

CHAPTER 254B

SUBSTANCE USE DISORDER TREATMENT

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|----------|---|----------|--|
| 254B.01 | DEFINITIONS. | 254B.08 | FEDERAL WAIVERS. |
| 254B.02 | CHEMICAL DEPENDENCY ALLOCATION PROCESS. | 254B.09 | INDIAN RESERVATION ALLOCATION OF CHEMICAL DEPENDENCY FUND. |
| 254B.03 | RESPONSIBILITY TO PROVIDE SUBSTANCE USE DISORDER TREATMENT. | 254B.12 | RATE METHODOLOGY. |
| 254B.04 | ELIGIBILITY FOR BEHAVIORAL HEALTH FUND SERVICES. | 254B.13 | PILOT PROJECTS; CHEMICAL HEALTH CARE. |
| 254B.041 | CHEMICAL DEPENDENCY RULES. | 254B.14 | CONTINUUM OF CARE PILOT PROJECTS; CHEMICAL HEALTH CARE. |
| 254B.05 | VENDOR ELIGIBILITY. | 254B.15 | SUBSTANCE USE DISORDER SYSTEM REFORM. |
| 254B.051 | SUBSTANCE USE DISORDER TREATMENT EFFECTIVENESS. | 254B.151 | SUBSTANCE USE DISORDER COMMUNITY OF PRACTICE. |
| 254B.06 | REIMBURSEMENT; PAYMENT; DENIAL. | 254B.16 | PILOT PROJECTS; TREATMENT FOR PREGNANT AND POSTPARTUM WOMEN WITH SUBSTANCE USE DISORDER. |
| 254B.07 | THIRD-PARTY LIABILITY. | | |

254B.01 DEFINITIONS.

Subdivision 1. [Repealed, 2014 c 262 art 3 s 18]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. 3. **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. 4. **Commissioner.** Unless otherwise indicated, "commissioner" means the commissioner of human services.

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.

[See Note.]

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.

[See Note.]

Subd. 5. **Local agency.** "Local agency" means the agency designated by a board of county commissioners, a local social services agency, or a human services board to make placements and submit state invoices according to Laws 1986, chapter 394, sections 8 to 20.

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 chemical dependency services eligible for payment according to Laws 1986, chapter 394, sections 8 to 20.

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 [Repealed, 2011 c 86 s 23]

Subd. 8. **Recovery community organization.** "Recovery community organization" means an independent organization led and governed by representatives of local communities of recovery. A recovery community organization mobilizes resources within and outside of the recovery community to increase the prevalence and quality of long-term recovery from alcohol and other drug addiction. 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.

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

NOTE: The amendment to subdivision 4a by Laws 2021, First Special Session chapter 7, article 11, section 9, is effective January 1, 2022, or upon federal approval, whichever is later. The commissioner shall

notify the revisor of statutes when federal approval is obtained. Laws 2021, First Special Session chapter 7, article 11, section 9, the effective date.

NOTE: Subdivision 4b, as added by Laws 2021, First Special Session chapter 7, article 11, section 10, is effective January 1, 2022, or upon federal approval, whichever is later. The commissioner shall notify the revisor of statutes when federal approval is obtained. Laws 2021, First Special Session chapter 7, article 11, section 10, the effective date.

254B.02 CHEMICAL DEPENDENCY ALLOCATION PROCESS.

Subdivision 1. **Chemical dependency treatment allocation.** The chemical dependency 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. [Repealed, 1Sp2010 c 1 art 19 s 24]

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

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

Subd. 5. **Administrative adjustment.** The commissioner may make payments to local agencies from money allocated under this section to support administrative activities under sections 254B.03 and 254B.04. The administrative payment must not exceed the lesser of: (1) five percent of the first \$50,000, four percent of the next \$50,000, and three percent of the remaining payments for services from the special revenue account according to subdivision 1; or (2) the local agency administrative 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

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

Subdivision 1. **Local agency duties.** (a) Every local agency shall provide chemical dependency services to persons residing within its jurisdiction who meet criteria established by the commissioner for placement in a chemical dependency residential or nonresidential treatment service. Chemical dependency 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 chemical dependency services who can provide economical and appropriate treatment. Unless the local agency is a social services department directly administered by a county or human services board, the local agency shall not be an eligible vendor under section 254B.05. 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) A culturally specific vendor that provides assessments under a variance under Minnesota Rules, part 9530.6610, shall be allowed to provide assessment services to persons not covered by the variance.

(d) Notwithstanding Minnesota Rules, parts 9530.6600 to 9530.6655, 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, paragraph (d). If the individual is enrolled in a prepaid health plan, the individual must comply with any provider network requirements or limitations.

(e) Beginning July 1, 2022, local agencies shall not make placement location determinations.

Subd. 2. **Behavioral health fund payment.** (a) Payment from the behavioral health fund is limited to payments for services identified in section 254B.05, 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 chemical dependency 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 chemical dependency 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 119B, 256D, and 256J, 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.05, subdivision 1a, 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 chemical dependency treatment program according to rules adopted under section 254A.03, subdivision 3; and

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

(b) A county may, from its own resources, provide chemical dependency services for which state payments are not made. A county may elect to use the same invoice procedures and obtain the same state payment services as are used for chemical dependency services for which state payments are made under this section if county payments are made to the state in advance of state payments to vendors. When a county uses the state system for payment, the commissioner shall make monthly billings to the county using the most recent available information to determine the anticipated services for which payments will be made in the coming month. Adjustment of any overestimate or underestimate based on actual expenditures shall be made by the state agency by adjusting the estimate for any succeeding month.

(c) The commissioner shall coordinate chemical dependency services and determine whether there is a need for any proposed expansion of chemical dependency 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.

(d) 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.

(e) 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. **Local agencies to pay state for county share.** Local agencies shall pay the state for the county share of the services authorized by the local agency, 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 chemical dependency services, except for those services provided to persons enrolled in medical assistance under chapter 256B and room and board services under section 254B.05, subdivision 5, paragraph (b), clause (12). 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. The commissioner shall establish an appeals process for use by recipients when services certified by the county are disputed. The commissioner shall adopt rules and standards for the appeal process to assure adequate redress for persons referred to inappropriate services.

Subd. 6. [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. [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.05, subdivision 1;

(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

254B.04 ELIGIBILITY FOR BEHAVIORAL HEALTH FUND SERVICES.

Subdivision 1. **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 chemical dependency treatment pursuant to an assessment under section 260E.20, subdivision 1, or a case plan under section 260C.201, subdivision 6, or 260C.212, shall be assisted by the local agency 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), persons enrolled in medical assistance are eligible for room and board services under section 254B.05, subdivision 5, paragraph (b), clause (12).

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

Subd. 2a. **Eligibility for treatment in residential settings.** Notwithstanding provisions of Minnesota Rules, part 9530.6622, subparts 5 and 6, related to an assessor's discretion in making placements to residential treatment settings, a person eligible for services under this section must score at level 4 on assessment dimensions related to relapse, continued use, or recovery environment in order to be assigned to services with a room and board component reimbursed under this section. Whether a treatment facility has been designated an institution for mental diseases under United States Code, title 42, section 1396d, shall not be a factor in making placements.

Subd. 2b. **Eligibility for placement in opioid treatment programs.** Prior to placement of an individual who is determined by the assessor to require treatment for opioid addiction, the assessor must provide educational information concerning treatment options for opioid addiction, including the use of a medication for the use of opioid addiction. The commissioner shall develop educational materials supported by research and updated periodically that must be used by assessors to comply with this requirement.

Subd. 2c. **Eligibility to receive peer recovery support and treatment service coordination.** Notwithstanding Minnesota Rules, part 9530.6620, subpart 6, a placing authority may authorize peer recovery support and treatment service coordination for a person who scores a severity of one or more in dimension 4, 5, or 6, under Minnesota Rules, part 9530.6622. Authorization for peer recovery support and treatment service coordination under this subdivision does not need to be provided in conjunction with treatment services under Minnesota Rules, part 9530.6622, subpart 4, 5, or 6.

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

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

254B.041 CHEMICAL DEPENDENCY RULES.

Subdivision 1. [Repealed, 1996 c 305 art 2 s 67]

Subd. 2. **Vendor collections; rule amendment.** The commissioner may amend Minnesota Rules, parts 9530.7000 to 9530.7025, to require a vendor of chemical dependency transitional and extended care rehabilitation services to collect the cost of care received under a program from an eligible person who has been determined to be partially responsible for treatment costs, and to remit the collections to the commissioner. The commissioner shall pay to a vendor, for the collections, an amount equal to five percent of the collections remitted to the commissioner by the vendor.

History: 1990 c 568 art 2 s 91; 1996 c 305 art 2 s 44

254B.05 VENDOR ELIGIBILITY.

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

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

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

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

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

Subd. 1a. **Room and board provider requirements.** (a) Effective January 1, 2000, 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 24 hours per day;

(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 licensed according to Minnesota Rules, chapter 2960, are exempt from paragraph (a), clauses (5) to (15).

(c) Licensed programs providing intensive residential treatment services or residential crisis stabilization services pursuant to section 256B.0622 or 256B.0624 are eligible vendors of room and board and are exempt from paragraph (a), clauses (6) to (15).

Subd. 1b. **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 chemical dependency 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 chemical dependency 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. 2. 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 clause.

Subd. 3. Fee reductions. If the commissioner determines that the methods in subdivision 2, 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.

Subd. 4. Regional treatment centers. Regional treatment center chemical dependency treatment units are eligible vendors. The commissioner may expand the capacity of chemical dependency 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.041, 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. 5. **Rate requirements.** (a) The commissioner shall establish rates for substance use disorder services and service enhancements funded under this chapter.

(b) Eligible substance use disorder treatment services include:

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

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

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

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

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

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

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

(8) high, medium, and low intensity residential treatment services that are licensed according to sections 245G.01 to 245G.17 and 245G.21 or applicable tribal license which provide, respectively, 30, 15, and five hours of clinical services each week;

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

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

(11) high-intensity residential treatment services that are licensed according to sections 245G.01 to 245G.17 and 245G.21 or applicable tribal license, which provide 30 hours of clinical services each week provided by a state-operated vendor or to clients who have been civilly committed to the commissioner, present the most complex and difficult care needs, and are a potential threat to the community; and

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

being served. Reimbursement shall be at the same rates and under the same conditions that would otherwise apply to direct face-to-face services.

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

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

[See Note.]

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; 1Sp1995 c 3 art 16 s 13; 1999 c 245 art 5 s 18; 2003 c 130 s 12; 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 228 art 4 s 1; 2014 c 262 art 3 s 10; 2014 c 291 art 3 s 7; 2015 c 21 art 1 s 52; 2015 c 71 art 2 s 20; 2015 c 78 art 2 s 3; 2016 c 189 art 16 s 7; 1Sp2017 c 6 art 8 s 58-60; 2018 c 182 art 2 s 17,18; 2019 c 50 art 1 s 70; 1Sp2019 c 9 art 2 s 104,105; art 6 s 47-49; 1Sp2020 c 2 art 5 s 34; 2021 c 30 art 13 s 83; 1Sp2021 c 7 art 6 s 8; art 11 s 11

NOTE: Note: The amendment to subdivision 5 by Laws 2021, First Special Session chapter 7, article 6, section 8, is effective upon federal approval. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained. Laws 2021, First Special Session chapter 7, article 6, section 8, the effective date.

NOTE: The amendment to subdivision 5 by Laws 2021, First Special Session chapter 7, article 11, section 11, is effective January 1, 2022, or upon federal approval, whichever is later. Laws 2021, First Special Session chapter 7, article 11, section 11, 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.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 chemical dependency 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 chemical dependency 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.

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

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 waived 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 CHEMICAL DEPENDENCY 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 local agency responsibilities regarding:

(1) the form and manner of invoicing; and

(2) provide that only invoices for eligible vendors according to section 254B.05 will be included in invoices sent to the commissioner for payment, to the extent that money allocated under subdivisions 4 and 5 is used.

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

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

Subd. 5. [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. [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

254B.10 [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 commissioner, 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. **Chemical dependency provider rate increase.** For the chemical dependency 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 section 254B.05.

Subd. 4. **Culturally specific or culturally responsive program and disability responsive program provider rate increase.** For the chemical dependency services listed in section 254B.05, subdivision 5, provided by programs that meet the requirements of section 254B.05, subdivision 5, paragraph (c), clauses (1), (2), and (3), 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.

[See Note.]

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

NOTE: Subdivision 4, as added by Laws 2021, First Special Session chapter 7, article 11, section 12, is effective January 1, 2022, or upon federal approval, whichever is later. The commissioner shall notify the revisor of statutes when federal approval is obtained. Laws 2021, First Special Session chapter 7, article 11, section 12, the effective date.

254B.13 PILOT PROJECTS; CHEMICAL HEALTH CARE.

Subdivision 1. **Authorization for navigator pilot projects.** The commissioner may approve and implement navigator pilot projects developed under the planning process required under Laws 2009, chapter 79, article 7, section 26, to provide alternatives to and enhance coordination of the delivery of chemical health services required under section 254B.03.

Subd. 2. **Program design and implementation.** (a) The commissioner and counties participating in the navigator pilot projects shall continue to work in partnership to refine and implement the navigator pilot projects initiated under Laws 2009, chapter 79, article 7, section 26.

(b) The commissioner and counties participating in the navigator pilot projects shall complete the planning phase and, if approved by the commissioner for implementation, enter into agreements governing the operation of the navigator pilot projects.

Subd. 2a. **Eligibility for navigator pilot program.** (a) To be considered for participation in a navigator pilot program, an individual must:

- (1) be a resident of a county with an approved navigator program;
- (2) be eligible for behavioral health fund services;
- (3) be a voluntary participant in the navigator program;
- (4) satisfy one of the following items:

(i) have at least one severity rating of three or above in dimension four, five, or six in a comprehensive assessment under section 245G.05, subdivision 2, paragraph (c), clauses (4) to (6); or

(ii) have at least one severity rating of two or above in dimension four, five, or six in a comprehensive assessment under section 245G.05, subdivision 2, paragraph (c), clauses (4) to (6), and be currently participating in a Rule 31 treatment program under chapter 245G or be within 60 days following discharge after participation in a Rule 31 treatment program; and

(5) have had at least two treatment episodes in the past two years, not limited to episodes reimbursed by the behavioral health fund. An admission to an emergency room, a detoxification program, or a hospital may be substituted for one treatment episode if it resulted from the individual's substance use disorder.

(b) New eligibility criteria may be added as mutually agreed upon by the commissioner and participating navigator programs.

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

Subd. 4. **Notice of navigator pilot project discontinuation.** Each county's participation in the navigator pilot project may be discontinued for any reason by the county or the commissioner of human services after 30 days' written notice to the other party.

Subd. 5. **Duties of commissioner.** (a) Notwithstanding any other provisions in this chapter, the commissioner may authorize navigator pilot projects to use the behavioral health fund to pay for nontreatment navigator pilot services:

(1) in addition to those authorized under section 254B.03, subdivision 2, paragraph (a); and

(2) by vendors in addition to those authorized under section 254B.05 when not providing chemical dependency treatment services.

(b) For purposes of this section, "nontreatment navigator pilot services" include navigator services, peer support, family engagement and support, housing support, rent subsidies, supported employment, and independent living skills.

(c) State expenditures for chemical dependency services and nontreatment navigator pilot services provided by or through the navigator pilot projects must not be greater than the behavioral health fund expected share of forecasted expenditures in the absence of the navigator pilot projects. The commissioner may restructure the schedule of payments between the state and participating counties under the local agency share and division of cost provisions under section 254B.03, subdivisions 3 and 4, as necessary to facilitate the operation of the navigator pilot projects.

(d) The commissioner may waive administrative rule requirements that are incompatible with the implementation of the navigator pilot project, except that any chemical dependency treatment funded under this section must continue to be provided by a licensed treatment provider.

(e) The commissioner shall not approve or enter into any agreement related to navigator pilot projects authorized under this section that puts current or future federal funding at risk.

(f) The commissioner shall provide participating navigator pilot projects with transactional data, reports, provider data, and other data generated by county activity to assess and measure outcomes. This information must be transmitted or made available in an acceptable form to participating navigator pilot projects at least once every six months or within a reasonable time following the commissioner's receipt of information from the counties needed to comply with this paragraph.

Subd. 6. **Duties of county board.** The county board, or other county entity that is approved to administer a navigator pilot project, shall:

(1) administer the navigator pilot project in a manner consistent with the objectives described in subdivision 2 and the planning process in subdivision 5;

(2) ensure that no one is denied chemical dependency treatment services for which they would otherwise be eligible under section 254A.03, subdivision 3; and

(3) provide the commissioner with timely and pertinent information as negotiated in agreements governing operation of the navigator pilot projects.

Subd. 7. **Managed care.** An individual who is eligible for the navigator pilot program under subdivision 2a is excluded from mandatory enrollment in managed care until these services are included in the health plan's benefit set.

Subd. 8. **Authorization for continuation of navigator pilots.** The navigator pilot projects implemented pursuant to subdivision 1 are authorized to continue operation after July 1, 2013, under existing agreements governing operation of the pilot projects.

History: 2010 c 376 s 1; 1Sp2010 c 1 art 19 s 16; 2011 c 86 s 10; 2013 c 108 art 4 s 12; 1Sp2017 c 6 art 8 s 67; 2019 c 50 art 1 s 71; 2021 c 30 art 13 s 83

254B.14 CONTINUUM OF CARE PILOT PROJECTS; CHEMICAL HEALTH CARE.

Subdivision 1. **Authorization for continuum of care pilot projects.** The commissioner shall establish chemical dependency continuum of care pilot projects to begin implementing the measures developed with stakeholder input and identified in the report completed pursuant to Laws 2012, chapter 247, article 5, section 8. The pilot projects are intended to improve the effectiveness and efficiency of the service continuum for chemically dependent individuals in Minnesota while reducing duplication of efforts and promoting scientifically supported practices.

Subd. 2. **Program implementation.** (a) The commissioner, in coordination with representatives of the Minnesota Association of County Social Service Administrators and the Minnesota Inter-County Association, shall develop a process for identifying and selecting interested counties and providers for participation in the continuum of care pilot projects. There shall be three pilot projects: one representing the northern region, one for the metro region, and one for the southern region. The selection process of counties and providers must include consideration of population size, geographic distribution, cultural and racial demographics, and provider accessibility. The commissioner shall identify counties and providers that are selected for participation in the continuum of care pilot projects no later than September 30, 2013.

(b) The commissioner and entities participating in the continuum of care pilot projects shall enter into agreements governing the operation of the continuum of care pilot projects. The agreements shall identify pilot project outcomes and include timelines for implementation and beginning operation of the pilot projects.

(c) Entities that are currently participating in the navigator pilot project are eligible to participate in the continuum of care pilot project subsequent to or instead of participating in the navigator pilot project.

(d) The commissioner may waive administrative rule requirements that are incompatible with implementation of the continuum of care pilot projects.

(e) Notwithstanding section 254A.19, the commissioner may designate noncounty entities to complete chemical use assessments and placement authorizations required under section 254A.19 and Minnesota Rules, parts 9530.6600 to 9530.6655. Section 254A.19, subdivision 3, is applicable to the continuum of care pilot projects at the discretion of the commissioner.

Subd. 3. **Program design.** (a) The operation of the pilot projects shall include:

- (1) new services that are responsive to the chronic nature of substance use disorder;
- (2) telehealth services, when appropriate to address barriers to services;
- (3) services that assure integration with the mental health delivery system when appropriate;
- (4) services that address the needs of diverse populations; and

(5) 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.

(b) Prior to implementation of the continuum of care pilot projects, a utilization review process must be developed and agreed to by the commissioner, participating counties, and providers. The utilization review process shall be described in the agreements governing operation of the continuum of care pilot projects.

Subd. 4. **Notice of project discontinuation.** Each entity's participation in the continuum of care pilot project may be discontinued for any reason by the county or the commissioner after 30 days' written notice to the entity.

Subd. 5. **Duties of commissioner.** (a) Notwithstanding any other provisions in this chapter, the commissioner may authorize the behavioral health fund to pay for nontreatment services arranged by continuum of care pilot projects. Individuals who are currently accessing Rule 31 treatment services are eligible for concurrent participation in the continuum of care pilot projects.

(b) County expenditures for continuum of care pilot project services shall not be greater than their expected share of forecasted expenditures in the absence of the continuum of care pilot projects.

Subd. 6. **Managed care.** An individual who is eligible for the continuum of care pilot project is excluded from mandatory enrollment in managed care unless these services are included in the health plan's benefit set.

History: 2013 c 108 art 4 s 13; 2021 c 30 art 13 s 83

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; and

(9) representatives from managed care organizations.

(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*

254B.16 PILOT PROJECTS; TREATMENT FOR PREGNANT AND POSTPARTUM WOMEN WITH SUBSTANCE USE DISORDER.

Subdivision 1. **Pilot projects established.** (a) Within the limits of federal funds available specifically for this purpose, the commissioner of human services shall establish pilot projects to provide substance use disorder treatment and services to pregnant and postpartum women with a primary diagnosis of substance use disorder, including opioid use disorder. Pilot projects funded under this section must:

(1) promote flexible uses of funds to provide treatment and services to pregnant and postpartum women with substance use disorders;

(2) fund family-based treatment and services for pregnant and postpartum women with substance use disorders;

(3) identify gaps in services along the continuum of care that are provided to pregnant and postpartum women with substance use disorders; and

(4) encourage new approaches to service delivery and service delivery models.

(b) A pilot project funded under this section must provide at least a portion of its treatment and services to women who receive services on an outpatient basis.

Subd. 2. **Federal funds.** The commissioner shall apply for any available grant funds from the federal Center for Substance Abuse Treatment for these pilot projects.

History: 2016 c 189 art 16 s 10