CHAPTER 254B

SUBSTANCE USE DISORDER TREATMENT

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 [Repealed, 2014 c 262 art 3 s 18]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. 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.05, subdivision 1, must develop to respond to an individual's peer recovery support services needs and goals.

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 authorized under section 254B.03, subdivision 1, to determine financial eligibility for the behavioral health fund.

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

Subd. 11. **Sober home.** A sober home is a cooperative living residence, a room and board residence, an apartment, or any other living accommodation that:

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

(2) stipulates that residents must abstain from using alcohol or other illicit drugs or substances not prescribed by a physician;

(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 section 254B.05, 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*

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. [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. **Local agency allocation.** The commissioner may make payments to local agencies from money allocated under this section to support individuals with substance use disorders. The payment must not be less than 133 percent of the local agency 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*

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

Subdivision 1. **Local agency duties.** (a) Every local agency 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. 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) 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.

(d) 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 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.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 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. **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 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.05, subdivision 5, paragraph (b). 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. [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; 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*

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 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), any person enrolled in medical assistance or MinnesotaCare is eligible for room and board services under section 254B.05, subdivision 5, paragraph (b), 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 9505.0150;

(3) is eligible for general assistance, general assistance medical care, or work readiness as determined under Minnesota Rules, parts 9500.1200 to 9500.1318; 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 a local agency 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.05, subdivision 4.

(i) Persons enrolled in MinnesotaCare are eligible for room and board services when provided through intensive residential treatment services and residential crisis services under section 256B.0622.

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

Subd. 2a. **Eligibility for room and board services for persons in outpatient substance use disorder treatment.** A person eligible for room and board services under section 254B.05, subdivision 5, paragraph (b), must score at level 4 on assessment dimensions related to readiness to change, 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. MS 2022 [Repealed, 2023 c 50 art 2 s 63]

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

Subd. 3. [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. **Local agency responsibility to provide services.** The local agency may employ individuals to conduct administrative activities and facilitate access to substance use disorder treatment services.

Subd. 6. **Local agency to determine client financial eligibility.** (a) The local agency 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 local agency shall pay for eligible clients according to chapter 256G. Client eligibility must be determined using only forms prescribed by the commissioner unless the local agency has a reasonable basis for believing that the information submitted on a form is false. To determine a client's eligibility, the local agency 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 local agency 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 local agency 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 local agency must provide the required eligibility information to the department in the manner specified by the department.

(f) The local agency 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.

(g) The local agency must redetermine a client's eligibility for the behavioral health fund every 12 months.

(h) 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 (f). 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 local agency 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

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

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

254B.05 VENDOR ELIGIBILITY.

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

(b) A licensed professional in private practice as defined in section 245G.01, subdivision 17, who meets the requirements of section 245G.11, subdivisions 1 and 4, is an eligible vendor of a comprehensive assessment provided according to section 254A.19, subdivision 3, 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 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 care coordination services when provided by an individual who meets the staffing credentials of section 245G.11, subdivisions 1 and 7, and provided according to the requirements of section 245G.07, subdivision 1, paragraph (a), clause (5). A county is an eligible vendor of peer recovery services when the services are provided by an individual who meets the requirements of section 245G.11, subdivision 8.

(d) A recovery community organization that meets the requirements of clauses (1) to (14) and meets certification or accreditation requirements of the Alliance for Recovery Centered Organizations, the Council on Accreditation of Peer Recovery Support Services, or a Minnesota statewide recovery organization identified by the commissioner is an eligible vendor of peer recovery support services. A Minnesota statewide recovery organization identified by the commissioner must update recovery community organization applicants for certification or accreditation on the status of the application within 45 days of receipt. If the approved statewide recovery organization denies an application, it must provide a written explanation for the denial to the recovery community organization. Eligible vendors under this paragraph must:

(1) be nonprofit organizations under section 501(c)(3) of the Internal Revenue Code, be free from conflicting self-interests, and be autonomous in decision-making, program development, peer recovery support services provided, and advocacy efforts for the purpose of supporting the recovery community organization's mission;

(2) be led and governed by individuals in the recovery community, with more than 50 percent of the board of directors or advisory board members self-identifying as people in personal recovery from substance use disorders;

(3) 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; and

(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.

(e) 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 (d) by September 1, 2024, in order to be considered as an eligible vendor of peer recovery support services.

(f) A recovery community organization that is aggrieved by an accreditation, certification, or membership determination and believes it meets the requirements under paragraph (d) may appeal the determination under section 256.045, subdivision 3, paragraph (a), clause (14), for reconsideration as an eligible vendor. If the human services judge determines that the recovery community organization meets the requirements under paragraph (d), the recovery community organization is an eligible vendor of peer recovery support services.

(g) All recovery community organizations must be certified or accredited by an entity listed in paragraph (d) by June 30, 2025.

(h) 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.

(i) 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.

(j) 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.

[See Note.]

Subd. 1a. **Room and board provider 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 licensed according to Minnesota Rules, chapter 2960, are exempt from paragraph (a), clauses (5) to (15).

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

(d) 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.

(e) 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).

(f) 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.

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 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. 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 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. 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) 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). The commissioner shall use the base payment rate of $79.84 per day for services provided under this item;

(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. The commissioner shall use the base payment rate of $166.13 per day for services provided under this item;

(vii) ASAM level 3.3 clinically managed population-specific high-intensity residential services provided according to section 254B.19, subdivision 1, clause (6). The commissioner shall use the specified base payment rate of $224.06 per day for services provided under this item; and

(viii) ASAM level 3.5 clinically managed high-intensity residential services provided according to section 254B.19, subdivision 1, clause (7). The commissioner shall use the specified base payment rate of $224.06 per day for services provided under this item;

(2) comprehensive assessments provided according to section 254A.19, subdivision 3;

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

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

(5) withdrawal management services provided according to chapter 245F;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(e) Adolescent residential programs that meet the requirements of Minnesota Rules, parts 2960.0430 to 2960.0490 and 2960.0580 to 2960.0690, are exempt from the requirements in paragraph (c), clause (5), items (i) to (iv).

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

(g) For the purpose of reimbursement under this section, substance use disorder treatment services provided in a group setting without a group participant maximum or maximum client to staff ratio under chapter 245G shall not exceed a client to staff ratio of 48 to one. At least one of the attending staff must

meet the qualifications as established under this chapter for the type of treatment service provided. A recovery peer may not be included as part of the staff ratio.

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

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

(j) 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 paragraph if the license holder can document the reason the client missed services and the interventions done to address the client's absence.

(k) Hours in a treatment week may be reduced in observance of federally recognized holidays.

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

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

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

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

[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; 2022 c 98 art 4 s 30,51; art 6 s 25; 2022 c 99 art 1 s 15; 2023 c 50 art 1 s 21,22; art 2 s 52; art 3 s 6; 2023 c 61 art 4 s 9,10; 2023 c 70 art 9 s 24,25; 2024 c 79 art 4 s 12; 2024 c 85 s 59; 2024 c 108 art 4 s 22,23; 2024 c 125 art 3 s 7,8; 2024 c 127 art 48 s 7,8*

NOTE: The amendment to subdivision 1 by Laws 2023, chapter 70, article 9, section 24, is effective upon federal approval. Laws 2023, chapter 70, article 9, section 24, the effective date.

NOTE: The amendments to subdivision 1 adding paragraph (d), clauses (13) and (14), and paragraph (j) by Laws 2024, chapter 125, article 3, section 7; and Laws 2024, chapter 127, article 48, section 7, are effective July 1, 2025. Laws 2024, chapter 125, article 3, section 7; and Laws 2024, chapter 127, article 48, section 7, the effective dates.

NOTE: The amendment to subdivision 5 by Laws 2021, First Special Session chapter 7, article 11, section 11, is effective upon federal approval. Laws 2021, First Special Session chapter 7, article 11, section 11, the effective date.

NOTE: The amendment to subdivision 5 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.

NOTE: The amendments to subdivision 5, paragraph (b), clause (1), items (i) to (iv), by Laws 2023, chapter 50, article 2, section 52, are effective January 1, 2025, or upon federal approval, whichever is later. The amendments to subdivision 5, paragraph (b), clause (1), items (v) to (vii), by Laws 2023, chapter 50, article 2, section 52, are effective upon federal approval. Laws 2023, chapter 50, article 2, section 52, the effective date.

NOTE: The amendment to subdivision 5 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 5, paragraph (b), 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 inform the revisor of statutes of the effective date upon federal approval. Laws 2024, chapter 108, article 4, section 23, 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 an individual recovery plan if provided by a recovery community organization or county, a treatment plan if provided in a substance use disorder treatment program under chapter 245G, or a stabilization plan if provided by a withdrawal management program under chapter 245F.

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

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

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

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

(1) the client's name;

(2) the recovery peer's name;

(3) the name of the recovery peer's supervisor;

(4) the client's recovery goals;

(5) the client's resources and assets to support recovery;

(6) activities that may support meeting identified goals; and

(7) the planned frequency of peer recovery support services sessions between the recovery peer and the client.

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

(1) the client's comprehensive assessment under section 245G.05 that led to the client's referral for peer recovery support services;

(2) the client's individual recovery plan; and

(3) documentation of each billed peer recovery support services interaction between the client and the recovery peer, including the date, start and end time with a.m. and p.m. designations, the client's response, and the name of the recovery peer who provided the service.

History: *2024 c 125 art 3 s 9; 2024 c 127 art 48 s 9*

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.

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*

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 local agency responsibilities regarding the form and manner of invoicing.

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; 2023 c 25 s 133*

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 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 section 254B.05.

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.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.

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*

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.05, subdivision 5, paragraph (a); 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*

NOTE: This section, as added by Laws 2023, chapter 61, article 4, section 11, is effective January 1, 2026, or upon federal approval, whichever is later. 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. [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 or new withdrawal management programs licensed under chapter 245F that will meet medically monitored or clinically monitored levels of care. Grants may be used for expenses that are not reimbursable under Minnesota health care programs, including but not limited to:

(1) costs associated with hiring staff;

(2) costs associated with staff retention;

(3) the purchase of office equipment and supplies;

(4) the purchase of software;

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

(6) business formation costs;

(7) costs associated with staff training; and

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

History: *2023 c 61 art 4 s 12*

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 SOBER HOMES.

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

(1) maintain a supply of an opiate antagonist in the home in a conspicuous location and post information on proper use;

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

(3) have written policies regarding evictions;

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

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

(6) maintain contact information for emergency resources in the community to address mental health and health emergencies;

(7) have policies on staff qualifications and prohibition against fraternization;

(8) permit residents to use, as directed by a licensed prescriber, legally prescribed and dispensed or administered pharmacotherapies approved by the United States Food and Drug Administration for the treatment of opioid use disorder;

(9) permit residents to use, as directed by a licensed prescriber, legally prescribed and dispensed or administered pharmacotherapies approved by the United States Food and Drug Administration to treat co-occurring substance use disorders and mental health conditions;

(10) have a fee schedule and refund policy;

(11) have rules for residents;

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

(13) have policies requiring abstinence from alcohol and illicit drugs; and

(14) distribute the sober home bill of rights.

[See Note.]

Subd. 2. **Bill of rights.** An individual living in a sober home 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 sober home's policies and procedures regarding disclosure of such information;

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

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

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

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

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

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

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

Subd. 3. **Complaints; ombudsman for mental health and developmental disabilities.** Any complaints about a sober home may be made to and reviewed or investigated by the ombudsman for mental health and developmental disabilities, pursuant to sections 245.91 and 245.94.

Subd. 4. **Private right of action.** In addition to pursuing other remedies, an individual may bring an action to recover damages caused by a violation of this section.

History: *2023 c 61 art 4 s 14; 2024 c 108 art 4 s 24*

NOTE: Subdivision 1, clause (9), as added by Laws 2024, chapter 108, article 2, section 24, is effective June 1, 2026. Laws 2024, chapter 108, article 2, section 24, the effective date.

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 (c).

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

(3) For ASAM level 2.1 intensive outpatient clients, adults must receive nine to 19 hours per week of skilled treatment services and adolescents must receive six or more hours per week. Vendors must be licensed according to section 245G.20 and must meet requirements under section 256B.0759. Peer recovery services and treatment coordination may be provided beyond the hourly skilled treatment service hours allowable per week. If clinically indicated on the client's treatment plan, this service may be provided in conjunction with room and board according to section 254B.05, subdivision 1a.

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

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

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

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

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

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

(b) Notwithstanding the minimum daily skilled 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.

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 (c);

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

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

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

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

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

History: *2023 c 50 art 2 s 53; 2024 c 125 art 3 s 10; 2024 c 127 art 48 s 10*

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*