SENATE
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S.F. No. 4388

(SENATE AUTHORS: WIKLUND)

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03/12/2026	6664	Introduction and first reading Referred to Health and Human Services

A bill for an act

relating to human services; establishing early childhood mental health consultation grants; modifying protection-related rights for home and community-based services; modifying day treatment program requirements; modifying intensive rehabilitative mental health services; requiring reports; amending Minnesota Statutes 2024, sections 245D.04, subdivision 3, by adding a subdivision; 256B.0947, subdivision 5; Minnesota Statutes 2025 Supplement, sections 245.4889, subdivision 1; 256B.0943, subdivisions 1, 9; proposing coding for new law in Minnesota Statutes, chapter 245.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MINNESOTA:

Section 1. Minnesota Statutes 2025 Supplement, section 245.4889, subdivision 1, is amended to read:

Subdivision 1. **Establishment and authority.** (a) The commissioner is authorized to make grants from available appropriations to assist:

(1) counties;

(2) Indian tribes;

(3) children's collaboratives under section 142D.15 or 245.493; or

(4) mental health service providers.

(b) The following services are eligible for grants under this section:

(1) services to children with mental illness as defined in section 245.4871, subdivision 15, and their families;

(2) transition services under section 245.4875, subdivision 8, for young adults under age 21 and their families;

(3) respite care services for children with mental illness or serious mental illness who are at risk of residential treatment or hospitalization; who are already in residential treatment or therapeutic foster care or in family foster settings as defined in chapter 142B and at risk of change in foster care or placement in a residential facility or other higher level of care; who have utilized crisis services or emergency room services; or who have experienced a loss of in-home staffing support. Allowable activities and expenses for respite care services are defined under subdivision 4. A child is not required to have case management services to receive respite care services. Counties must work to provide access to regularly scheduled respite care;

(4) children's mental health crisis services;

(5) child-, youth-, and family-specific mobile response and stabilization services models;

(6) mental health services for people from cultural and ethnic minorities, including supervision of clinical trainees who are Black, indigenous, or people of color;

(7) children's mental health screening and follow-up diagnostic assessment and treatment;

(8) services to promote and develop the capacity of providers to use evidence-based practices in providing children's mental health services;

(9) school-linked mental health services under section 245.4901;

(10) building evidence-based mental health intervention capacity for children birth to age five;

(11) suicide prevention and counseling services that use text messaging statewide;

(12) mental health first aid training;

(13) training for parents, collaborative partners, and mental health providers on the impact of adverse childhood experiences and trauma and development of an interactive website to share information and strategies to promote resilience and prevent trauma;

(14) transition age services to develop or expand mental health treatment and supports for adolescents and young adults 26 years of age or younger;

(15) early childhood mental health consultation under section 245.4908;

(16) evidence-based interventions for youth at risk of developing or experiencing a first episode of psychosis, and a public awareness campaign on the signs and symptoms of psychosis;

(17) psychiatric consultation for primary care practitioners;

(18) providers to begin operations and meet program requirements when establishing a new children's mental health program. These may be start-up grants; and

(19) evidence-based interventions for youth and young adults at risk of developing or experiencing an early episode of bipolar disorder.

(c) Services under paragraph (b) must be designed to help each child to function and remain with the child's family in the community and delivered consistent with the child's treatment plan. Transition services to eligible young adults under this paragraph must be designed to foster independent living in the community.

(d) As a condition of receiving grant funds, a grantee shall obtain all available third-party reimbursement sources, if applicable.

(e) The commissioner may establish and design a pilot program to expand the mobile response and stabilization services model for children, youth, and families. The commissioner may use grant funding to consult with a qualified expert entity to assist in the formulation of measurable outcomes and explore and position the state to submit a Medicaid state plan amendment to scale the model statewide.

Sec. 2. **[245.4908] EARLY CHILDHOOD MENTAL HEALTH CONSULTATION GRANTS.**

Subdivision 1. **Establishment.** The commissioner of human services must establish an early childhood mental health consultation grant program to support the delivery of specialized mental health care to children five years of age or younger. The care may include providing mental health consultation to child care professionals for the development of knowledge and skills to provide child care to young children with significant mental health needs.

Subd. 2. **Eligible applicants.** An applicant is eligible for an early childhood mental health consultation grant under this section if the applicant is:

(1) a mental health clinic certified under section 245I.20;

(2) a community mental health center under section 256B.0625, subdivision 5;

(3) an Indian health service facility or a facility owned and operated by a Tribe or Tribal organization operating under United States Code, title 25, section 5321; or

(4) a provider of children's therapeutic services and supports, as defined in section 256B.0943.

Subd. 3. **Allowable grant activities and related expenses.** (a) Grant funds must be used to provide early childhood mental health consultation, including but not limited to:

(1) identifying and diagnosing mental health conditions for children five years of age or younger;

(2) training clinicians on evidence-based or evidence-informed clinical practices for children five years of age or younger and their caregivers, including train the trainer models to build capacity for grantees to train their own staff. The commissioner may recommend specific clinical practices, modalities, and trainings under this clause;

(3) providing direct consultation to child care providers in licensed child care centers, Head Start, and licensed family child care settings; and

(4) family psychoeducation and individual and group skills for families of children receiving early childhood mental health services.

(b) Grantees must obtain all available third-party reimbursement sources as a condition of receiving a grant.

Subd. 4. **Data collection and outcome measurement.** (a) The commissioner must consult with grantees to develop ongoing outcome measures for program capacity and performance.

(b) Grantees must provide data to the commissioner for the purpose of evaluating the effectiveness of the early childhood mental health consultation grant program. The commissioner must not request data from grantees more than twice per year.

(c) Grantees must provide the following quantitative data to the commissioner:

(1) the number of clients served;

(2) client demographics;

(3) payor information; and

(4) client-related clinical and ancillary services, including hours of direct client services and hours of consultation provided in child care settings.

(d) Qualitative data may also be collected and provided to the commissioner to demonstrate outcomes.

(e) By July 1, 2027, and every July 1 thereafter, the commissioner must provide a report to the chairs and ranking minority members of the legislative committees with jurisdiction over behavioral health. The report must include the number of grantees receiving money

under this section, the number of individuals served under this section, data from the evaluation conducted under this subdivision, and information on the use of state and federal money for the services provided under this section. This paragraph expires June 30, 2037.

EFFECTIVE DATE. This section is effective July 1, 2026.

Sec. 3. Minnesota Statutes 2024, section 245D.04, subdivision 3, is amended to read:

Subd. 3. **Protection-related rights.** (a) A person's protection-related rights include the right to:

(1) have personal, financial, service, health, and medical information kept private, and be advised of disclosure of this information by the license holder;

(2) access records and recorded information about the person in accordance with applicable state and federal law, regulation, or rule;

(3) be free from maltreatment;

(4) be free from restraint, time out, seclusion, restrictive intervention, or other prohibited procedure identified in section 245D.06, subdivision 5, or successor provisions, except for: (i) emergency use of manual restraint to protect the person from imminent danger to self or others according to the requirements in section 245D.061 or successor provisions; or (ii) the use of safety interventions as part of a positive support transition plan under section 245D.06, subdivision 8, or successor provisions;

(5) receive services in a clean and safe environment when the license holder is the owner, lessor, or tenant of the service site;

(6) be treated with courtesy and respect and receive respectful treatment of the person's property;

(7) reasonable observance of cultural and ethnic practice and religion;

(8) be free from bias and harassment regarding race, gender, age, disability, spirituality, and sexual orientation;

(9) be informed of and use the license holder's grievance policy and procedures, including knowing how to contact persons responsible for addressing problems and to appeal under section 256.045;

(10) know the name, telephone number, and the website, email, and street addresses of protection and advocacy services, including the appropriate state-appointed ombudsman, and a brief description of how to file a complaint with these offices;

(11) assert these rights personally, or have them asserted by the person's family, authorized representative, or legal representative, without retaliation;

(12) give or withhold written informed consent to participate in any research or experimental treatment;

(13) associate with other persons of the person's choice in the community;

(14) personal privacy, including the right to use the lock on the person's bedroom or unit door;

(15) engage in chosen activities; and

(16) access to the person's personal possessions at any time, including financial resources.

(b) For a person residing in a residential site licensed according to chapter 245A, or where the license holder is the owner, lessor, or tenant of the residential service site, protection-related rights also include the right to:

(1) have daily, private access to and use of a non-coin-operated telephone for local calls and long-distance calls made collect or paid for by the person;

(2) receive and send, without interference, uncensored, unopened mail or electronic correspondence or communication;

(3) have use of and free access to common areas in the residence and the freedom to come and go from the residence at will;

(4) choose the person's visitors and time of visits and have privacy for visits with the person's spouse, next of kin, legal counsel, religious adviser, or others, in accordance with section 363A.09 of the Human Rights Act, including privacy in the person's bedroom;

(5) have access to three nutritionally balanced meals and nutritious snacks between meals each day;

(6) have freedom and support to access food and potable water at any time;

(7) have the freedom to furnish and decorate the person's bedroom or living unit;

(8) a setting that is clean and free from accumulation of dirt, grease, garbage, peeling paint, mold, vermin, and insects;

(9) a setting that is free from hazards that threaten the person's health or safety; and

(10) a setting that meets the definition of a dwelling unit within a residential occupancy as defined in the State Fire Code.

(c) Except as provided under subdivision 4, restriction of a person's rights under paragraph (a), clauses (13) to (16), or paragraph (b) is allowed only if determined necessary to ensure the health, safety, and well-being of the person. Any restriction of those rights must be documented in the person's support plan or support plan addendum. The restriction must be implemented in the least restrictive alternative manner necessary to protect the person and provide support to reduce or eliminate the need for the restriction in the most integrated setting and inclusive manner. The documentation must include the following information:

(1) the justification for the restriction based on an assessment of the person's vulnerability related to exercising the right without restriction;

(2) the objective measures set as conditions for ending the restriction;

(3) a schedule for reviewing the need for the restriction based on the conditions for ending the restriction to occur semiannually from the date of initial approval, at a minimum, or more frequently if requested by the person, the person's legal representative, if any, and case manager; and

(4) signed and dated approval for the restriction from the person, or the person's legal representative, if any. A restriction may be implemented only when the required approval has been obtained. Approval may be withdrawn at any time. If approval is withdrawn, the right must be immediately and fully restored.

Sec. 4. Minnesota Statutes 2024, section 245D.04, is amended by adding a subdivision to read:

Subd. 4. **Rights of minor children.** (a) For the purposes of this subdivision:

(1) "developmentally appropriate" means, for a person under 18 years of age, activities or items that are determined to be developmentally appropriate based on the development of a person's cognitive, emotional, physical, and behavioral capacities that are typical for the person's age or age group; and

(2) "reasonable and prudent parenting" means, for a person under 18 years of age, the standards characterized by careful and sensible parenting decisions that maintain a person's health and safety; cultural, religious, and Tribal values; and best interests while encouraging the person's emotional and developmental growth.

(b) A person under 18 years of age who is receiving services under this chapter has a right to:

(1) participate in activities or events that are generally accepted as suitable for minor children of the same chronological age or are developmentally appropriate; and

(2) receive reasonable and prudent parenting.

(c) Restriction of the rights under subdivision 3, paragraph (a), clauses (13) to (16), or (b), clauses (1) to (4), for a person under 18 years of age is allowed only if determined necessary to ensure the health, safety, and well-being of the person or pursuant to reasonable and prudent parenting standards.

Sec. 5. Minnesota Statutes 2025 Supplement, section 256B.0943, subdivision 1, is amended to read:

Subdivision 1. **Definitions.** (a) For purposes of this section, the following terms have the meanings given ~~them~~.

(b) "Children's therapeutic services and supports" means the flexible package of mental health services for children who require varying therapeutic and rehabilitative levels of intervention to treat a diagnosed mental illness, as defined in section 245.462, subdivision 20, or 245.4871, subdivision 15. The services are time-limited interventions that are delivered using various treatment modalities and combinations of services designed to reach treatment outcomes identified in the individual treatment plan.

(c) "Clinical trainee" means a staff person who is qualified according to section 245I.04, subdivision 6.

(d) "Crisis planning" has the meaning given in section 245.4871, subdivision 9a.

(e) "Culturally competent provider" means a provider who understands and can utilize to a client's benefit the client's culture when providing services to the client. A provider may be culturally competent because the provider is of the same cultural or ethnic group as the client or the provider has developed the knowledge and skills through training and experience to provide services to culturally diverse clients.

(f) "Day treatment program" for children means a site-based structured mental health program consisting of psychotherapy for ~~three~~ two or more individuals and individual or group skills training provided by a team, under the treatment supervision of a mental health professional.

(g) "Direct service time" means the time that a mental health professional, clinical trainee, mental health practitioner, or mental health behavioral aide spends face-to-face with a client and the client's family or providing covered services through telehealth as defined under

section 256B.0625, subdivision 3b. Direct service time includes time in which the provider obtains a client's history, develops a client's treatment plan, records individual treatment outcomes, or provides service components of children's therapeutic services and supports. Direct service time does not include time doing work before and after providing direct services, including scheduling or maintaining clinical records.

(h) "Direction of mental health behavioral aide" means the activities of a mental health professional, clinical trainee, or mental health practitioner in guiding the mental health behavioral aide in providing services to a client. The direction of a mental health behavioral aide must be based on the client's individual treatment plan and meet the requirements in subdivision 6, paragraph (b), clause (7).

(i) "Individual treatment plan" means the plan described in section 245I.10, subdivisions 7 and 8.

(j) "Mental health behavioral aide services" means medically necessary one-on-one activities performed by a mental health behavioral aide qualified according to section 245I.04, subdivision 16, to assist a child retain or generalize psychosocial skills as previously trained by a mental health professional, clinical trainee, or mental health practitioner and as described in the child's individual treatment plan and individual behavior plan. Activities involve working directly with the child or child's family as provided in subdivision 9, paragraph (b), clause (4).

(k) "Mental health certified family peer specialist" means a staff person who is qualified according to section 245I.04, subdivision 12.

(l) "Mental health practitioner" means a staff person who is qualified according to section 245I.04, subdivision 4.

(m) "Mental health professional" means a staff person who is qualified according to section 245I.04, subdivision 2.

(n) "Mental health service plan development" includes:

(1) development and revision of a child's individual treatment plan; and

(2) administering and reporting standardized outcome measurements approved by the commissioner, as periodically needed to evaluate the effectiveness of treatment.

(o) "Mental illness" has the meaning given in section 245.462, subdivision 20, paragraph (a), for persons at least 18 years of age but under 21 years of age, and has the meaning given in section 245.4871, subdivision 15, for children under 18 years of age.

(p) "Psychotherapy" means the treatment described in section 256B.0671, subdivision 11.

(q) "Rehabilitative services" or "psychiatric rehabilitation services" means interventions to: (1) restore a child or adolescent to an age-appropriate developmental trajectory that had been disrupted by a psychiatric illness; or (2) enable the child to self-monitor, compensate for, cope with, counteract, or replace psychosocial skills deficits or maladaptive skills acquired over the course of a psychiatric illness. Psychiatric rehabilitation services for children combine coordinated psychotherapy to address internal psychological, emotional, and intellectual processing deficits, and skills training to restore personal and social functioning. Psychiatric rehabilitation services establish a progressive series of goals with each achievement building upon a prior achievement.

(r) "Skills training" means individual, family, or group training, delivered by or under the supervision of a mental health professional, designed to facilitate the acquisition of psychosocial skills that are medically necessary to rehabilitate the child to an age-appropriate developmental trajectory heretofore disrupted by a psychiatric illness or to enable the child to self-monitor, compensate for, cope with, counteract, or replace skills deficits or maladaptive skills acquired over the course of a psychiatric illness. Skills training is subject to the service delivery requirements under subdivision 9, paragraph (b), clause (2).

(s) "Standard diagnostic assessment" means the assessment described in section 245I.10, subdivision 6.

(t) "Treatment supervision" means the supervision described in section 245I.06.

Sec. 6. Minnesota Statutes 2025 Supplement, section 256B.0943, subdivision 9, is amended to read:

Subd. 9. **Service delivery criteria.** (a) In delivering services under this section, a certified provider entity must ensure that:

(1) the provider's caseload size should reasonably enable the provider to play an active role in service planning, monitoring, and delivering services to meet the client's and client's family's needs, as specified in each client's individual treatment plan;

(2) site-based programs, including day treatment programs, provide staffing and facilities to ensure the client's health, safety, and protection of rights, and that the programs are able to implement each client's individual treatment plan; and

(3) a day treatment program is provided to a group of clients by a team under the treatment supervision of a mental health professional. The day treatment program must be provided

in and by: (i) an outpatient hospital accredited by the Joint Commission on Accreditation of Health Organizations and licensed under sections 144.50 to 144.55; (ii) a community mental health center under section 245.62; or (iii) an entity that is certified under subdivision 4 to operate a program that meets the requirements of section 245.4884, subdivision 2, and Minnesota Rules, parts 9505.0170 to 9505.0475. The day treatment program must stabilize the client's mental health status while developing and improving the client's independent living and socialization skills. The goal of the day treatment program must be to reduce or relieve the effects of mental illness and provide training to enable the client to live in the community. The remainder of the structured treatment program may include patient and/or family or group psychotherapy, and individual or group skills training, if included in the client's individual treatment plan. Day treatment programs are not part of inpatient or residential treatment services. When a day treatment group that meets the minimum group size requirement temporarily falls below the minimum group size because of a member's temporary absence, medical assistance covers a group session conducted for the group members in attendance. ~~A day treatment program may provide fewer than the minimally required hours for a particular child during a billing period in which the child is transitioning into, or out of, the program.~~

(b) To be eligible for medical assistance payment, a provider entity must deliver at least one of the service components of children's therapeutic services and supports in compliance with the following requirements:

(1) psychotherapy to address the child's underlying mental health disorder must be documented as part of the child's ongoing treatment. A provider must deliver or arrange for medically necessary psychotherapy unless the child's parent or caregiver chooses not to receive it or the provider determines that psychotherapy is no longer medically necessary. When a provider determines that psychotherapy is no longer medically necessary, the provider must update required documentation, including but not limited to the individual treatment plan, the child's medical record, or other authorizations, to include the determination. When a provider determines that a child needs psychotherapy but psychotherapy cannot be delivered due to a shortage of licensed mental health professionals in the child's community, the provider must document the lack of access in the child's medical record;

(2) individual, family, or group skills training is subject to the following requirements:

(i) a mental health professional, clinical trainee, or mental health practitioner shall provide skills training;

(ii) skills training delivered to a child or the child's family must be targeted to the specific deficits or maladaptations of the child's mental health disorder and must be prescribed in the child's individual treatment plan;

(iii) group skills training may be provided to multiple recipients who, because of the nature of their emotional, behavioral, or social dysfunction, can derive mutual benefit from interaction in a group setting, which must be staffed as follows:

(A) one mental health professional, clinical trainee, or mental health practitioner must work with a group of ~~three~~ two to eight clients; or

(B) any combination of two mental health professionals, clinical trainees, or mental health practitioners must work with a group of nine to 12 clients;

(iv) a mental health professional, clinical trainee, or mental health practitioner must have taught the psychosocial skill before a mental health behavioral aide may practice that skill with the client; and

(v) for group skills training, when a skills group that meets the minimum group size requirement temporarily falls below the minimum group size because of a group member's temporary absence, the provider may conduct the session for the group members in attendance;

(3) crisis planning to a child and family must include development of a written plan that anticipates the particular factors specific to the child that may precipitate a psychiatric crisis for the child in the near future. The written plan must document actions that the family should be prepared to take to resolve or stabilize a crisis, such as advance arrangements for direct intervention and support services to the child and the child's family. Crisis planning must include preparing resources designed to address abrupt or substantial changes in the functioning of the child or the child's family when sudden change in behavior or a loss of usual coping mechanisms is observed, or the child begins to present a danger to self or others;

(4) mental health behavioral aide services must be medically necessary treatment services, identified in the child's individual treatment plan.

To be eligible for medical assistance payment, mental health behavioral aide services must be delivered to a child who has been diagnosed with a mental illness, as provided in subdivision 1, paragraph (a). The mental health behavioral aide must document the delivery of services in written progress notes. Progress notes must reflect implementation of the

treatment strategies, as performed by the mental health behavioral aide and the child's responses to the treatment strategies; and

(5) mental health service plan development must be performed in consultation with the child's family and, when appropriate, with other key participants in the child's life by the child's treating mental health professional or clinical trainee or by a mental health practitioner and approved by the treating mental health professional. Treatment plan drafting consists of development, review, and revision by face-to-face or electronic communication. The provider must document events, including the time spent with the family and other key participants in the child's life to approve the individual treatment plan. Medical assistance covers service plan development before completion of the child's individual treatment plan. Service plan development is covered only if a treatment plan is completed for the child. If upon review it is determined that a treatment plan was not completed for the child, the commissioner shall recover the payment for the service plan development.

Sec. 7. Minnesota Statutes 2024, section 256B.0947, subdivision 5, is amended to read:

Subd. 5. **Standards for intensive nonresidential rehabilitative providers.** (a) Services must meet the standards in this section and chapter 245I as required in section 245I.011, subdivision 5.

(b) The treatment team must have specialized training in providing services to the specific age group of youth that the team serves. An individual treatment team ~~must serve youth who are: (1) at least eight years of age or older and under 16 years of age, or (2) at least 14 years of age or older and under 21 years of age~~ may limit services to a specific age group of youth based on the training and expertise of the team.

(c) The treatment team for intensive nonresidential rehabilitative mental health services comprises both permanently employed core team members and client-specific team members as follows:

(1) Based on professional qualifications and client needs, clinically qualified core team members are assigned on a rotating basis as the client's lead worker to coordinate a client's care. The core team must comprise at least four full-time equivalent direct care staff and must minimally include:

(i) a mental health professional who serves as team leader to provide administrative direction and treatment supervision to the team;

(ii) an advanced-practice registered nurse with certification in psychiatric or mental health care or a board-certified ~~child and adolescent~~ psychiatrist, either of which must be credentialed to prescribe medications;

(iii) a mental health certified peer specialist who is qualified according to section 245I.04, subdivision 10, and is also a former children's mental health consumer; and

(iv) a co-occurring disorder specialist who meets the requirements under section 256B.0622, subdivision 7a, paragraph (a), clause (4), who will provide or facilitate the provision of co-occurring disorder treatment to clients.

(2) The core team may also include any of the following:

(i) additional mental health professionals;

(ii) a vocational specialist;

(iii) an educational specialist with knowledge and experience working with youth regarding special education requirements and goals, special education plans, and coordination of educational activities with health care activities;

(iv) a child and adolescent psychiatrist who may be retained on a consultant basis;

(v) a clinical trainee qualified according to section 245I.04, subdivision 6;

(vi) a mental health practitioner qualified according to section 245I.04, subdivision 4;

(vii) a case management service provider, as defined in section 245.4871, subdivision 4;

(viii) a housing access specialist; ~~and~~

(ix) a family peer specialist as defined in subdivision 2, paragraph (j)~~.~~<u>; and</u>

<u>(x) a registered nurse, as defined in section 148.171, subdivision 20.</u>

(3) A treatment team may include, in addition to those in clause (1) or (2), ad hoc members not employed by the team who consult on a specific client and who must accept overall clinical direction from the treatment team for the duration of the client's placement with the treatment team and must be paid by the provider agency at the rate for a typical session by that provider with that client or at a rate negotiated with the client-specific member. Client-specific treatment team members may include:

(i) the mental health professional treating the client prior to placement with the treatment team;

(ii) the client's current substance use counselor, if applicable;

(iii) a lead member of the client's individualized education program team or school-based mental health provider, if applicable;

(iv) a representative from the client's health care home or primary care clinic, as needed to ensure integration of medical and behavioral health care;

(v) the client's probation officer or other juvenile justice representative, if applicable; and

(vi) the client's current vocational or employment counselor, if applicable.

(d) The treatment supervisor shall be an active member of the treatment team and shall function as a practicing clinician at least on a part-time basis. The treatment team shall meet with the treatment supervisor at least weekly to discuss recipients' progress and make rapid adjustments to meet recipients' needs. The team meeting must include client-specific case reviews and general treatment discussions among team members. Client-specific case reviews and planning must be documented in the individual client's treatment record.

(e) The staffing ratio must not exceed ten clients to one full-time equivalent treatment team position.

(f) The treatment team shall serve no more than 80 clients at any one time. Should local demand exceed the team's capacity, an additional team must be established rather than exceed this limit.

(g) Nonclinical staff shall have prompt access in person or by telephone to a mental health practitioner, clinical trainee, or mental health professional. The provider shall have the capacity to promptly and appropriately respond to emergent needs and make any necessary staffing adjustments to ensure the health and safety of clients.

(h) The intensive nonresidential rehabilitative mental health services provider shall participate in evaluation of the assertive community treatment for youth (Youth ACT) model as conducted by the commissioner, including the collection and reporting of data and the reporting of performance measures as specified by contract with the commissioner.

(i) A regional treatment team may serve multiple counties.