October 2024

Substance Use Disorder Treatment Programs: 2024 Legislative changes and program implementation plan

The 2024 Legislature made changes to several laws that impact Department of Human Services (DHS) licensed substance use disorder treatment programs. The sections below contain an overview of each change, instructions for what programs need to do about the change, a link to the change in law, and the date the change is effective.

The hyperlinks within this document go to where the new law can be found. The hyperlink will go to the exact section in session law, but it may take a few seconds for the page to scroll down to the right spot. When reviewing the new law:

- Text that is stricken with a line through it reflects words that are being removed from the law.
- Text that is underlined reflects words that are being added to the law.
- Text that is unchanged reflects what the law was before and continues to be the law.

Later this year, the Minnesota Office of the Revisor of Statutes will update the statutes on their website to reflect the new laws.

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Location of services

Overview

The requirements for treatment service locations change to clarify how programs can provide services at other locations in the community, at a client's home, and at satellite locations (currently known as secondary locations). Several changes reduce provider paperwork and simplify the approval process for satellite locations. This section explains each location and how to provide services there. Additional telehealth requirements are in the next section.

Main licensed location

Programs can continue to provide all individual and group treatment services at any of the license holder's main licensed locations and no changes were made to this area.

Client's home or residence

Standards for providing treatment services at a client's home or residence were added because the licensing chapter did not clearly allow services at this location. A program may provide all types of nonresidential (outpatient) individual treatment services at a client's home or other place of residence. The program must not provide outpatient group treatment services at a client's home or place of residence unless the client is taking part in a group by telehealth. Treatment service documentation must include that the service location was a client's home or residence. The client's home is exempt from the program abuse prevention plan requirements. If the client is a vulnerable adult, their individual abuse prevention plan must address services in the home or residence.

Community locations

The treatment services you may provide away from the program at any other suitable location expands to include two additional services. The list now includes:

- therapeutic recreation
- stress management and physical well-being
- living skills development
- socialization skills development (**new addition**), and
- peer recovery support services (**new addition**).

The location you provide the service at must be appropriate for the service. To assist providers with reducing paperwork, these changes eliminate the requirements to detail each off-site location in the treatment service description and the program abuse prevention plan. If the client is a vulnerable adult, their individual abuse prevention plan must include measures to include the specific actions the program will take to minimize the risk of abuse within the scope of the licensed services, including if services are provided within the community. Treatment service documentation must include the location the service was provided at.

Outpatient school, jail, or nursing home satellite locations

One licensed program may have an unlimited number of satellite locations that are in a school, jail, or nursing home. This flexibility is to ensure people have easy access to services in these locations. Due to the existing oversight of these facilities by other agencies and to help providers, these locations are exempt from the requirement to document compliance with building codes, fire and safety codes, health rules, and zoning ordinances. These locations are also exempt from program abuse prevention plan requirements due to other protections already in place for clients in these settings. If the client is a vulnerable adult, the individual abuse prevention plan must address services in these locations. Only clients who are students in the school, incarcerated at the jail, or living at the nursing home may receive services at these satellite locations. DHS must approve each satellite location. To add a satellite location that is not currently on your license, please contact your licensor directly or email dhs.mhcdlicensing@state.mn.us.

Outpatient other satellite locations

DHS may also approve other suitable satellite locations for outpatient treatment services. The limit for satellites beyond those in the previous section is two per main licensed location. These locations must go through the typical inspection process as main locations and must be part of a program abuse prevention plan. DHS must approve each satellite location. To add satellite locations that are not currently on your license, please contact your licensor directly or email dhs.mhcdlicensing@state.mn.us.

All locations

Regardless of where services are provided, the main licensed location is where the license holder must provide DHS with access to all files, documentation, staff persons, and any other information necessary to show licensing requirements are met. DHS will coordinate with providers during reviews and inspections on how to get the necessary documents from the satellite location. DHS may review or inspect a satellite location if necessary.

See Chapter 127, Article 62, Section 32 (2024 Minnesota Statutes, section 245G.07).

Effective January 1, 2025.

What programs need to do

Programs must train staff and update policies to meet the new requirements. To add satellite locations that are not currently on your license or to discuss new locations, please contact your licensor directly or email dhs.mhcdlicensing@state.mn.us.

Telehealth

Overview

Standards for providing treatment services by telehealth were established because the licensing chapter did not clearly permit it. The new standards include requirements for all telehealth services and additional standards for group telehealth services.

Outpatient and residential – Individual services

Allowed: Both outpatient and residential programs can provide treatment services by telehealth individually to a client. This means a qualified staff provides a treatment service to one client at a time. Outpatient programs may determine the location for the staff and client for individual telehealth services if the additional requirements below are met. Residential programs may provide individual telehealth services when a qualified staff is at their home and the client is at the residential program or while the counselor is at the program and the client is in another part of the program or away from the facility.

Group treatment services

The requirements for group treatment services are different for outpatient and residential programs so we explain each separately.

Outpatient – Group services

Allowed: Outpatient programs may provide group treatment services when a qualified staff is at one location and each client is at their own separate physical location.

Allowed: Outpatient programs may allow clients and additional staff to join an in-person group by telehealth if a staff member qualified to provide the treatment service is physically present with the group of clients meeting together in person.

Not allowed: Outpatient programs must not provide group treatment services remotely by telehealth to a group of clients meeting physically in a room or location together in person. This is not allowed due to the need for a qualified staff to be present to provide the service while clients are meeting together in person. If an emergency arises and you need a short-term variance to this requirement, please contact your licensor directly or email dhs.mhcdlicensing@state.mn.us.

Residential – Group services

For residential group services, typically the qualified professional providing the services and the clients receiving the service are all physically in the same room together. Programs may instead utilize telehealth to provide group treatment services in the following allowed instances.

Allowed*:* The qualified staff is at the residential program and is providing group treatment services by telehealth to clients in different rooms at the program. This may be necessary to isolate clients or staff due to an infectious disease or other reasons the program determines.

Allowed: Residential programs may allow clients and additional staff to join an in-person group by telehealth if a staff member qualified to provide the treatment service is physically present with the group of clients meeting together in person.

Allowed: When weather or short-term illness prohibits a qualified professional from traveling to the residential program, they may provide a residential group treatment service remotely by telehealth from their home or other location if all these conditions are met:

- another qualified professional cannot provide the service,
- the service is provided remotely for only one day at a time, and
- a staff qualified as a paraprofessional is physically present with the group of clients.

When this occurs, the license holder must document:

- in **each clients record** the reason for providing the group telehealth service remotely, and
- in a **central log** the dates the group treatment services were provided by telehealth remotely.

Not allowed: Residential programs must not provide any other remote telehealth group treatment services unless allowed by the previous section.

All telehealth services

For **all** services by telehealth, residential, outpatient, individual and groups, the license holder must meet these additional requirements:

- The license holder must ensure the use of telehealth to deliver the service is medically appropriate to the condition and needs of the person being served (Minnesota Statutes, section 254B.05, subd. 5, paragraph (f)).

- The license holder must meet all requirements for telehealth in Minnesota Statutes, section 256B.0625, subdivision 3b. This includes several important requirements and definitions that providers must know and follow. The requirement to attest to the items in Minnesota Statutes, section 256B.0625, subdivision 3b, paragraph (b) is completed Telehealth Provider Assurance Statement which is available on the Telehealth Delivery of Substance Use Disorder Services webpage along with other important billing requirements.

- The license holder must document all items in Minnesota Statutes, section 256B.0625, subdivision 3b, paragraph (c), for every client and service, regardless of payment type or whether the client is a medical assistance enrollee. The person providing the service must document the following in the client record:

    1) the type of service provided,
    2) the time the service began and ended, with a.m. and p.m. designations,
    3) the service provider's basis for determining that telehealth is an appropriate and effective means for delivering the service to the client,
    4) the mode of transmission of the service through telehealth and records evidencing that a particular mode of transmission was utilized,

5) the location of the originating site (client location) and the distant site (provider location), and
6) compliance with the criteria attested to by the provider in Minnesota Statutes, section 256B.0625, subdivision 3b, paragraph (b).

This documentation is in addition to the requirements in Minnesota Statutes, Chapter 245G and Minnesota Rules, part 9505.2175.

All programs must maintain a licensed physical location in Minnesota where they offer all treatment services in Minnesota Statutes, section 245G.07, subdivision 1, paragraph (a), clauses (1) to (4), physically in-person to each client. License holders must be able to offer in-person services if the client decides they do not want telehealth services or if the person providing the service determines that telehealth services for the client is not appropriate, effective, or safe.

Note: Telehealth includes audio-only communication between provider and a patient until July 1, 2025.

See Chapter 127, Article 62, Section 32 (2024 Minnesota Statutes, section 245G.07).

Effective January 1, 2025.

What programs need to do

The telehealth documentation and other standards in Minnesota Statutes, section 256B.0625, subdivision 3b have been in place for several years and providers should already be following these requirements as a condition of payment. Beginning January 1, 2025, these will also become licensing requirements. The requirements for telehealth groups will also be effective January 1, 2025. Programs should train staff and update their policies to ensure all telehealth requirements are met.

Emergency overdose medications

Overview

In 2023, programs were required to maintain a supply of opiate antagonists (example, naloxone or Narcan®) for the emergency treatment of opioid overdoses. This session, DHS proposed technical changes to exempt programs from several medication storage and training requirements to ensure greater access to these lifesaving medications. These flexibilities now allow:

- staff and adult clients to freely carry emergency overdose medications anywhere at the program,
- staff and adult clients to store these medications in unlocked locations,
- staff who only administer emergency overdose medications to only receive training in how to administer that medication, and
- staff to receive this training from any knowledgeable trainer.

Additionally, outpatient programs that don't administer any medications beyond emergency opiate antagonist medications are exempt from the full set of medication policies and procedures in Minnesota Statutes, section 245G.08, subdivisions 5 and 6. Program's must instead simply describe their procedures for administering

opiate antagonist medications as part of the description of health care services under Minnesota Statutes, section 245G.08, subdivision 1.

For freely carry, unlocked storage, training, and policy exemptions, see Chapter 127, Article 62, Section 13 (2024 Minnesota Statutes, section 245A.242). For conforming technical changes, see Chapter 127, Article 62, Sections 33 & 34 (2024 Minnesota Statutes, section 245G.08).

Effective May 25, 2024.

What programs need to do

Programs should update their policies and procedures for medication administration and training to reflect any of the exemptions they choose to use. Programs may choose to not use any of the exemptions if they determine there is a need to have more stringent policies and procedures in place.

Key staff position change notification

Overview

New standards require programs to notify DHS within five business days of a change or vacancy in any of these three key staff positions:

- treatment director,
- alcohol and drug counselor supervisor, or
- the registered nurse responsible for staff supervision.

The notification processes for changes and vacancies are slightly different and the next section explains the steps. This process will help programs to ensure staff in these positions are qualified according to licensing standards and will assist programs when there is a vacancy.

See Chapter 127, Article 62, Section 35 (2024 Minnesota Statutes, section 245G.10).

Effective January 1, 2025.

What programs need to do

Changes in a key position

If there is a change in a key position, complete the following steps:

1. Email or call your licensor within five business days to notify them that there will be a change and to request a Change in License Information Form (CLIF). Include all license numbers the change will impact. If you do not know who your licensor is, email dhs.mhcdlicensing@state.mn.us.

2. Your licensor will email you a CLIF for each license with the current information for each license.

3. When you receive the CLIF, draw a line through the person no longer in the position and add the name and contact information for the new person in the position.

4. Email the CLIF to your licensor with the staff person's qualifications for the position. This will include, as applicable, a copy or screenshot of the registered nurse's, alcohol and drug counselor's, or mental health professional's license and verification of the additional qualifications in Minnesota Statutes, section 245G.11, subdivision 3 or 4.

5. Your licensor will review the qualifications and update your license information.

Vacancy in a key position

If there is a vacancy in a key position, email or call you program licensor to discuss your program's plan for fulfilling the duties of the position during the vacancy. If you do not know who your licensor is, email dhs.mhcdlicensing@state.mn.us.

Peer recovery services

Overview

The requirements for providing peer recovery support services and the qualifications for those who provide it change in several ways across different areas of statute. This section explains each change including the different effective dates for the changes.

Providing peer recovery support services

The description for peer recovery support services includes language referring to new standards in Minnesota Statutes, Chapter 254B, which must be followed by both licensed programs and unlicensed providers. The following requirements must be met for each peer recovery support service provided.

- A qualified recovery peer must provide the service.
- The service must be a one-to-one and face-to-face interaction between one recovery peer and one client at a time. Face-to-face may include telehealth services if the additional telehealth requirements are met.
- The service must be provided according to the client's treatment plan.
- Specific goals in the client's treatment plan must be discussed and addressed during the service.
- The service must promote the client's recovery goals, self-sufficiency, self-advocacy, and development of natural supports to support maintenance of a client's recovery.

The license holder must always ensure that a client receiving peer recovery support services is participating in the services voluntarily and must provide written notice to the client that peer recovery support services will be provided. Peer recovery support services may not be provided to a client residing with or employed by a recovery peer from whom they receive services.

Effective January 1, 2025. See Chapter 127, Article 48, Section 3 (2024 Minnesota Statutes, section 245G.07) and Section 9 (2024 Minnesota Statutes, section 254B.052).

Documenting services

Existing requirements in Minnesota Statutes, section 245G.06, subdivision 2a, for all treatment services already require the recovery peer who provides a service to document in the client record the date, type, and amount of each peer recovery support service and the client's response to each service. New standards in Minnesota Statutes, section 254B.052, subdivision 3, require this documentation to also include each peer recovery support service interaction between the client and the recovery peer and the start and end time with a.m. and p.m. designations of the service.

See Chapter 127, Article 48, Section 9 (2024 Minnesota Statutes, section 252B.052).

Effective January 1, 2025.

Recovery peer supervision and scope of practice

The supervision requirements for a recovery peer change in the following ways:

- The qualifications for who must supervise a recovery peer change to allow either a Licensed Alcohol and Drug Counselor (LADC) or a mental health professional qualified under Minnesota Statutes, section 245I.04, subdivision 2 to provide the supervision.
- The standards increase to require supervision once each month. Previously there was no specific frequency.
- The LADC or mental health professional supervision must be face-to-face with the recovery peer. Face-to-face may be in person or remotely.
- The supervision must include reviewing documentation of peer recovery support services provided for clients.
- The supervision may also include client updates, discussion of ethical considerations, and any other questions or issues relevant to peer recovery support services.

See Chapter 127, Article 48, Section 4 (2024 Minnesota Statutes, section 245I.04)

Effective July 1, 2024.

Recovery peer employment status

License holders must not classify or treat a recovery peer as an independent contractor.

- For recovery peers hired **on or after** July 1, 2024, this became effective July 1, 2024.
- For recovery peers hired **before** July 1, 2024, this becomes effective January 1, 2025.

See Chapter 108, Article 4, Section 15 (2024 Minnesota Statutes, section 245I.04).

What programs need to do

License holder must begin meeting the new requirements upon each effective date listed above.

Licensing candidate limit

Overview

The limit on unlicensed treatment staff no longer applies to licensing candidates. The limit continues to apply to other unlicensed staff and no more than 50 percent of the treatment staff may be student interns or former students.

See Chapter 108, Article 4, Section 10 (2024 Minnesota Statutes, section 245G.11).

Effective August 1, 2024.

What programs need to do

License holders must ensure that no more than 50 percent of the treatment staff are student interns or former students and must document the amount of time that directly relates to the provision of treatment services for which the staff are authorized.

Opioid education

Overview

The requirements for providing this opioid educational material change to ensure all clients receive this important information quickly. Programs must provide the opioid educational material to all clients and must provide it to each client on the day of service initiation.

See Chapter 108, Article 4, Sections 7-9 (2024 Minnesota Statutes, section 245G.04).

Effective January 1, 2025.

What programs need to do

Beginning January 1, 2025, license holders must ensure that every client receives this opioid educational material on the day of service initiation.

Residential missed treatment hours

Overview

Residential programs must provide a certain amount of skilled treatment services depending on the service level. The DHS Licensing Division reviews for compliance with these skilled treatment service requirements. If DHS receives federal approval, license holders will be able to use these new flexibilities.

- A license holder that is unable to provide all residential treatment services because a client missed services will remain eligible to bill for the client's intensity level of services if the license holder documents the reason the client missed the services and the interventions done to address the client's absence.
- A program will be able to reduce hours in a treatment week in observance of federally recognized holidays.

See Chapter 108, Article 4, Section 23 (2024 Minnesota Statutes, section 254B.05).

Effective upon federal approval. DHS has determined this will require federal approval and will inform providers when it is received.

The Behavioral Health Division provided additional information about changes to the residential levels of care in this Behavioral Health e-Memo.

What programs need to do

Wait to implement these changes until DHS notifies providers of federal approval.

Rate enhancement requirements

Overview

Some providers receive a complexity add-on rate for providing additional mental health and medical services as part of a client's substance use disorder treatment. The DHS Licensing Division reviews for compliance with the standards for these rates. The requirements to receive the following complexity add-on rates are reduced as follows.

Co-occurring complexity rate

The mental health staff ratios are removed and replaced with a requirement to employ at least one licensed mental health professional. The new standards require no specific amount of hours but programs must continue to ensure there is enough mental professional time to meet all other requirements for this rate.

See Chapter 108, Article 4, Section 23 (2024 Minnesota Statutes, section 254B.05).

Effective August 1, 2024.

Medical services complexity rate

The service standards for this rate reduce the amount of medical services from two hours down to one hour per client per week. Programs must offer medical services delivered by appropriately credentialed health care staff in an amount equal to one hour per client per week. The program must document in the client file the medical needs of the client and the nature and provision of any medical services provided.

See Chapter 108, Article 4, Section 23 (2024 Minnesota Statutes, section 254B.05).

Effective August 1, 2024.

What license holders need to do

License holders may reduce their services according to the new requirements.

Change in ownership

Overview

A license holder must notify DHS and follow specific processes if there will be a change in ownership. These existing standards were revised to clarify and improve the process. The description of the types of changes that require a new license replaces legal terms with easier to understand language. These updates are technical and the types of changes that require a new license will stay the same. The requirements clarify there are two different processes: (1) standard change of ownership process and (2) emergency change in ownership process. Most will use the standard process unless a specific emergency occurs.

The notification and application timeframes for the standard change of ownership process increase to align with the 90 days DHS has to act on a complete application. Other updates in this area clarify the existing language.

The new emergency change in ownership process explains the steps to take if a license holder is inaccessible or unable to operate a program. This process allows another party to assume operation of a program if they notify DHS, receive approval, and meet certain requirements.

The requirements remove the temporary change in ownership license and most ownership transitions will use the standard change in ownership process.

See Chapter 127, Article 62, Sections 3-7 (2024 Minnesota Statutes, section 245A.043).

Effective January 1, 2025.

What programs need to do

License holders do not need to take any action unless they anticipate a change in ownership. The current process will change beginning January 1, 2025. Contact your program's licensor to discuss this process.

Public email address

Overview

The license holder's email address will become public data. The license holder can choose which email to provide as their public license holder email address.

See Chapter 115, Article 19, Section 1 (2024 Minnesota Statutes, section 13.46).

Effective January 1, 2025.

What programs need to do

Programs do not need to make any changes at this time. DHS Licensing will provide further guidance prior to January 1, 2025.

Child passenger restraint systems

Overview

This section applies to any program that transports any children under the age of 18. Starting August 1, 2024, new guidance on child seats, booster seats and seat belts became effective that may change how children ride in a vehicle. Every driver who transports children under age 18 in a vehicle are required to have them restrained in a child safety seat or with a seat belt. The updated law specifies ages for rear- and forward-facing car seats, booster seats and seat belts (subject to weight and height depending on the child seat manufacturer).

The Department of Public Safety explains how to implement these changes and provides links to several resources in their news release: Changes to Minnesota's Child Passenger Safety Law go into effect Aug. 1 (mn.gov).

All licensed programs that transport children are required to follow this law by the licensing requirements in Minnesota Statutes, section 245A.18, subdivision 1.

See Chapter 104, Article 1, Sec. 42 (2024 Minnesota Statutes, section 169.685).

Effective August 1, 2024.

What programs need to do

Programs that serve children under 18 years old must ensure staff who transport a child are aware of the new language in section 169.685 and comply with those requirements for safely transporting children.

Reporting maltreatment of minors definitions

Overview

The following two revisions are made to definitions in the maltreatment of minors reporting statute.

The definition for threatened injury (a type of maltreatment) adds the term parent.

See Chapter 115, Article 18, Section 45 (2024 Minnesota Statutes, section 260E.03).

Effective July 1, 2024.

The definition for substantial child endangerment (another type of maltreatment) adds labor trafficking.

See Chapter 115, Article 12, Sections 13 and 16 (2024 Minnesota Statutes, section 260E.03).

Effective July 1, 2025.

What programs need to do

Programs should update any program materials if they contain these definitions including maltreatment of minors reporting policies, procedures, client orientation material, staff training material, and postings. Staff should be trained according to the new definitions upon orientation or at their next annual training.

Practitioner definition change – Opioid treatment programs licensed under 245G.22 (OTP) only

Overview

To align with changes in federal rules for opioid treatment programs, this change in the state licensing statute eliminates the requirement for an advanced practice registered nurse or physician assistant to receive a variance to perform the duties of a practitioner in an opioid treatment program.

See Chapter 108, Article 4, Section 11 (2024 Minnesota Statutes, section 245G.22).

Effective May 18, 2024.

What programs need to do

Programs no longer need to request a variance to allow an advanced practice registered nurse or physician assistant to perform the duties of a practitioner. All practitioners including advanced practice registered nurses and physician assistants must be currently registered with the Drug Enforcement Administration to order or dispense controlled substances in Schedules II to V.

Unsupervised use or take-home dose definition – OTP only

Overview

To align with terms in federal rules, the definition for unsupervised use medication was updated to also include the term take-home dose. The terms unsupervised use and take-home dose have the same meaning.

See Chapter 108, Article 4, Section 11 (2024 Minnesota Statutes, section 245G.22).

Effective May 18, 2024.

What programs need to do

Programs should update their policies with the new language if necessary.

Closed days – OTP only

Overview

To align with new federal rules, state standards change to allow a program to choose to be closed on one weekend day, either Saturday or Sunday. Programs may continue to close for state and federal holidays. Additional conforming changes were made to policy requirements in Minnesota Statutes, section 245G.22, subdivision 17.

See Chapter 108, Article 4, Sections 12 & 14 (2024 Minnesota Statutes, section 245G.22).

Effective May 18, 2024.

What programs need to do

Programs may adjust their program schedule to close on either Saturday or Sunday but must be open one weekend day each weekend unless a state or federal holiday is on a weekend.

Criteria for take-home use medications – OTP only

Overview

To align with new federal rules, state standards for determining if it is safe and appropriate for a client to have take-home doses are replaced with a citation to the new revised 6-point criteria in federal rules. The new criteria is similar in several points but has changed in many areas.

The new criteria are that the medical director or practitioner must consider, among other pertinent factors that indicate that the therapeutic benefits of unsupervised doses outweigh the risks, the following criteria:

- Absence of active substance use disorders, other physical or behavioral health conditions that increase the risk of patient harm as it relates to the potential for overdose, or the ability to function safely,
- Regularity of attendance for supervised medication administration,
- Absence of serious behavioral problems that endanger the patient, the public or others;
- Absence of known recent diversion activity,
- Whether take-home medication can be safely transported and stored, and
- Any other criteria that the medical director or medical practitioner considers relevant to the patient's safety and the public's health.

The full version of the federal standards is available at Code of Federal Regulations, title 42, section 8.12(i)(2).

State statute also clarifies that a practitioner must be the person to document this determination and the basis for the determination in the client's medical record.

See Chapter 108, Article 4, Section 12 (2024 Minnesota Statutes, section 245G.22).

Effective May 18, 2024.

What programs need to do

Programs must begin using the new 6 point criteria by October 2, 2024 but may begin using it any time before then.

Number of take-home doses of methadone – OTP only

Overview

To align with new federal rules and to increase access to services, state standards replace the list of how many take-home doses of methadone a client may receive at a time with a reference to the new federal requirements for these amounts. The new federal requirements allow a client to receive more take-home doses earlier in their treatment. If it is determined that a patient is safely able to manage unsupervised doses of methadone, they may be given the following amounts based on their number of days in treatment.

1. During the first 14 days of treatment, the take-home supply (beyond those allowed for a weekend day or holiday by the Code of Federal Regulations, title 42, section 8.12(i)(1)) is limited to 7 days.

2. From 15 days of treatment, the take-home supply (beyond those allowed for a weekend day or holiday by the Code of Federal Regulations, title 42, section 8.12(i)(1)) is limited to 14 days.

3. From 31 days of treatment, the take-home supply (beyond those allowed for a weekend day or holiday by the Code of Federal Regulations, title 42, section 8.12(i)(1)) provided to a patient is not to exceed 28 days.

For each timeframe in 1 to 3 above, the practitioner determines the number of take-home doses up to the allowed amount in each but decisions must be based on the criteria listed in the Code of Federal Regulations, title 42, section 8.12(i)(2).

See Chapter 108, Article 4, Section 13 (2024 Minnesota Statutes, section 245G.22).

Effective May 18, 2024.

What programs need to do

Programs must follow the new amounts based on a client's time in treatment.

Counselor to client ratio – OTP only

Overview

The counselor to client ratio for OTPs change to allow programs the flexibility to determine the right amount of clients per counselor based on the needs of the clients and the abilities of each counselor. This allows a program to determine the appropriate number of clients for each counselor as long as the program maintains a program-wide ratio of one full-time equivalent (FTE) alcohol and drug counselor for every 60 clients. For example, one full-time counselor can be responsible for 55 clients while a second full-time counselor is responsible for 65 clients. Full-time equivalent means working at least 32 hours each week.

See Chapter 108, Article 4, Section 14 (2024 Minnesota Statutes, section 245G.22).

Effective July 1, 2024.

What programs need to do

Programs must:

- determine the appropriate number of clients for which each counselor is responsible based on the needs of each client, and
- maintain documentation of the clients assigned to each counselor to demonstrate compliance with this requirement.

Removes high dose requirements – OTP only

Overview

The requirement for a client to meet face-to-face with a practitioner before increasing a client's dose above 150 milligrams of methadone or 24 milligrams of buprenorphine is eliminated.

See Chapter 108, Article 4, Section 28 (2024 Minnesota Statutes, section 245G.22).

Effective August 1, 2024.

What programs need to do

The practitioner may determine when a client needs to meet face-to-face with them before increasing the client's dose or for other reasons.

Questions

If you have questions about this implementation plan or other licensing requirements, please contact your licensor directly or email dhs.mhcdlicensing@state.mn.us.

Background studies

Updates on legislative changes related to background studies are posted on the "What's new" for background studies webpage.