegedly erroneous;

(2) explain why the specified part is erroneous; and

(3) include documentation to support the allegation of error.

(c) A request for reconsideration does not stay any provision or requirement of the correction order. The commissioner's disposition of a request for reconsideration is final and not subject to appeal.

(d) If the commissioner finds that the applicant or certification holder failed to correct the violation specified in the correction order, the commissioner may decertify the certified recovery residence according to subdivision 4.

(e) Nothing in this subdivision prohibits the commissioner from decertifying a recovery residence according to subdivision 4.

Subd. 4. **Decertification.** (a) The commissioner may decertify a recovery residence if a certification holder:

(1) failed to comply with an applicable law or rule; or

(2) knowingly withheld relevant information from or gave false or misleading information to the commissioner in connection with an application for certification, during an investigation, or regarding compliance with applicable laws or rules.

(b) When considering decertification of a recovery residence, the commissioner must consider the nature, chronicity, or severity of the violation of law or rule and the effect of the violation on the health, safety, or rights of residents.

(c) If the commissioner decertifies a recovery residence, the order of decertification must inform the certification holder of the right to have a contested case hearing under chapter 14 and Minnesota Rules, parts 1400.8505 to 1400.8612. The certification holder may appeal the decertification. The certification holder must appeal a decertification in writing and send or deliver the appeal to the commissioner by certified mail or personal service. If the certification holder mails the appeal, the appeal must be postmarked and sent to the commissioner within ten calendar days after the certification holder receives the order of decertification. If the certification holder delivers an appeal by personal service, the commissioner must receive the appeal within ten calendar days after the certification holder received the order. If the certification holder submits a timely appeal of an order of decertification, the certification holder may continue to operate the program until the commissioner issues a final order on the decertification.

(d) If the commissioner decertifies a recovery residence pursuant to paragraph (a), clause (1), based on a determination that the recovery residence was responsible for maltreatment under chapter 260E or section 626.557, the final decertification determination is stayed until the commissioner issues a final decision regarding the maltreatment appeal if the certification holder appeals the decertification according to paragraph (c) and appeals the maltreatment determination pursuant to chapter 260E or section 626.557.

Subd. 5. **Notifications required and noncompliance.** (a) Changes in recovery residence organization, staffing, services, or quality assurance procedures that affect the ability of the certification holder to comply with the minimum standards of this chapter must be reported in writing by the certification holder to the

commissioner, in a manner approved by the commissioner, within 15 days of the occurrence. The commissioner must review the change. If the change would result in noncompliance in minimum standards, the commissioner must give the recovery residence written notice and up to 180 days to correct the areas of noncompliance before being decertified. The recovery residence must develop interim procedures to resolve the noncompliance on a temporary basis and submit the interim procedures in writing to the commissioner for approval within 30 days of the commissioner's determination of the noncompliance. The commissioner must immediately decertify a recovery residence that fails to report a change that results in noncompliance within 15 days, fails to develop an approved interim procedure within 30 days of the determination of the noncompliance, or does not resolve the noncompliance within 180 days.

(b) The commissioner may require the recovery residence to submit written information to document that the recovery residence has maintained compliance with this section.

History: *1Sp2025 c 9 art 4 s 42*

254B.215 CERTIFICATION LEVELS.

Subdivision 1. **Certification levels.** When certifying a recovery residence, the commissioner must specify whether the residence is a level-one or level-two certified recovery residence.

Subd. 2. **Level-one certification.** (a) The commissioner must designate a certified residence as a level-one certified recovery residence when the residence is peer run. A level-one certified recovery residence must:

(1) not permit an allowance for on-site paid staff or operator of the recovery residence;

(2) permit only nonpaid staff to live or work within the residence; and

(3) ensure that decisions are made solely by residents.

(b) Staff of a level-one certified recovery residence must not provide billable peer recovery support services to residents of the recovery residence.

Subd. 3. **Level-two certification.** (a) The commissioner must designate a certified residence as a level-two certified recovery residence when the residence is managed by someone other than the residents. A level-two certified recovery residence must have staff to model and teach recovery skills and behaviors.

(b) A level-two certified recovery residence must:

(1) have written job descriptions for each staff member position, including position responsibilities and qualifications;

(2) have written policies and procedures for ongoing performance development of staff;

(3) provide annual training on emergency procedures, resident bill of rights, grievance policies and procedures, and code of ethics;

(4) provide community or house meetings, peer supports, and involvement in self-help or off-site treatment services;

(5) have identified recovery goals;

(6) maintain documentation that residents are linked with community resources such as job search, education, family services, and health and housing programs; and

(7) maintain documentation of referrals made for additional services.

(c) Staff of a level-two certified recovery residence must not provide billable peer support services to residents of the recovery residence.

History: *1Sp2025 c 9 art 4 s 43*

254B.216 RESIDENT RECORD.

A certified recovery residence must maintain documentation with a resident's signature stating that each resident received the following prior to or on the first day of residency:

(1) the recovery resident bill of rights in section 254B.211, subdivision 3;

(2) the residence's financial obligations and agreements, refund policy, and payments from third-party payers for any fees paid on the resident's behalf;

(3) a description of the services provided by the recovery residence;

(4) relapse policies;

(5) policies regarding personal property;

(6) orientation to emergency procedures;

(7) orientation to resident rules; and

(8) all other applicable orientation materials identified in sections 254B.21 to 254B.216.

History: *1Sp2025 c 9 art 4 s 44*