

1.1 A bill for an act

1.2 relating to human services; modifying the office of ombudsman for long-term care,
 1.3 mental health treatment services, and miscellaneous policy provisions; amending
 1.4 Minnesota Statutes 2014, sections 245A.11, subdivision 2a; 256.974; 256.9741,
 1.5 subdivision 5, by adding subdivisions; 256.9742; 256B.0622, as amended;
 1.6 256B.0947, subdivision 2; Minnesota Statutes 2015 Supplement, sections
 1.7 256.01, subdivision 12a; 256I.04, subdivision 2a; 402A.18, subdivision 3.

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

1.9 **ARTICLE 1**

1.10 **OMBUDSMAN FOR LONG-TERM CARE**

1.11 Section 1. Minnesota Statutes 2014, section 256.974, is amended to read:

1.12 **256.974 OFFICE OF OMBUDSMAN FOR LONG-TERM CARE; ~~LOCAL~~**
 1.13 **PROGRAMS.**

1.14 The ombudsman for long-term care serves in the classified service under section
 1.15 256.01, subdivision 7, in an office within the Minnesota Board on Aging that incorporates
 1.16 the long-term care ombudsman program required by the Older Americans Act, as
 1.17 amended, United States Code, title 42, ~~section~~ sections 3027(a)(9) and 3058g(a), and
 1.18 ~~established within the Minnesota Board on Aging. The Minnesota Board on Aging may~~
 1.19 ~~make grants to and designate local programs for the provision of ombudsman services to~~
 1.20 ~~clients in county or multicounty areas. The local program~~ Code of Federal Regulations,
 1.21 title 45, parts 1321 and 1327. The office shall be a distinct entity, separately identifiable
 1.22 from other state agencies and may not be an agency engaged in the provision of nursing
 1.23 home care, hospital care, or home care services either directly or by contract, or have the
 1.24 responsibility for planning, coordinating, funding, or administering nursing home care,
 1.25 hospital care, or home care services.

2.1 **EFFECTIVE DATE.** This section is effective the day following final enactment.

2.2 Sec. 2. Minnesota Statutes 2014, section 256.9741, subdivision 5, is amended to read:

2.3 Subd. 5. **Office.** "Office" means the office ~~of ombudsman~~ established within the
2.4 Minnesota Board on Aging ~~or local ombudsman programs that the Board on Aging~~
2.5 ~~designates.~~ and is the organizational unit headed by the state long-term care ombudsman.

2.6 **EFFECTIVE DATE.** This section is effective the day following final enactment.

2.7 Sec. 3. Minnesota Statutes 2014, section 256.9741, is amended by adding a subdivision
2.8 to read:

2.9 Subd. 7. **Representatives of the office.** "Representatives of the office" means
2.10 employees of the office, as well as employees designated as regional ombudsman and
2.11 volunteers designated as certified ombudsman volunteers by the state long-term care
2.12 ombudsman.

2.13 **EFFECTIVE DATE.** This section is effective the day following final enactment.

2.14 Sec. 4. Minnesota Statutes 2014, section 256.9741, is amended by adding a subdivision
2.15 to read:

2.16 Subd. 8. **State long-term care ombudsman.** "State long-term care ombudsman"
2.17 or "ombudsman" means the individual serving on a full-time basis and who in the
2.18 individual's official capacity, or through representatives of the office, is responsible to
2.19 fulfill the functions, responsibilities, and duties set forth in section 256.9742.

2.20 **EFFECTIVE DATE.** This section is effective the day following final enactment.

2.21 Sec. 5. Minnesota Statutes 2014, section 256.9742, is amended to read:

2.22 **256.9742 DUTIES AND POWERS OF THE OFFICE.**

2.23 Subdivision 1. **Duties.** The ~~ombudsman's program~~ office shall:

2.24 (1) gather information and evaluate any act, practice, policy, procedure, or
2.25 administrative action of a long-term care facility, acute care facility, home care service
2.26 provider, or government agency that may adversely affect the health, safety, welfare, or
2.27 rights of any client;

2.28 (2) mediate or advocate on behalf of clients;

2.29 (3) monitor the development and implementation of federal, state, or local laws,
2.30 rules, regulations, and policies affecting the rights and benefits of clients;

3.1 (4) comment on and recommend to public and private agencies regarding laws,
3.2 rules, regulations, and policies affecting clients;

3.3 (5) inform public agencies about the problems of clients;

3.4 (6) provide for training of volunteers and promote the development of citizen
3.5 participation in the work of the office;

3.6 (7) conduct public forums to obtain information about and publicize issues affecting
3.7 clients;

3.8 (8) provide public education regarding the health, safety, welfare, and rights of
3.9 clients; and

3.10 (9) collect and analyze data relating to complaints, conditions, and services.

3.11 Subd. 1a. **Designation; local ombudsman staff and volunteers of representatives**
3.12 **of the office.** (a) In designating ~~an individual~~ a representative of the office to perform
3.13 duties under this section, the ombudsman must determine that the individual is qualified to
3.14 perform the duties required by this section.

3.15 (b) ~~An individual designated as ombudsman staff under this section~~ A representative
3.16 of the office designated as a regional ombudsman must successfully complete an
3.17 orientation training conducted under the direction of the ombudsman or approved by the
3.18 ombudsman. Orientation training shall be at least 20 hours and will consist of training
3.19 in: investigation, dispute resolution, health care regulation, confidentiality, resident and
3.20 patients' rights, and health care reimbursement.

3.21 (c) The ombudsman shall develop and implement a continuing education program
3.22 for ~~individuals~~ representatives of the office designated as ~~ombudsman staff~~ regional
3.23 ombudsmen under this section. ~~The continuing education program shall be,~~ who shall
3.24 complete at least 60 hours annually.

3.25 (d) ~~An individual~~ A representative of the office designated as ~~an ombudsman~~ a
3.26 certified ombudsman volunteer under this section must successfully complete an approved
3.27 orientation training course with a minimum curriculum including federal and state bills
3.28 of rights for long-term care residents, acute hospital patients and home care clients, the
3.29 Vulnerable Adults Act, confidentiality, and the role of the ombudsman.

3.30 (e) The ombudsman shall develop and implement a continuing education program
3.31 for certified ombudsman volunteers ~~which will provide,~~ who shall complete a minimum of
3.32 12 hours of continuing education per year.

3.33 (f) The ombudsman may withdraw ~~an individual's~~ a representative's designation if
3.34 the ~~individual~~ representative fails to perform duties of this section or meet continuing
3.35 education requirements. The ~~individual~~ representative may request a reconsideration of

4.1 such action by the Board on Aging ~~whose decision~~, but any further decision of the state
4.2 ombudsman about designation shall be final.

4.3 Subd. 2. **Immunity from liability.** The ombudsman ~~or designee including staff~~
4.4 ~~and volunteers under this section is~~ and representatives of the office are immune from
4.5 civil liability that otherwise might result from the person's actions or omissions if the
4.6 person's actions are in good faith, are within the scope of the person's responsibilities as an
4.7 ombudsman or designee, and do not constitute willful or reckless misconduct.

4.8 Subd. 3. **Posting.** Every long-term care facility and acute care facility shall post
4.9 in a conspicuous place the address and telephone number of the office. A home care
4.10 service provider shall provide all recipients, including those in housing with services
4.11 under chapter 144D, with the address and telephone number of the office. Counties shall
4.12 provide clients receiving long-term care consultation services under section 256B.0911 or
4.13 home and community-based services through a state or federally funded program with
4.14 the name, address, and telephone number of the office. The posting or notice is subject
4.15 to approval by the ombudsman.

4.16 Subd. 4. **Access to long-term care and acute care facilities and clients.** The
4.17 ombudsman or ~~designee~~ representative of the office may:

4.18 (1) enter any long-term care facility without notice at any time;

4.19 (2) enter any acute care facility without notice during normal business hours;

4.20 (3) enter any acute care facility without notice at any time to interview a patient or
4.21 observe services being provided to the patient as part of an investigation of a matter
4.22 that is within the scope of the ombudsman's authority, but only if the ombudsman's ~~or~~
4.23 ~~designee's~~ or representative's presence does not intrude upon the privacy of another patient
4.24 or interfere with routine hospital services provided to any patient in the facility;

4.25 (4) communicate privately and without restriction with any client, as long as the
4.26 ombudsman or representative of the office has the client's consent for such communication;

4.27 (5) inspect records of a long-term care facility, home care service provider, or
4.28 acute care facility that pertain to the care of the client according to sections 144.291 to
4.29 144.298; and

4.30 (6) with the consent of a client or client's legal guardian, the ombudsman or
4.31 ~~designated staff~~ representatives of the office shall have access to review records pertaining
4.32 to the care of the client according to sections 144.291 to 144.298. If a client cannot
4.33 consent and has no legal guardian, or if the ombudsman or representative of the office has
4.34 reason to believe that the legal guardian is not acting in the best interests of the client,
4.35 access to the records is authorized by this section.

5.1 A person who denies access to the ombudsman or ~~designee~~ representative of the
 5.2 office in violation of this subdivision or aids, abets, invites, compels, or coerces another to
 5.3 do so is guilty of a misdemeanor.

5.4 Subd. 5. **Access to state records.** The ombudsman or ~~designee, excluding~~
 5.5 ~~volunteers~~, has access to data of a state agency necessary for the discharge of the
 5.6 ombudsman's or representative of the office's duties, including records classified
 5.7 confidential or private under chapter 13, or any other law. The data requested must be
 5.8 related to a specific case and is subject to section 13.03, subdivision 4. If the data concerns
 5.9 an individual, the ombudsman or ~~designee~~ representative of the office shall first obtain the
 5.10 individual's consent. If the individual cannot consent and has no legal guardian, or if the
 5.11 ombudsman or representative of the office has reason to believe that the legal guardian is not
 5.12 acting in the best interests of the client, then access to the data is authorized by this section.

5.13 Each state agency responsible for licensing, regulating, and enforcing state and
 5.14 federal laws and regulations concerning long-term care, home care service providers, and
 5.15 acute care facilities shall forward to the ombudsman ~~on a quarterly basis~~ upon request,
 5.16 copies of all correction orders, penalty assessments, and complaint investigation reports,
 5.17 for all long-term care facilities, acute care facilities, and home care service providers.

5.18 Subd. 6. **Prohibition against discrimination or retaliation.** (a) No entity shall
 5.19 take discriminatory, disciplinary, or retaliatory action against ~~an employee or volunteer~~ the
 5.20 ombudsman, representative of the office, or a ~~patient, resident~~ client, or guardian or family
 5.21 member of a ~~patient, resident, or guardian~~ client, for filing in good faith a complaint
 5.22 with or providing information to the ombudsman or ~~designee including volunteers~~
 5.23 representative of the office. A person who violates this subdivision or who aids, abets,
 5.24 invites, compels, or coerces another to do so is guilty of a misdemeanor.

5.25 (b) There shall be a rebuttable presumption that any adverse action, as defined below,
 5.26 within 90 days of report, is discriminatory, disciplinary, or retaliatory. For the purpose
 5.27 of this clause, the term "adverse action" refers to action taken by the entity involved in a
 5.28 report against the person making the report or the person with respect to whom the report
 5.29 was made because of the report, and includes, but is not limited to:

- 5.30 (1) discharge or transfer from a facility;
- 5.31 (2) termination of service;
- 5.32 (3) restriction or prohibition of access to the facility or its residents;
- 5.33 (4) discharge from or termination of employment;
- 5.34 (5) demotion or reduction in remuneration for services; and
- 5.35 (6) any restriction of rights set forth in section 144.651, 144A.44, or 144A.751.

5.36 **EFFECTIVE DATE.** This section is effective the day following final enactment.

6.1 **ARTICLE 2**

6.2 **CHEMICAL AND MENTAL HEALTH SERVICES**

6.3 Section 1. Minnesota Statutes 2014, section 256B.0622, as amended by Laws 2015,
6.4 chapter 71, article 2, sections 23 to 32, is amended to read:

6.5 **256B.0622 INTENSIVE REHABILITATIVE MENTAL HEALTH SERVICES**
6.6 **ASSERTIVE COMMUNITY TREATMENT AND INTENSIVE RESIDENTIAL**
6.7 **TREATMENT SERVICES.**

6.8 Subdivision 1. **Scope.** Subject to federal approval, medical assistance covers
6.9 medically necessary, assertive community treatment for clients as defined in subdivision
6.10 3 and intensive residential treatment services as defined in subdivision 2; for recipients
6.11 clients as defined in subdivision 3, 4 when the services are provided by an entity meeting
6.12 the standards in this section.

6.13 Subd. 2. **Definitions.** (a) For purposes of this section, the following terms have
6.14 the meanings given them.

6.15 (b) "ACT team" means the group of interdisciplinary mental health staff who work
6.16 as a team to provide assertive community treatment.

6.17 (a) (c) "Assertive community treatment" means intensive nonresidential treatment
6.18 and rehabilitative mental health services provided according to the evidence-based practice
6.19 of assertive community treatment model. Assertive community treatment provides a
6.20 single, fixed point of responsibility for treatment, rehabilitation, and support needs for
6.21 clients. Services are offered 24 hours per day, seven days per week, in a community-based
6.22 setting. Core elements of this service include, but are not limited to:

6.23 (1) a multidisciplinary staff who utilize a total team approach and who serve as a
6.24 fixed point of responsibility for all service delivery;

6.25 (2) providing services 24 hours per day and seven days per week;

6.26 (3) providing the majority of services in a community setting;

6.27 (4) offering a low ratio of recipients to staff; and

6.28 (5) providing service that is not time-limited.

6.29 (d) "Individual treatment plan" means the document that results from a
6.30 person-centered planning process of determining real-life outcomes with clients and
6.31 developing strategies to achieve those outcomes.

6.32 (e) "Assertive engagement" means the use of collaborative strategies to engage
6.33 clients to receive services.

6.34 (f) "Benefits and finance support" means assisting clients in capably managing
6.35 financial affairs. Services include, but are not limited to, assisting clients in applying for

7.1 benefits; assisting with redetermination of benefits; providing financial crisis management;
7.2 teaching and supporting budgeting skills and asset development; and coordinating with a
7.3 client's representative payee, if applicable.

7.4 (g) "Co-occurring disorder treatment" means the treatment of co-occurring mental
7.5 illness and substance use disorders and is characterized by assertive outreach, stage-wise
7.6 comprehensive treatment, treatment goal setting, and flexibility to work within each stage
7.7 of treatment. Services include, but are not limited to, assessing and tracking clients' stages
7.8 of change readiness and treatment; applying the appropriate treatment based on stages
7.9 of change, such as outreach and motivational interviewing techniques to work with
7.10 clients in earlier stages of change readiness and cognitive behavioral approaches and
7.11 relapse prevention to work with clients in later stages of change; and facilitating access
7.12 to community supports.

7.13 (h) "Crisis assessment and intervention" means mental health crisis response services
7.14 as defined in section 256B.0624, subdivision 2, paragraphs (c) to (e).

7.15 (i) "Employment services" means assisting clients to work at jobs of their choosing.
7.16 Services must follow the principles of the individual placement and support (IPS)
7.17 employment model, including focusing on competitive employment; emphasizing
7.18 individual client preferences and strengths; ensuring employment services are integrated
7.19 with mental health services; conducting rapid job searches and systematic job development
7.20 according to client preferences and choices; providing benefits counseling; and offering
7.21 all services in an individualized and time-unlimited manner. Services shall also include
7.22 educating clients about opportunities and benefits of work and school and assisting the
7.23 client in learning job skills, navigating the work place, and managing work relationships.

7.24 (j) "Family psychoeducation and support" means services provided to the client's
7.25 family and other natural supports to restore and strengthen the client's unique social
7.26 and family relationships. Services include, but are not limited to, individualized
7.27 psychoeducation about the client's illness and the role of the family and other significant
7.28 people in the therapeutic process; family intervention to restore contact, resolve conflict,
7.29 and maintain relationships with family and other significant people in the client's life;
7.30 ongoing communication and collaboration between the ACT team and the family;
7.31 introduction and referral to family self-help programs and advocacy organizations that
7.32 promote recovery and family engagement, individual supportive counseling, parenting
7.33 training, and service coordination to help clients fulfill parenting responsibilities;
7.34 coordinating services for the child and restoring relationships with children who are not in
7.35 the client's custody; and coordinating with child welfare and family agencies, if applicable.
7.36 These services must be provided with the client's agreement and consent.

8.1 (k) "Housing access support" means assisting clients to find, obtain, retain, and
 8.2 move to safe and adequate housing of their choice. Housing access support includes,
 8.3 but is not limited to, locating housing options with a focus on integrated independent
 8.4 settings; applying for housing subsidies, programs, or resources; assisting the client in
 8.5 developing relationships with local landlords; providing tenancy support and advocacy for
 8.6 the individual's tenancy rights at the client's home; and assisting with relocation.

8.7 (l) "Individual treatment team" means a minimum of three members of the ACT
 8.8 team who are responsible for consistently carrying out most of a client's assertive
 8.9 community treatment services.

8.10 (m) "Intensive residential treatment services treatment team" means all staff
 8.11 who provide intensive residential treatment services under this section to clients. At
 8.12 a minimum, this includes the clinical supervisor, mental health professionals as defined
 8.13 in section 245.462, subdivision 18, clauses (1) to (6); mental health practitioners as
 8.14 defined in section 245.462, subdivision 17; mental health rehabilitation workers under
 8.15 section 256B.0623, subdivision 5, clause (4); and mental health certified peer specialists
 8.16 under section 256B.0615.

8.17 ~~(b)~~ (n) "Intensive residential treatment services" means short-term, time-limited
 8.18 services provided in a residential setting to recipients clients who are in need of more
 8.19 restrictive settings and are at risk of significant functional deterioration if they do not receive
 8.20 these services. Services are designed to develop and enhance psychiatric stability, personal
 8.21 and emotional adjustment, self-sufficiency, and skills to live in a more independent setting.
 8.22 Services must be directed toward a targeted discharge date with specified client outcomes.

8.23 ~~(e) "Evidence-based practices" are nationally recognized mental health services that~~
 8.24 ~~are proven by substantial research to be effective in helping individuals with serious~~
 8.25 ~~mental illness obtain specific treatment goals.~~

8.26 (o) "Medication assistance and support" means assisting clients in accessing
 8.27 medication, developing the ability to take medications with greater independence, and
 8.28 providing medication setup. This includes the prescription, administration, and order of
 8.29 medication by appropriate medical staff.

8.30 (p) "Medication education" means educating clients on the role and effects of
 8.31 medications in treating symptoms of mental illness and the side effects of medications.

8.32 ~~(d)~~ (q) "Overnight staff" means a member of the intensive residential rehabilitative
 8.33 mental health treatment services team who is responsible during hours when recipients
 8.34 clients are typically asleep.

8.35 ~~(e) "Treatment team" means all staff who provide services under this section to~~
 8.36 ~~recipients. At a minimum, this includes the clinical supervisor, mental health professionals~~

9.1 ~~as defined in section 245.462, subdivision 18, clauses (1) to (6); mental health practitioners~~
9.2 ~~as defined in section 245.462, subdivision 17; mental health rehabilitation workers under~~
9.3 ~~section 256B.0623, subdivision 5, clause (3); and certified peer specialists under section~~
9.4 ~~256B.0615.~~

9.5 (r) "Mental health certified peer specialists services" has the meaning given in
9.6 section 256B.0615.

9.7 (s) "Physical health services" means any service or treatment to meet the physical
9.8 health needs of the client to support the client's mental health recovery. Services include,
9.9 but are not limited to, education on primary health issues, including wellness education;
9.10 medication administration and monitoring; providing and coordinating medical screening
9.11 and follow-up; scheduling routine and acute medical and dental care visits; tobacco
9.12 cessation strategies; assisting clients in attending appointments; communicating with other
9.13 providers; and integrating all physical and mental health treatment.

9.14 (t) "Primary team member" means the person who leads and coordinates the
9.15 activities of the individual treatment team and is the individual treatment team member
9.16 who has primary responsibility for establishing and maintaining a therapeutic relationship
9.17 with the client on a continuing basis.

9.18 (u) "Rehabilitative mental health services" means mental health services that are
9.19 rehabilitative and enable the client to develop and enhance psychiatric stability, social
9.20 competencies, personal and emotional adjustment, independent living, parenting skills,
9.21 and community skills, when these abilities are impaired by the symptoms of mental illness.

9.22 (v) "Symptom management" means supporting clients in identifying and targeting
9.23 the symptoms and occurrence patterns of their mental illness and developing strategies
9.24 to reduce the impact of those symptoms.

9.25 (w) "Therapeutic interventions" means empirically supported techniques to address
9.26 specific symptoms and behaviors such as anxiety, psychotic symptoms, emotional
9.27 dysregulation, and trauma symptoms. Interventions include empirically supported
9.28 psychotherapies including, but not limited to, cognitive behavioral therapy, exposure
9.29 therapy, acceptance and commitment therapy, interpersonal therapy, and motivational
9.30 interviewing.

9.31 (x) "Wellness self-management and prevention" means a combination of approaches
9.32 to working with the client to build and apply skills related to recovery, and to support
9.33 the client in participating in leisure and recreational activities, civic participation, and
9.34 meaningful structure.

10.1 Subd. 2a. Eligibility for assertive community treatment. An eligible client
10.2 for assertive community treatment is an individual who meets the following criteria as
10.3 assessed by an ACT team:

10.4 (1) is age 18 or older. Individuals ages 16 and 17 may be eligible upon approval by
10.5 the commissioner;

10.6 (2) has a primary diagnosis of schizophrenia, schizoaffective disorder, major
10.7 depressive disorder with psychotic features, other psychotic disorders, or bipolar disorder.
10.8 Individuals with other psychiatric illnesses may qualify for assertive community treatment
10.9 if they have a serious mental illness and meet the criteria outlined in clauses (3) and (4), but
10.10 no more than ten percent of an ACT team's clients may be eligible based on this criteria.

10.11 Individuals with a primary diagnosis of a substance use disorder, intellectual developmental
10.12 disabilities, borderline personality disorder, antisocial personality disorder, traumatic brain
10.13 injury, or an autism spectrum disorder are not eligible for assertive community treatment;

10.14 (3) has significant functional impairment as demonstrated by at least one of the
10.15 following conditions:

10.16 (i) significant difficulty consistently performing the range of routine tasks required
10.17 for basic adult functioning in the community or persistent difficulty performing daily
10.18 living tasks without significant support or assistance;

10.19 (ii) significant difficulty maintaining employment at a self-sustaining level or
10.20 significant difficulty consistently carrying out the head-of-household responsibilities; or

10.21 (iii) significant difficulty maintaining a safe living situation;

10.22 (4) has a need for continuous high-intensity services as evidenced by at least two of
10.23 the following:

10.24 (i) two or more psychiatric hospitalizations or residential crisis stabilization services
10.25 in the previous 12 months;

10.26 (ii) frequent utilization of mental health crisis services in the previous six months;

10.27 (iii) 30 or more consecutive days of psychiatric hospitalization in the previous
10.28 24 months;

10.29 (iv) intractable, persistent, or prolonged severe psychiatric symptoms;

10.30 (v) coexisting mental health and substance use disorders lasting at least six months;

10.31 (vi) recent history of involvement with the criminal justice system or demonstrated
10.32 risk of future involvement;

10.33 (vii) significant difficulty meeting basic survival needs;

10.34 (viii) residing in substandard housing, experiencing homelessness, or facing
10.35 imminent risk of homelessness;

- 11.1 (ix) significant impairment with social and interpersonal functioning such that basic
 11.2 needs are in jeopardy;
- 11.3 (x) coexisting mental health and physical health disorders lasting at least six months;
 11.4 (xi) residing in an inpatient or supervised community residence but clinically assessed
 11.5 to be able to live in a more independent living situation if intensive services are provided;
 11.6 (xii) requiring a residential placement if more intensive services are not available; or
 11.7 (xiii) difficulty effectively using traditional office-based outpatient services;
- 11.8 (5) there are no indications that other available community-based services would
 11.9 be equally or more effective as evidenced by consistent and extensive efforts to treat
 11.10 the individual; and
- 11.11 (6) in the written opinion of a licensed mental health professional, has the need for
 11.12 mental health services that cannot be met with other available community-based services,
 11.13 or is likely to experience a mental health crisis or require a more restrictive setting if
 11.14 assertive community treatment is not provided.
- 11.15 **Subd. 2b. Continuing stay and discharge criteria for assertive community**
 11.16 **treatment.** (a) A client receiving assertive community treatment is eligible to continue
 11.17 receiving services if:
- 11.18 (1) the client has not achieved the desired outcomes of their individual treatment plan;
 11.19 (2) the client's level of functioning has not been restored, improved, or sustained
 11.20 over the time frame outlined in the individual treatment plan;
 11.21 (3) the client continues to be at risk for relapse based on current clinical assessment,
 11.22 history, or the tenuous nature of the functional gains; or
- 11.23 (4) the client is functioning effectively with this service and discharge would
 11.24 otherwise be indicated but without continued services the client's functioning would
 11.25 decline; and
- 11.26 (5) one of the following must also apply:
- 11.27 (i) the client has achieved current individual treatment plan goals but additional
 11.28 goals are indicated as evidenced by documented symptoms;
 11.29 (ii) the client is making satisfactory progress toward meeting goals and there
 11.30 is documentation that supports that continuation of this service shall be effective in
 11.31 addressing the goals outlined in the individualized treatment plan;
 11.32 (iii) the client is making progress, but the specific interventions in the individual
 11.33 treatment plan need to be modified so that greater gains, which are consistent with the
 11.34 client's potential level of functioning, are possible; or
- 11.35 (iv) the client fails to make progress or demonstrates regression in meeting goals
 11.36 through the interventions outlined in the individual treatment plan.

12.1 (b) Clients receiving assertive community treatment are eligible to be discharged if
12.2 they meet at least one of the following criteria:

12.3 (1) the client and the ACT team determine that assertive community treatment
12.4 services are no longer needed based on the attainment of goals as identified in the individual
12.5 treatment plan and a less intensive level of care would adequately address current goals;

12.6 (2) the client moves out of the ACT team's service area and the ACT team has
12.7 facilitated the referral to either a new ACT team or other appropriate mental health service
12.8 and has assisted the individual in the transition process;

12.9 (3) the client, or the client's legal guardian when applicable, chooses to withdraw
12.10 from assertive community treatment services and documented attempts by the ACT team
12.11 to re-engage the client with the service have not been successful;

12.12 (4) the client has a demonstrated need for a medical nursing home placement lasting
12.13 more than three months, as determined by a physician;

12.14 (5) the client is hospitalized, in residential treatment, or in jail for a period of greater
12.15 than three months. However, the ACT team must make provisions for the client to return to
12.16 the ACT team upon their discharge or release from the hospital or jail if the client still meets
12.17 eligibility criteria for assertive community treatment and the team is not at full capacity;

12.18 (6) the ACT team is unable to locate, contact, and engage the client for a period of
12.19 greater than three months after persistent efforts by the ACT team to locate the client; or

12.20 (7) the client requests a discharge, despite repeated and proactive efforts by the ACT
12.21 team to engage the client in service planning. The ACT team must develop a transition
12.22 plan to arrange for alternate treatment for clients in this situation who have a history of
12.23 suicide attempts, assault, or forensic involvement.

12.24 (c) For all clients who are discharged from assertive community treatment to another
12.25 service provider within the ACT team's service area there is a three-month transfer period,
12.26 from the date of discharge, during which a client who does not adjust well to the new
12.27 service, may voluntarily return to the ACT team. During this period, the ACT team must
12.28 maintain contact with the client's new service provider.

12.29 **Subd. 3. Eligibility for intensive residential treatment services.** An eligible
12.30 recipient client for intensive residential treatment services is an individual who:

12.31 (1) is age 18 or older;

12.32 (2) is eligible for medical assistance;

12.33 (3) is diagnosed with a mental illness;

12.34 (4) because of a mental illness, has substantial disability and functional impairment
12.35 in three or more of the areas listed in section 245.462, subdivision 11a, so that
12.36 self-sufficiency is markedly reduced;

13.1 (5) has one or more of the following: a history of recurring or prolonged inpatient
 13.2 hospitalizations in the past year, significant independent living instability, homelessness,
 13.3 or very frequent use of mental health and related services yielding poor outcomes; and

13.4 (6) in the written opinion of a licensed mental health professional, has the need for
 13.5 mental health services that cannot be met with other available community-based services,
 13.6 or is likely to experience a mental health crisis or require a more restrictive setting if
 13.7 intensive rehabilitative mental health services are not provided.

13.8 **Subd. 3a. Provider certification and contract requirements for assertive**
 13.9 **community treatment.** (a) The assertive community treatment provider must:

13.10 (1) have a contract with the host county to provide assertive community treatment
 13.11 services; and

13.12 (2) have each ACT team be certified by the state following the certification process
 13.13 and procedures developed by the commissioner. The certification process determines
 13.14 whether the ACT team meets the standards for assertive community treatment under
 13.15 this section as well as minimum program fidelity standards as measured by a nationally
 13.16 recognized fidelity tool approved by the commissioner. Recertification must occur at least
 13.17 every three years.

13.18 (b) An ACT team certified under this subdivision must meet the following standards:

13.19 (1) have capacity to recruit, hire, manage, and train required ACT team members;

13.20 (2) have adequate administrative ability to ensure availability of services;

13.21 (3) ensure adequate preservice and ongoing training for staff;

13.22 (4) ensure that staff is capable of implementing culturally specific services that are
 13.23 culturally responsive and appropriate as determined by the client's culture, beliefs, values,
 13.24 and language as identified in the individual treatment plan;

13.25 (5) ensure flexibility in service delivery to respond to the changing and intermittent
 13.26 care needs of a client as identified by the client and the individual treatment plan;

13.27 (6) develop and maintain client files, individual treatment plans, and contact charting;

13.28 (7) develop and maintain staff training and personnel files;

13.29 (8) submit information as required by the state;

13.30 (9) keep all necessary records required by law;

13.31 (10) comply with all applicable laws;

13.32 (11) be an enrolled Medicaid provider;

13.33 (12) establish and maintain a quality assurance plan to determine specific service
 13.34 outcomes and the client's satisfaction with services; and

13.35 (13) develop and maintain written policies and procedures regarding service
 13.36 provision and administration of the provider entity.

14.1 (c) The commissioner may intervene at any time and decertify an ACT team with
 14.2 cause. The commissioner shall establish a process for decertification of an ACT team and
 14.3 shall require corrective action, medical assistance repayment, or decertification of an
 14.4 ACT team that no longer meets the requirements in this section or that fails to meet the
 14.5 clinical quality standards or administrative standards provided by the commissioner in the
 14.6 application and certification process. The decertification is subject to appeal to the state.

14.7 **Subd. 4. Provider certification licensure and contract requirements for intensive**
 14.8 **residential treatment services.** ~~(a) The assertive community treatment provider must:~~

14.9 ~~(1) have a contract with the host county to provide intensive adult rehabilitative~~
 14.10 ~~mental health services; and~~

14.11 ~~(2) be certified by the commissioner as being in compliance with this section and~~
 14.12 ~~section 256B.0623.~~

14.13 ~~(b)~~ (a) The intensive residential treatment services provider must:

14.14 (1) be licensed under Minnesota Rules, parts 9520.0500 to 9520.0670;

14.15 (2) not exceed 16 beds per site;

14.16 (3) comply with the additional standards in this section; and

14.17 (4) have a contract with the host county to provide these services.

14.18 ~~(e)~~ (b) The commissioner shall develop procedures for counties and providers
 14.19 to submit contracts and other documentation as needed to allow the commissioner to
 14.20 determine whether the standards in this section are met.

14.21 **Subd. 5. Standards applicable to both assertive community treatment and**

14.22 **residential providers.** ~~(a) Services must be provided by qualified staff as defined in section~~
 14.23 ~~256B.0623, subdivision 5, who are trained and supervised according to section 256B.0623,~~
 14.24 ~~subdivision 6, except that mental health rehabilitation workers acting as overnight staff are~~
 14.25 ~~not required to comply with section 256B.0623, subdivision 5, clause (4), item (iv).~~

14.26 ~~(b) The clinical supervisor must be an active member of the treatment team. The~~
 14.27 ~~treatment team must meet with the clinical supervisor at least weekly to discuss recipients'~~
 14.28 ~~progress and make rapid adjustments to meet recipients' needs. The team meeting shall~~
 14.29 ~~include recipient-specific case reviews and general treatment discussions among team~~
 14.30 ~~members. Recipient-specific case reviews and planning must be documented in the~~
 14.31 ~~individual recipient's treatment record.~~

14.32 ~~(c) Treatment staff must have prompt access in person or by telephone to a mental~~
 14.33 ~~health practitioner or mental health professional. The provider must have the capacity to~~
 14.34 ~~promptly and appropriately respond to emergent needs and make any necessary staffing~~
 14.35 ~~adjustments to assure the health and safety of recipients.~~

15.1 ~~(d) The initial functional assessment must be completed within ten days of intake~~
15.2 ~~and updated at least every 30 days for intensive residential treatment services and every~~
15.3 ~~six months for assertive community treatment, or prior to discharge from the service,~~
15.4 ~~whichever comes first.~~

15.5 ~~(e) The initial individual treatment plan must be completed within ten days of~~
15.6 ~~intake for assertive community treatment and within 24 hours of admission for intensive~~
15.7 ~~residential treatment services. Within ten days of admission, the initial treatment plan~~
15.8 ~~must be refined and further developed for intensive residential treatment services, except~~
15.9 ~~for providers certified according to Minnesota Rules, parts 9533.0010 to 9533.0180.~~
15.10 ~~The individual treatment plan must be reviewed with the recipient and updated at least~~
15.11 ~~monthly for intensive residential treatment services and at least every six months for~~
15.12 ~~assertive community treatment.~~

15.13 ~~Subd. 6. **Standards for intensive residential rehabilitative mental health services.**~~

15.14 ~~(a) The provider of intensive residential services must have sufficient staff to provide~~
15.15 ~~24-hour-per-day coverage to deliver the rehabilitative services described in the treatment~~
15.16 ~~plan and to safely supervise and direct the activities of recipients given the recipient's level~~
15.17 ~~of behavioral and psychiatric stability, cultural needs, and vulnerability. The provider~~
15.18 ~~must have the capacity within the facility to provide integrated services for chemical~~
15.19 ~~dependency, illness management services, and family education when appropriate.~~

15.20 ~~(b) At a minimum:~~

15.21 ~~(1) staff must be available and provide direction and supervision whenever recipients~~
15.22 ~~are present in the facility;~~

15.23 ~~(2) staff must remain awake during all work hours;~~

15.24 ~~(3) there must be a staffing ratio of at least one to nine recipients for each day and~~
15.25 ~~evening shift. If more than nine recipients are present at the residential site, there must be~~
15.26 ~~a minimum of two staff during day and evening shifts, one of whom must be a mental~~
15.27 ~~health practitioner or mental health professional;~~

15.28 ~~(4) if services are provided to recipients who need the services of a medical~~
15.29 ~~professional, the provider shall assure that these services are provided either by the~~
15.30 ~~provider's own medical staff or through referral to a medical professional; and~~

15.31 ~~(5) the provider must assure the timely availability of a licensed registered~~
15.32 ~~nurse, either directly employed or under contract, who is responsible for ensuring the~~
15.33 ~~effectiveness and safety of medication administration in the facility and assessing patients~~
15.34 ~~for medication side effects and drug interactions.~~

16.1 Subd. 5a. Standards for intensive residential rehabilitative mental health

16.2 services. (a) The standards in this subdivision apply to intensive residential mental health
16.3 services.

16.4 (b) The provider of intensive residential treatment services must have sufficient staff
16.5 to provide 24-hour-per-day coverage to deliver the rehabilitative services described in the
16.6 treatment plan and to safely supervise and direct the activities of clients, given the client's
16.7 level of behavioral and psychiatric stability, cultural needs, and vulnerability. The provider
16.8 must have the capacity within the facility to provide integrated services for chemical
16.9 dependency, illness management services, and family education, when appropriate.

16.10 (c) At a minimum:

16.11 (1) staff must provide direction and supervision whenever clients are present in
16.12 the facility;

16.13 (2) staff must remain awake during all work hours;

16.14 (3) there must be a staffing ratio of at least one to nine clients for each day and
16.15 evening shift. If more than nine clients are present at the residential site, there must be a
16.16 minimum of two staff during day and evening shifts, one of whom must be a mental health
16.17 practitioner or mental health professional;

16.18 (4) if services are provided to clients who need the services of a medical professional,
16.19 the provider shall ensure that these services are provided either by the provider's own
16.20 medical staff or through referral to a medical professional; and

16.21 (5) the provider must ensure the timely availability of a licensed registered
16.22 nurse, either directly employed or under contract, who is responsible for ensuring the
16.23 effectiveness and safety of medication administration in the facility and assessing clients
16.24 for medication side effects and drug interactions.

16.25 (d) Services must be provided by qualified staff as defined in section 256B.0623,
16.26 subdivision 5, who are trained and supervised according to section 256B.0623, subdivision
16.27 6, except that mental health rehabilitation workers acting as overnight staff are not
16.28 required to comply with section 256B.0623, subdivision 5, clause (4), item (iv).

16.29 (e) The clinical supervisor must be an active member of the intensive residential
16.30 services treatment team. The team must meet with the clinical supervisor at least weekly
16.31 to discuss clients' progress and make rapid adjustments to meet clients' needs. The team
16.32 meeting shall include client-specific case reviews and general treatment discussions
16.33 among team members. Client-specific case reviews and planning must be documented
16.34 in the client's treatment record.

16.35 (f) Treatment staff must have prompt access in person or by telephone to a mental
16.36 health practitioner or mental health professional. The provider must have the capacity to

17.1 promptly and appropriately respond to emergent needs and make any necessary staffing
 17.2 adjustments to ensure the health and safety of clients.

17.3 (g) The initial functional assessment must be completed within ten days of intake and
 17.4 updated at least every 30 days, or prior to discharge from the service, whichever comes first.

17.5 (h) The initial individual treatment plan must be completed within 24 hours of
 17.6 admission. Within ten days of admission, the initial treatment plan must be refined and
 17.7 further developed, except for providers certified according to Minnesota Rules, parts
 17.8 9533.0010 to 9533.0180. The individual treatment plan must be reviewed with the client
 17.9 and updated at least monthly.

17.10 Subd. 7. **Additional standards for Assertive community treatment service**
 17.11 **standards.** ~~The standards in this subdivision apply to assertive community treatment~~
 17.12 ~~services.~~

17.13 ~~(1) The treatment team must use team treatment, not an individual treatment model.~~

17.14 ~~(2) The clinical supervisor must function as a practicing clinician at least on a~~
 17.15 ~~part-time basis.~~

17.16 ~~(3) The staffing ratio must not exceed ten recipients to one full-time equivalent~~
 17.17 ~~treatment team position.~~

17.18 ~~(4) Services must be available at times that meet client needs.~~

17.19 ~~(5) The treatment team must actively and assertively engage and reach out to the~~
 17.20 ~~recipient's family members and significant others, after obtaining the recipient's permission.~~

17.21 ~~(6) The treatment team must establish ongoing communication and collaboration~~
 17.22 ~~between the team, family, and significant others and educate the family and significant~~
 17.23 ~~others about mental illness, symptom management, and the family's role in treatment.~~

17.24 ~~(7) The treatment team must provide interventions to promote positive interpersonal~~
 17.25 ~~relationships.~~

17.26 (a) ACT teams must offer and have the capacity to directly provide the following
 17.27 services:

17.28 (1) assertive engagement;

17.29 (2) benefits and finance support;

17.30 (3) co-occurring disorder treatment;

17.31 (4) crisis assessment and intervention;

17.32 (5) employment services;

17.33 (6) family psychoeducation and support;

17.34 (7) housing access support;

17.35 (8) medication assistance and support;

17.36 (9) medication education;

- 18.1 (10) mental health certified peer specialists services;
18.2 (11) physical health services;
18.3 (12) rehabilitative mental health services;
18.4 (13) symptom management;
18.5 (14) therapeutic interventions;
18.6 (15) wellness self-management and prevention; and
18.7 (16) other services based on client needs as identified in a client's assertive
18.8 community treatment individual treatment plan.

18.9 (b) ACT teams must ensure the provision of all services necessary to meet a client's
18.10 needs as identified in the client's individualized treatment plan.

18.11 Subd. 7b. **Assertive community treatment team staff requirements and roles.**

18.12 (a) The required treatment staff qualifications and roles for an ACT team are:

18.13 (1) the team leader:

18.14 (i) shall be a licensed mental health professional who is qualified under Minnesota
18.15 Rules, part 9505.0371, subpart 5, item A. Individuals who are not licensed but who are
18.16 eligible for licensure and are otherwise qualified may also fulfill this role but must obtain
18.17 full licensure within 24 months of assuming the role of team leader;

18.18 (ii) must be an active member of the ACT team and provide some direct services
18.19 to clients;

18.20 (iii) must be a single full-time staff member, dedicated to the ACT team, who is
18.21 responsible for overseeing the administrative operations of the team, providing clinical
18.22 oversight of services in conjunction with the psychiatrist or psychiatric care provider, and
18.23 supervising team members to ensure delivery of best and ethical practices; and

18.24 (iv) must be available to provide overall clinical oversight to the ACT team after
18.25 regular business hours and on weekends and holidays. The team leader may delegate this
18.26 duty to another qualified member of the ACT team;

18.27 (2) the psychiatric care provider:

18.28 (i) must be a licensed psychiatrist certified by the American Board of Psychiatry
18.29 and Neurology or eligible for board certification or a psychiatric nurse who is qualified
18.30 under Minnesota Rules, part 9505.0371, subpart 5, item A. The psychiatric care provider
18.31 must have demonstrated clinical experience working with individuals with serious and
18.32 persistent mental illness;

18.33 (ii) shall collaborate with the team leader in sharing overall clinical responsibility for
18.34 screening and admitting clients; monitoring clients' treatment and team member service
18.35 delivery; educating staff on psychiatric and nonpsychiatric medications, their side effects,

19.1 and health-related conditions; actively collaborating with nurses; and helping provide
19.2 clinical supervision to the team;

19.3 (iii) shall fulfill the following functions for assertive community treatment clients:
19.4 provide assessment and treatment of clients' symptoms and response to medications,
19.5 including side effects; provide brief therapy to clients; provide diagnostic and medication
19.6 education to clients, with medication decisions based on shared decision making; monitor
19.7 clients' nonpsychiatric medical conditions and nonpsychiatric medications; and conduct
19.8 home and community visits;

19.9 (iv) shall serve as the point of contact for psychiatric treatment if a client is
19.10 hospitalized for mental health treatment and shall communicate directly with the client's
19.11 inpatient psychiatric care providers to ensure continuity of care;

19.12 (v) shall have a minimum full-time equivalency that is prorated at a rate of 16 hours
19.13 per 50 clients. Part-time psychiatric care providers shall have designated hours to work
19.14 on the team, with sufficient blocks of time on consistent days to carry out the provider's
19.15 clinical, supervisory, and administrative responsibilities. No more than two psychiatric
19.16 care providers may share this role;

19.17 (vi) may not provide specific roles and responsibilities by telemedicine unless
19.18 approved by the commissioner; and

19.19 (vii) shall provide psychiatric backup to the program after regular business hours
19.20 and on weekends and holidays. The psychiatric care provider may delegate this duty
19.21 to another qualified psychiatric provider;

19.22 (3) the nursing staff:

19.23 (i) shall consist of one to three registered nurses or advanced practice registered
19.24 nurses, of whom at least one has a minimum of one-year experience working with adults
19.25 with serious mental illness and a working knowledge of psychiatric medications. No more
19.26 than two individuals can share a full-time equivalent position;

19.27 (ii) are responsible for managing medication, administering and documenting
19.28 medication treatment, and managing a secure medication room; and

19.29 (iii) shall develop strategies, in collaboration with clients, to maximize taking
19.30 medications as prescribed; screen and monitor clients' mental and physical health
19.31 conditions and medication side effects; engage in health promotion, prevention, and
19.32 education activities; communicate and coordinate services with other medical providers;
19.33 facilitate the development of the individual treatment plan for clients assigned; and
19.34 educate the ACT team in monitoring psychiatric and physical health symptoms and
19.35 medication side effects;

19.36 (4) the co-occurring disorder specialist:

20.1 (i) shall be a full-time equivalent co-occurring disorder specialist who has received
20.2 specific training on co-occurring disorders that is consistent with national evidence-based
20.3 practices. The training must include practical knowledge of common substances and
20.4 how they affect mental illnesses, the ability to assess substance use disorders and the
20.5 client's stage of treatment, motivational interviewing, and skills necessary to provide
20.6 counseling to clients at all different stages of change and treatment. The co-occurring
20.7 disorder specialist may also be an individual who is a licensed alcohol and drug counselor
20.8 as described in section 148F.01, subdivision 5, or a counselor who otherwise meets the
20.9 training, experience, and other requirements in Minnesota Rules, part 9530.6450, subpart
20.10 5. No more than two co-occurring disorder specialists may occupy this role; and

20.11 (ii) shall provide or facilitate the provision of co-occurring disorder treatment to
20.12 clients. The co-occurring disorder specialist shall serve as a consultant and educator to
20.13 fellow ACT team members on co-occurring disorders;

20.14 (5) the vocational specialist:

20.15 (i) shall be a full-time vocational specialist who has at least one-year experience
20.16 providing employment services or advanced education that involved field training in
20.17 vocational services to individuals with mental illness. An individual who does not meet
20.18 these qualifications may also serve as the vocational specialist upon completing a training
20.19 plan approved by the commissioner;

20.20 (ii) shall provide or facilitate the provision of vocational services to clients. The
20.21 vocational specialist serves as a consultant and educator to fellow ACT team members on
20.22 these services; and

20.23 (iii) should not refer individuals to receive any type of vocational services or linkage
20.24 by providers outside of the ACT team;

20.25 (6) the mental health certified peer specialist:

20.26 (i) shall be a full-time equivalent mental health certified peer specialist as defined in
20.27 section 256B.0615. No more than two individuals can share this position. The mental
20.28 health certified peer specialist is a fully integrated team member who provides highly
20.29 individualized services in the community and promotes the self-determination and shared
20.30 decision-making abilities of clients. This requirement may be waived due to workforce
20.31 shortages upon approval of the commissioner;

20.32 (ii) must provide coaching, mentoring, and consultation to the clients to promote
20.33 recovery, self-advocacy, and self-direction, promote wellness management strategies, and
20.34 assist clients in developing advance directives; and

20.35 (iii) must model recovery values, attitudes, beliefs, and personal action to encourage
20.36 wellness and resilience, provide consultation to team members, promote a culture where

21.1 the clients' points of view and preferences are recognized, understood, respected, and
 21.2 integrated into treatment, and serve in a manner equivalent to other team members;

21.3 (7) the program administrative assistant shall be a full-time office-based program
 21.4 administrative assistant position assigned to solely work with the ACT team, providing a
 21.5 range of supports to the team, clients, and families; and

21.6 (8) additional staff:

21.7 (i) shall be based on team size. Additional treatment team staff may include licensed
 21.8 mental health professionals as defined in Minnesota Rules, part 9505.0371, subpart 5, item
 21.9 A; mental health practitioners as defined in Minnesota Rules, part 9505.0370, subpart 17;
 21.10 or mental health rehabilitation workers as defined in section 256B.0623, subdivision 5,
 21.11 clause (4). These individuals shall have the knowledge, skills, and abilities required by the
 21.12 population served to carry out rehabilitation and support functions; and

21.13 (ii) shall be selected based on specific program needs or the population served.

21.14 (b) Each ACT team must clearly document schedules for all ACT team members.

21.15 (c) Each ACT team member must serve as a primary team member for clients
 21.16 assigned by the team leader and are responsible for facilitating the individual treatment
 21.17 plan process for those clients. The primary team member for a client is the responsible
 21.18 team member knowledgeable about the client's life and circumstances and writes the
 21.19 individualized treatment plan. The primary team member provides individual supportive
 21.20 therapy or counseling, and provides primary support and education to the client's family
 21.21 and support system.

21.22 (d) Members of the ACT team must have strong clinical skills, professional
 21.23 qualifications, experience, and competency to provide a full breadth of rehabilitation
 21.24 services. Each staff member shall be proficient in their respective discipline and be able
 21.25 to work collaboratively as a member of a multidisciplinary team to deliver the majority
 21.26 of the treatment, rehabilitation, and support services clients require to fully benefit from
 21.27 receiving assertive community treatment.

21.28 (e) Each ACT team member must fulfill training requirements established by the
 21.29 commissioner.

21.30 Subd. 7c. **Assertive community treatment program size and opportunities.** (a)
 21.31 Each ACT team shall maintain an annual average caseload that does not exceed 100
 21.32 clients. Staff-to-client ratios shall be based on team size as follows:

21.33 (1) a small ACT team must:

21.34 (i) employ at least six but no more than seven full-time treatment team staff,
 21.35 excluding the program assistant and the psychiatric care provider;

21.36 (ii) serve an annual average maximum of no more than 50 clients;

- 22.1 (iii) ensure at least one full-time equivalent position for every eight clients served;
22.2 (iv) schedule ACT team staff for at least eight-hour shift coverage on weekdays and
22.3 on-call duty to provide crisis services and deliver services after hours when staff are not
22.4 working;
22.5 (v) provide crisis services during business hours if the small ACT team does not
22.6 have sufficient staff numbers to operate an after-hours on-call system. During all other
22.7 hours, the ACT team may arrange for coverage for crisis assessment and intervention
22.8 services through a reliable crisis-intervention provider as long as there is a mechanism by
22.9 which the ACT team communicates routinely with the crisis-intervention provider and
22.10 the on-call ACT team staff are available to see clients face-to-face when necessary or if
22.11 requested by the crisis-intervention services provider;
22.12 (vi) adjust schedules and provide staff to carry out the needed service activities in
22.13 the evenings or on weekend days or holidays, when necessary;
22.14 (vii) arrange for and provide psychiatric backup during all hours the psychiatric care
22.15 provider is not regularly scheduled to work. If availability of the ACT team's psychiatric
22.16 care provider during all hours is not feasible, alternative psychiatric prescriber backup
22.17 must be arranged and a mechanism of timely communication and coordination established
22.18 in writing;
22.19 (viii) be composed of, at minimum, one full-time team leader, at least 16 hours
22.20 each week per 50 clients of psychiatric provider time, or equivalent if fewer clients, one
22.21 full-time equivalent nursing, one full-time substance abuse specialist, one full-time
22.22 equivalent mental health certified peer specialist, one full-time vocational specialist, one
22.23 full-time program assistant, and at least one additional full-time ACT team member who
22.24 has mental health professional or practitioner status; and
22.25 (2) a midsize ACT team shall:
22.26 (i) be composed of, at minimum, one full-time team leader, at least 16 hours of
22.27 psychiatry time for 51 clients, with an additional two hours for every six clients added
22.28 to the team, 1.5 to two full-time equivalent nursing staff, one full-time substance abuse
22.29 specialist, one full-time equivalent mental health certified peer specialist, one full-time
22.30 vocational specialist, one full-time program assistant, and at least 1.5 to two additional
22.31 full-time equivalent ACT members, with at least one dedicated full-time staff member
22.32 with mental health professional status. Remaining team members may have mental health
22.33 professional or practitioner status;
22.34 (ii) employ seven or more treatment team full-time equivalents, excluding the
22.35 program assistant and the psychiatric care provider;
22.36 (iii) serve an annual average maximum caseload of 51 to 74 clients;

- 23.1 (iv) ensure at least one full-time equivalent position for every nine clients served;
 23.2 (v) schedule ACT team staff for a minimum of ten-hour shift coverage on weekdays
 23.3 and six- to eight-hour shift coverage on weekends and holidays. In addition to these
 23.4 minimum specifications, staff are regularly scheduled to provide the necessary services on
 23.5 a client-by-client basis in the evenings and on weekends and holidays;
 23.6 (vi) schedule ACT team staff on-call duty to provide crisis services and deliver
 23.7 services when staff are not working;
 23.8 (vii) have the authority to arrange for coverage for crisis assessment and intervention
 23.9 services through a reliable crisis-intervention provider as long as there is a mechanism by
 23.10 which the ACT team communicates routinely with the crisis-intervention provider and
 23.11 the on-call ACT team staff are available to see clients face-to-face when necessary or if
 23.12 requested by the crisis-intervention services provider; and
 23.13 (viii) arrange for and provide psychiatric backup during all hours the psychiatric care
 23.14 provider is not regularly scheduled to work. If availability of the psychiatric care provider
 23.15 during all hours is not feasible, alternative psychiatric prescriber backup must be arranged
 23.16 and a mechanism of timely communication and coordination established in writing;
 23.17 (3) a large ACT team must:
 23.18 (i) be composed of, at minimum, one full-time team leader, at least 32 hours
 23.19 each week per 100 clients, or equivalent of psychiatry time, three full-time equivalent
 23.20 nursing staff, one full-time substance abuse specialist, one full-time equivalent mental
 23.21 health certified peer specialist, one full-time vocational specialist, one full-time program
 23.22 assistant, and at least two additional full-time equivalent ACT team members, with at least
 23.23 one dedicated full-time staff member with mental health professional status. Remaining
 23.24 team members may have mental health professional or mental health practitioner status;
 23.25 (ii) employ nine or more treatment team full-time equivalents, excluding the
 23.26 program assistant and psychiatric care provider;
 23.27 (iii) serve an annual average maximum caseload of 75 to 100 clients;
 23.28 (iv) ensure at least one full-time equivalent position for every nine individuals served;
 23.29 (v) schedule staff to work two eight-hour shifts, with a minimum of two staff on the
 23.30 second shift providing services at least 12 hours per day weekdays. For weekends and
 23.31 holidays, the team must operate and schedule ACT team staff to work one eight-hour shift,
 23.32 with a minimum of two staff each weekend day and every holiday;
 23.33 (vi) schedule ACT team staff on-call duty to provide crisis services and deliver
 23.34 services when staff are not working; and
 23.35 (vii) arrange for and provide psychiatric backup during all hours the psychiatric care
 23.36 provider is not regularly scheduled to work. If availability of the ACT team psychiatric care

24.1 provider during all hours is not feasible, alternative psychiatric backup must be arranged
24.2 and a mechanism of timely communication and coordination established in writing.

24.3 (b) An ACT team of any size may have a staff-to-client ratio that is lower than the
24.4 requirements described in paragraph (a) upon approval by the commissioner, but may not
24.5 exceed a one-to-ten staff-to-client ratio.

24.6 Subd. 7d. **Assertive community treatment program organization and**
24.7 **communication requirements.** (a) An ACT team shall provide at least 75 percent of all
24.8 services in the community in nonoffice- or nonfacility-based settings.

24.9 (b) ACT team members must know all clients receiving services, and interventions
24.10 must be carried out with consistency and follow empirically supported practice.

24.11 (c) Each ACT team client shall be assigned an individual treatment team that is
24.12 determined by a variety of factors, including team members' expertise and skills, rapport,
24.13 and other factors specific to the individual's preferences. The majority of clients shall see
24.14 at least three ACT team members in a given month.

24.15 (d) The ACT team shall have the capacity to rapidly increase service intensity to a
24.16 client when the client's status requires it, regardless of geography, provide flexible service
24.17 in an individualized manner, and see clients on average three times per week for at least
24.18 120 minutes per week. Services must be available at times that meet client needs.

24.19 (e) ACT teams shall make deliberate efforts to assertively engage clients in services.
24.20 Input of family members, natural supports, and previous and subsequent treatment
24.21 providers is required in developing engagement strategies. ACT teams shall include the
24.22 client, identified family, and other support persons in the admission, initial assessment, and
24.23 planning process as primary stakeholders, meet with the client in the client's environment
24.24 at times of the day and week that honor the client's preferences, and meet clients at home
24.25 and in jails or prisons, streets, homeless shelters, or hospitals.

24.26 (f) ACT teams shall ensure that a process is in place for identifying individuals in
24.27 need of more or less assertive engagement. Interventions are monitored to determine the
24.28 success of these techniques and the need to adapt the techniques or approach accordingly.

24.29 (g) ACT teams shall conduct daily team meetings to systematically update clinically
24.30 relevant information, briefly discuss the status of assertive community treatment clients
24.31 over the past 24 hours, problem solve emerging issues, plan approaches to address and
24.32 prevent crises, and plan the service contacts for the following 24-hour period or weekend.
24.33 All team members scheduled to work shall attend this meeting.

24.34 (h) ACT teams shall maintain a clinical log that succinctly documents important
24.35 clinical information and develop a daily team schedule for the day's contacts based
24.36 on a central file of the clients' weekly or monthly schedules, which are derived from

25.1 interventions specified within the individual treatment plan. The team leader must have a
25.2 record to ensure that all assigned contacts are completed.

25.3 Subd. 7e. **Assertive community treatment assessment and individual treatment**
25.4 **plan.** (a) An initial assessment, including a diagnostic assessment that meets the
25.5 requirements of Minnesota Rules, part 9505.0372, subpart 1, and a 30-day treatment plan
25.6 shall be completed the day of the client's admission to assertive community treatment by
25.7 the ACT team leader or the psychiatric care provider, with participation by designated
25.8 ACT team members and the client. The team leader, psychiatric care provider, or other
25.9 mental health professional designated by the team leader or psychiatric care provider, must
25.10 update the client's diagnostic assessment at least annually.

25.11 (b) An initial functional assessment must be completed within ten days of intake
25.12 and updated every six months for assertive community treatment, or prior to discharge
25.13 from the service, whichever comes first.

25.14 (c) Within 30 days of the client's assertive community treatment admission, the
25.15 ACT team shall complete an in-depth assessment of the domains listed under section
25.16 245.462, subdivision 11a.

25.17 (d) Each part of the in-depth assessment areas shall be completed by each respective
25.18 team specialist or an ACT team member with skill and knowledge in the area being
25.19 assessed. The assessments are based upon all available information, including that from
25.20 client interview family and identified natural supports, and written summaries from other
25.21 agencies, including police, courts, county social service agencies, outpatient facilities,
25.22 and inpatient facilities, where applicable.

25.23 (e) Between 30 and 45 days after the client's admission to assertive community
25.24 treatment, the entire ACT team must hold a comprehensive case conference, where
25.25 all team members, including the psychiatric provider, present information discovered
25.26 from the completed in-depth assessments and provide treatment recommendations. The
25.27 conference must serve as the basis for the first six-month treatment plan, which must
25.28 be written by the primary team member.

25.29 (f) The client's psychiatric care provider, primary team member, and individual
25.30 treatment team members shall assume responsibility for preparing the written narrative
25.31 of the results from the psychiatric and social functioning history timeline and the
25.32 comprehensive assessment.

25.33 (g) The primary team member and individual treatment team members shall be
25.34 assigned by the team leader in collaboration with the psychiatric care provider by the time
25.35 of the first treatment planning meeting or 30 days after admission, whichever occurs first.

26.1 (h) Individual treatment plans must be developed through the following treatment
26.2 planning process:

26.3 (1) The individual treatment plan shall be developed in collaboration with the client
26.4 and the client's preferred natural supports, and guardian, if applicable and appropriate.
26.5 The ACT team shall evaluate, together with each client, the client's needs, strengths,
26.6 and preferences and develop the individual treatment plan collaboratively. The ACT
26.7 team shall make every effort to ensure that the client and the client's family and natural
26.8 supports, with the client's consent, are in attendance at the treatment planning meeting,
26.9 are involved in ongoing meetings related to treatment, and have the necessary supports to
26.10 fully participate. The client's participation in the development of the individual treatment
26.11 plan shall be documented.

26.12 (2) The client and the ACT team shall work together to formulate and prioritize
26.13 the issues, set goals, research approaches and interventions, and establish the plan. The
26.14 plan is individually tailored so that the treatment, rehabilitation, and support approaches
26.15 and interventions achieve optimum symptom reduction, help fulfill the personal needs
26.16 and aspirations of the client, take into account the cultural beliefs and realities of the
26.17 individual, and improve all the aspects of psychosocial functioning that are important to
26.18 the client. The process supports strengths, rehabilitation, and recovery.

26.19 (3) Each client's individual treatment plan shall identify service needs, strengths and
26.20 capacities, and barriers, and set specific and measurable short- and long-term goals for
26.21 each service need. The individual treatment plan must clearly specify the approaches
26.22 and interventions necessary for the client to achieve the individual goals, when the
26.23 interventions shall happen, and identify which ACT team member shall carry out the
26.24 approaches and interventions.

26.25 (4) The primary team member and the individual treatment team, together with the
26.26 client and the client's family and natural supports with the client's consent, are responsible
26.27 for reviewing and rewriting the treatment goals and individual treatment plan whenever
26.28 there is a major decision point in the client's course of treatment or at least every six months.

26.29 (5) The primary team member shall prepare a summary that thoroughly describes
26.30 in writing the client's and the individual treatment team's evaluation of the client's
26.31 progress and goal attainment, the effectiveness of the interventions, and the satisfaction
26.32 with services since the last individual treatment plan. The client's most recent diagnostic
26.33 assessment must be included with the treatment plan summary.

26.34 (6) The individual treatment plan and review must be signed or acknowledged by
26.35 the client, the primary team member, individual treatment team members, the team leader,

27.1 the psychiatric care provider, and all individual treatment team members. A copy of the
 27.2 signed individual treatment plan is made available to the client.

27.3 Subd. 7f. **ACT team variances.** The commissioner may grant a variance to specific
 27.4 requirements under subdivision 2a, 7b, 7c, or 7d for an ACT team when the ACT team
 27.5 demonstrates an inability to meet the specific requirement and how the team shall ensure
 27.6 the variance shall not negatively impact outcomes for clients. The commissioner may
 27.7 require a plan of action for the ACT team to come into compliance with the specific
 27.8 requirement being varied and establish specific time limits for the variance. A decision to
 27.9 grant or deny a variance request is final and not subject to appeal.

27.10 Subd. 8. **Medical assistance payment for intensive rehabilitative mental health**
 27.11 **services assertive community treatment and intensive residential treatment services.**

27.12 (a) Payment for intensive residential treatment services and assertive community treatment
 27.13 in this section shall be based on one daily rate per provider inclusive of the following
 27.14 services received by an eligible ~~recipient~~ client in a given calendar day: all rehabilitative
 27.15 services under this section, staff travel time to provide rehabilitative services under this
 27.16 section, and nonresidential crisis stabilization services under section 256B.0624.

27.17 (b) Except as indicated in paragraph (c), payment will not be made to more than one
 27.18 entity for each ~~recipient~~ client for services provided under this section on a given day. If
 27.19 services under this section are provided by a team that includes staff from more than one
 27.20 entity, the team must determine how to distribute the payment among the members.

27.21 (c) The commissioner shall determine one rate for each provider that will bill
 27.22 medical assistance for residential services under this section and one rate for each
 27.23 assertive community treatment provider. If a single entity provides both services, one
 27.24 rate is established for the entity's residential services and another rate for the entity's
 27.25 nonresidential services under this section. A provider is not eligible for payment under this
 27.26 section without authorization from the commissioner. The commissioner shall develop
 27.27 rates using the following criteria:

27.28 (1) the provider's cost for services shall include direct services costs, other program
 27.29 costs, and other costs determined as follows:

27.30 (i) the direct services costs must be determined using actual costs of salaries, benefits,
 27.31 payroll taxes, and training of direct service staff and service-related transportation;

27.32 (ii) other program costs not included in item (i) must be determined as a specified
 27.33 percentage of the direct services costs as determined by item (i). The percentage used shall
 27.34 be determined by the commissioner based upon the average of percentages that represent
 27.35 the relationship of other program costs to direct services costs among the entities that
 27.36 provide similar services;

28.1 (iii) physical plant costs calculated based on the percentage of space within the
28.2 program that is entirely devoted to treatment and programming. This does not include
28.3 administrative or residential space;

28.4 (iv) assertive community treatment physical plant costs must be reimbursed as
28.5 part of the costs described in item (ii); and

28.6 (v) subject to federal approval, up to an additional five percent of the total rate
28.7 may be added to the program rate as a quality incentive based upon the entity meeting
28.8 performance criteria specified by the commissioner;

28.9 (2) actual cost is defined as costs which are allowable, allocable, and reasonable, and
28.10 consistent with federal reimbursement requirements under Code of Federal Regulations,
28.11 title 48, chapter 1, part 31, relating to for-profit entities, and Office of Management and
28.12 Budget Circular Number A-122, relating to nonprofit entities;

28.13 (3) the number of service units;

28.14 (4) the degree to which ~~recipients~~ clients will receive services other than services
28.15 under this section; and

28.16 (5) the costs of other services that will be separately reimbursed.

28.17 (d) The rate for intensive residential treatment services and assertive community
28.18 treatment must exclude room and board, as defined in section 256I.03, subdivision 6, and
28.19 services not covered under this section, such as partial hospitalization, home care, and
28.20 inpatient services.

28.21 (e) Physician services that are not separately billed may be included in the rate to the
28.22 extent that a psychiatrist, or other health care professional providing physician services
28.23 within their scope of practice, is a member of the intensive residential treatment services
28.24 treatment team. Physician services, whether billed separately or included in the rate,
28.25 may be delivered by telemedicine. For purposes of this paragraph, "telemedicine" has
28.26 the meaning given to "mental health telemedicine" in section 256B.0625, subdivision 46,
28.27 when telemedicine is used to provide intensive residential treatment services.

28.28 (f) When services under this section are provided by an assertive community
28.29 treatment provider, case management functions must be an integral part of the team.

28.30 (g) The rate for a provider must not exceed the rate charged by that provider for
28.31 the same service to other payors.

28.32 (h) The rates for existing programs must be established prospectively based upon the
28.33 expenditures and utilization over a prior 12-month period using the criteria established
28.34 in paragraph (c). The rates for new programs must be established based upon estimated
28.35 expenditures and estimated utilization using the criteria established in paragraph (c).

29.1 (i) Entities who discontinue providing services must be subject to a settle-up process
 29.2 whereby actual costs and reimbursement for the previous 12 months are compared. In
 29.3 the event that the entity was paid more than the entity's actual costs plus any applicable
 29.4 performance-related funding due the provider, the excess payment must be reimbursed
 29.5 to the department. If a provider's revenue is less than actual allowed costs due to lower
 29.6 utilization than projected, the commissioner may reimburse the provider to recover
 29.7 its actual allowable costs. The resulting adjustments by the commissioner must be
 29.8 proportional to the percent of total units of service reimbursed by the commissioner and
 29.9 must reflect a difference of greater than five percent.

29.10 (j) A provider may request of the commissioner a review of any rate-setting decision
 29.11 made under this subdivision.

29.12 Subd. 9. **Provider enrollment; rate setting for county-operated entities.** Counties
 29.13 that employ their own staff to provide services under this section shall apply directly to the
 29.14 commissioner for enrollment and rate setting. In this case, a county contract is not required.

29.15 Subd. 10. **Provider enrollment; rate setting for specialized program.** A county
 29.16 contract is not required for a provider proposing to serve a subpopulation of eligible
 29.17 ~~recipients~~ clients under the following circumstances:

29.18 (1) the provider demonstrates that the subpopulation to be served requires a
 29.19 specialized program which is not available from county-approved entities; and

29.20 (2) the subpopulation to be served is of such a low incidence that it is not feasible to
 29.21 develop a program serving a single county or regional group of counties.

29.22 Subd. 11. **Sustainability grants.** The commissioner may disburse grant funds
 29.23 directly to intensive residential treatment services providers and assertive community
 29.24 treatment providers to maintain access to these services.

29.25 **EFFECTIVE DATE.** This section is effective July 1, 2016, for ACT teams certified
 29.26 after January 1, 2016. For ACT teams certified before January 1, 2016, this section is
 29.27 effective January 1, 2017.

29.28 Sec. 2. Minnesota Statutes 2014, section 256B.0947, subdivision 2, is amended to read:

29.29 Subd. 2. **Definitions.** For purposes of this section, the following terms have the
 29.30 meanings given them.

29.31 (a) "Intensive nonresidential rehabilitative mental health services" means child
 29.32 rehabilitative mental health services as defined in section 256B.0943, except that these
 29.33 services are provided by a multidisciplinary staff using a total team approach consistent
 29.34 with assertive community treatment, as adapted for youth, and are directed to recipients
 29.35 ages ~~16 to 21~~, 17, 18, 19, or 20 with a serious mental illness or co-occurring mental illness

30.1 and substance abuse addiction who require intensive services to prevent admission to an
30.2 inpatient psychiatric hospital or placement in a residential treatment facility or who require
30.3 intensive services to step down from inpatient or residential care to community-based care.

30.4 (b) "Co-occurring mental illness and substance abuse addiction" means a dual
30.5 diagnosis of at least one form of mental illness and at least one substance use disorder.
30.6 Substance use disorders include alcohol or drug abuse or dependence, excluding nicotine
30.7 use.

30.8 (c) "Diagnostic assessment" has the meaning given to it in Minnesota Rules, part
30.9 9505.0370, subpart 11. A diagnostic assessment must be provided according to Minnesota
30.10 Rules, part 9505.0372, subpart 1, and for this section must incorporate a determination of
30.11 the youth's necessary level of care using a standardized functional assessment instrument
30.12 approved and periodically updated by the commissioner.

30.13 (d) "Education specialist" means an individual with knowledge and experience
30.14 working with youth regarding special education requirements and goals, special education
30.15 plans, and coordination of educational activities with health care activities.

30.16 (e) "Housing access support" means an ancillary activity to help an individual find,
30.17 obtain, retain, and move to safe and adequate housing. Housing access support does not
30.18 provide monetary assistance for rent, damage deposits, or application fees.

30.19 (f) "Integrated dual disorders treatment" means the integrated treatment of
30.20 co-occurring mental illness and substance use disorders by a team of cross-trained
30.21 clinicians within the same program, and is characterized by assertive outreach, stage-wise
30.22 comprehensive treatment, treatment goal setting, and flexibility to work within each
30.23 stage of treatment.

30.24 (g) "Medication education services" means services provided individually or in
30.25 groups, which focus on:

30.26 (1) educating the client and client's family or significant nonfamilial supporters
30.27 about mental illness and symptoms;

30.28 (2) the role and effects of medications in treating symptoms of mental illness; and

30.29 (3) the side effects of medications.

30.30 Medication education is coordinated with medication management services and does not
30.31 duplicate it. Medication education services are provided by physicians, pharmacists, or
30.32 registered nurses with certification in psychiatric and mental health care.

30.33 (h) "Peer specialist" means an employed team member who is a mental health
30.34 certified peer specialist according to section 256B.0615 and also a former children's
30.35 mental health consumer who:

31.1 (1) provides direct services to clients including social, emotional, and instrumental
31.2 support and outreach;

31.3 (2) assists younger peers to identify and achieve specific life goals;

31.4 (3) works directly with clients to promote the client's self-determination, personal
31.5 responsibility, and empowerment;

31.6 (4) assists youth with mental illness to regain control over their lives and their
31.7 developmental process in order to move effectively into adulthood;

31.8 (5) provides training and education to other team members, consumer advocacy
31.9 organizations, and clients on resiliency and peer support; and

31.10 (6) meets the following criteria:

31.11 (i) is at least 22 years of age;

31.12 (ii) has had a diagnosis of mental illness, as defined in Minnesota Rules, part
31.13 9505.0370, subpart 20, or co-occurring mental illness and substance abuse addiction;

31.14 (iii) is a former consumer of child and adolescent mental health services, or a former
31.15 or current consumer of adult mental health services for a period of at least two years;

31.16 (iv) has at least a high school diploma or equivalent;

31.17 (v) has successfully completed training requirements determined and periodically
31.18 updated by the commissioner;

31.19 (vi) is willing to disclose the individual's own mental health history to team members
31.20 and clients; and

31.21 (vii) must be free of substance use problems for at least one year.

31.22 (i) "Provider agency" means a for-profit or nonprofit organization established to
31.23 administer an assertive community treatment for youth team.

31.24 (j) "Substance use disorders" means one or more of the disorders defined in the
31.25 diagnostic and statistical manual of mental disorders, current edition.

31.26 (k) "Transition services" means:

31.27 (1) activities, materials, consultation, and coordination that ensures continuity of
31.28 the client's care in advance of and in preparation for the client's move from one stage of
31.29 care or life to another by maintaining contact with the client and assisting the client to
31.30 establish provider relationships;

31.31 (2) providing the client with knowledge and skills needed posttransition;

31.32 (3) establishing communication between sending and receiving entities;

31.33 (4) supporting a client's request for service authorization and enrollment; and

31.34 (5) establishing and enforcing procedures and schedules.

31.35 A youth's transition from the children's mental health system and services to
31.36 the adult mental health system and services and return to the client's home and entry

32.1 or re-entry into community-based mental health services following discharge from an
 32.2 out-of-home placement or inpatient hospital stay.

32.3 (1) "Treatment team" means all staff who provide services to recipients under this
 32.4 section.

32.5 **EFFECTIVE DATE.** This section is effective the day following final enactment.

32.6 Sec. 3. **SUBSTANCE USE DISORDER SYSTEM REFORM.**

32.7 **Subdivision 1. Authorization of substance use disorder treatment system reform.**

32.8 The commissioner shall design a reform of Minnesota's substance use disorder treatment
 32.9 system to ensure a full continuum of care for individuals with substance use disorders.

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

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

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

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

32.17 (4) build aftercare and recovery support services;

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

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

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

32.24 **Subd. 3. Reform proposal.** (a) The commissioner shall develop a reform proposal
 32.25 that includes both systemic and practice reforms to develop a robust continuum of care
 32.26 to effectively treat the physical, behavioral, and mental dimensions of substance use
 32.27 disorders. The reform proposal shall include, but is not limited to:

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

32.30 (2) mechanisms for direct reimbursement of credentialed professionals;

32.31 (3) care coordination models to connect individuals with substance use disorder
 32.32 to appropriate providers;

32.33 (4) peer support services for people in recovery from substance use disorders;

32.34 (5) implementation of withdrawal management services pursuant to Minnesota
 32.35 Statutes, section 245F.21;

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

33.3 (7) development or modification of services to meet the needs of youth and
 33.4 adolescents and increase student access to substance use disorder services in educational
 33.5 settings;

33.6 (8) development of other new services and supports that are responsive to the
 33.7 chronic nature of substance use disorders; and

33.8 (9) available options to allow for exceptions to the federal Institution for Mental
 33.9 Disease (IMD) exclusion for medically necessary, rehabilitative, substance use disorder
 33.10 treatment provided in the most integrated and least restrictive setting.

33.11 (b) The commissioner shall seek all federal authority necessary to implement the
 33.12 proposal.

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

33.15 Subd. 4. **Legislative update.** By February 1, 2017, the commissioner shall present
 33.16 an update on the progress of the proposal to members of the legislative committees of the
 33.17 house of representatives and senate with jurisdiction over health and human services
 33.18 policy and finance on the progress of the proposal and shall make recommendations on
 33.19 legislative changes and state appropriations necessary to implement the proposal.

33.20 Subd. 5. **Stakeholder input.** In developing the proposal, the commissioner shall
 33.21 consult with stakeholders, including consumers, providers, counties, tribes, and health
 33.22 plans.

33.23 **ARTICLE 3**

33.24 **MISCELLANEOUS**

33.25 Section 1. Minnesota Statutes 2014, section 245A.11, subdivision 2a, is amended to
 33.26 read:

33.27 Subd. 2a. **Adult foster care and community residential setting license capacity.**

33.28 (a) The commissioner shall issue adult foster care and community residential setting
 33.29 licenses with a maximum licensed capacity of four beds, including nonstaff roomers and
 33.30 boarders, except that the commissioner may issue a license with a capacity of five beds,
 33.31 including roomers and boarders, according to paragraphs (b) to (f).

33.32 (b) The license holder may have a maximum license capacity of five if all persons
 33.33 in care are age 55 or over and do not have a serious and persistent mental illness or a
 33.34 developmental disability.

34.1 (c) The commissioner may grant variances to paragraph (b) to allow a facility with a
34.2 licensed capacity of up to five persons to admit an individual under the age of 55 if the
34.3 variance complies with section 245A.04, subdivision 9, and approval of the variance is
34.4 recommended by the county in which the licensed facility is located.

34.5 (d) The commissioner may grant variances to paragraph (b) to allow the use of
34.6 ~~a fifth~~ an additional bed, up to five, for emergency crisis services for a person with
34.7 serious and persistent mental illness or a developmental disability, regardless of age, if the
34.8 variance complies with section 245A.04, subdivision 9, and approval of the variance is
34.9 recommended by the county in which the licensed facility is located.

34.10 (e) The commissioner may grant a variance to paragraph (b) to allow for the use of
34.11 ~~a fifth~~ an additional bed, up to five, for respite services, as defined in section 245A.02,
34.12 for persons with disabilities, regardless of age, if the variance complies with sections
34.13 245A.03, subdivision 7, and 245A.04, subdivision 9, and approval of the variance is
34.14 recommended by the county in which the licensed facility is located. Respite care may be
34.15 provided under the following conditions:

34.16 (1) staffing ratios cannot be reduced below the approved level for the individuals
34.17 being served in the home on a permanent basis;

34.18 (2) no more than two different individuals can be accepted for respite services in
34.19 any calendar month and the total respite days may not exceed 120 days per program in
34.20 any calendar year;

34.21 (3) the person receiving respite services must have his or her own bedroom, which
34.22 could be used for alternative purposes when not used as a respite bedroom, and cannot be
34.23 the room of another person who lives in the facility; and

34.24 (4) individuals living in the facility must be notified when the variance is approved.
34.25 The provider must give 60 days' notice in writing to the residents and their legal
34.26 representatives prior to accepting the first respite placement. Notice must be given to
34.27 residents at least two days prior to service initiation, or as soon as the license holder is
34.28 able if they receive notice of the need for respite less than two days prior to initiation,
34.29 each time a respite client will be served, unless the requirement for this notice is waived
34.30 by the resident or legal guardian.

34.31 (f) The commissioner may issue an adult foster care or community residential setting
34.32 license with a capacity of five adults if the fifth bed does not increase the overall statewide
34.33 capacity of licensed adult foster care or community residential setting beds in homes that
34.34 are not the primary residence of the license holder, as identified in a plan submitted to the
34.35 commissioner by the county, when the capacity is recommended by the county licensing
34.36 agency of the county in which the facility is located and if the recommendation verifies that:

35.1 (1) the facility meets the physical environment requirements in the adult foster
35.2 care licensing rule;

35.3 (2) the five-bed living arrangement is specified for each resident in the resident's:

35.4 (i) individualized plan of care;

35.5 (ii) individual service plan under section 256B.092, subdivision 1b, if required; or

35.6 (iii) individual resident placement agreement under Minnesota Rules, part
35.7 9555.5105, subpart 19, if required;

35.8 (3) the license holder obtains written and signed informed consent from each
35.9 resident or resident's legal representative documenting the resident's informed choice
35.10 to remain living in the home and that the resident's refusal to consent would not have
35.11 resulted in service termination; and

35.12 (4) the facility was licensed for adult foster care before March 1, 2011.

35.13 (g) The commissioner shall not issue a new adult foster care license under paragraph
35.14 (f) after June 30, 2016. The commissioner shall allow a facility with an adult foster care
35.15 license issued under paragraph (f) before June 30, 2016, to continue with a capacity of five
35.16 adults if the license holder continues to comply with the requirements in paragraph (f).

35.17 **EFFECTIVE DATE.** This section is effective the day following final enactment.

35.18 Sec. 2. Minnesota Statutes 2015 Supplement, section 256.01, subdivision 12a, is
35.19 amended to read:

35.20 Subd. 12a. **Department of Human Services child fatality and near fatality**
35.21 **review team.** (a) The commissioner shall establish a Department of Human Services
35.22 child fatality and near fatality review team to review child fatalities and near fatalities
35.23 due to child maltreatment and child fatalities and near fatalities that occur in licensed
35.24 facilities and are not due to natural causes. The review team shall assess the entire child
35.25 protection services process from the point of a mandated reporter reporting the alleged
35.26 maltreatment through the ongoing case management process. Department staff shall lead
35.27 and conduct on-site local reviews and utilize supervisors from local county and tribal child
35.28 welfare agencies as peer reviewers. The review process must focus on critical elements of
35.29 the case and on the involvement of the child and family with the county or tribal child
35.30 welfare agency. The review team shall identify necessary program improvement planning
35.31 to address any practice issues identified and training and technical assistance needs of
35.32 the local agency. Summary reports of each review shall be provided to the state child
35.33 mortality review panel when completed.

35.34 (b) A member of the child fatality and near fatality review team shall not disclose
35.35 what transpired during the review, except to carry out the purposes of the child fatality

36.1 and near fatality review team. The proceedings and records of the child fatality and near
 36.2 fatality review team are protected nonpublic data as defined in section 13.02, subdivision
 36.3 13, and are not subject to discovery or introduction into evidence in a civil or criminal
 36.4 action against a professional, the state, or a county agency arising out of the matters the
 36.5 team is reviewing. Information, documents, and records otherwise available from other
 36.6 sources are not immune from discovery or use in a civil or criminal action solely because
 36.7 they were assessed or presented during proceedings of the review team. A person who
 36.8 presented information before the review team or who is a member of the team shall not
 36.9 be prevented from testifying about matters within the person's knowledge. In a civil or
 36.10 criminal proceeding a person shall not be questioned about the person's presentation of
 36.11 information to the review team or opinions formed by the person as a result of the review.

36.12 Sec. 3. Minnesota Statutes 2015 Supplement, section 256I.04, subdivision 2a, is
 36.13 amended to read:

36.14 Subd. 2a. **License required; staffing qualifications.** (a) Except as provided in
 36.15 paragraph (b), an agency may not enter into an agreement with an establishment to provide
 36.16 group residential housing unless:

36.17 (1) the establishment is licensed by the Department of Health as a hotel and restaurant;
 36.18 a board and lodging establishment; a boarding care home before March 1, 1985; or a
 36.19 supervised living facility, and the service provider for residents of the facility is licensed
 36.20 under chapter 245A. However, an establishment licensed by the Department of Health to
 36.21 provide lodging need not also be licensed to provide board if meals are being supplied to
 36.22 residents under a contract with a food vendor who is licensed by the Department of Health;

36.23 (2) the residence is: (i) licensed by the commissioner of human services under
 36.24 Minnesota Rules, parts 9555.5050 to 9555.6265; (ii) certified by a county human services
 36.25 agency prior to July 1, 1992, using the standards under Minnesota Rules, parts 9555.5050
 36.26 to 9555.6265; (iii) licensed by the commissioner under Minnesota Rules, parts 2960.0010
 36.27 to 2960.0120, with a variance under section 245A.04, subdivision 9; or (iv) licensed under
 36.28 section 245D.02, subdivision 4a, as a community residential setting by the commissioner
 36.29 of human services; or

36.30 (3) the establishment is registered under chapter 144D and provides three meals a day.

36.31 (b) The requirements under paragraph (a) do not apply to establishments exempt
 36.32 from state licensure because they are:

36.33 (1) located on Indian reservations and subject to tribal health and safety
 36.34 requirements; or

37.1 (2) a supportive housing establishment that has an approved habitability inspection
 37.2 and an individual lease agreement and that serves people who have experienced long-term
 37.3 homelessness and were referred through a coordinated assessment in section 256I.03,
 37.4 subdivision 15.

37.5 (c) Supportive housing establishments and emergency shelters must participate in
 37.6 the homeless management information system.

37.7 (d) Effective July 1, 2016, an agency shall not have an agreement with a provider
 37.8 of group residential housing or supplementary services unless all staff members who
 37.9 have direct contact with recipients:

37.10 (1) have skills and knowledge acquired through one or more of the following:

37.11 (i) a course of study in a health- or human services-related field leading to a bachelor
 37.12 of arts, bachelor of science, or associate's degree;

37.13 (ii) one year of experience with the target population served;

37.14 (iii) experience as a mental health certified peer specialist according to section
 37.15 256B.0615; or

37.16 (iv) meeting the requirements for unlicensed personnel under sections 144A.43
 37.17 to 144A.483;

37.18 (2) hold a current ~~Minnesota~~ driver's license appropriate to the vehicle driven
 37.19 if transporting recipients;

37.20 (3) complete training on vulnerable adults mandated reporting and child
 37.21 maltreatment mandated reporting, where applicable; and

37.22 (4) complete group residential housing orientation training offered by the
 37.23 commissioner.

37.24 **EFFECTIVE DATE.** This section is effective the day following final enactment.

37.25 Sec. 4. Minnesota Statutes 2015 Supplement, section 402A.18, subdivision 3, is
 37.26 amended to read:

37.27 Subd. 3. **Conditions prior to imposing remedies.** (a) The commissioner
 37.28 shall notify a county or service delivery authority that it must submit a performance
 37.29 improvement plan if:

37.30 (1) the county or service delivery authority does not meet the minimum performance
 37.31 threshold for a measure; or

37.32 (2) the county or service delivery authority ~~does not meet the minimum performance~~
 37.33 ~~threshold for one or more racial or ethnic subgroup for which there is a statistically valid~~
 37.34 ~~population size for three or more measures,~~ has a performance disparity, as recommended

38.1 by the council and determined by the commissioner, for a racial or ethnic subgroup, even
38.2 if the county or service delivery authority met the threshold for the overall population.

38.3 The commissioner must approve the performance improvement plan. The county or
38.4 service delivery authority may negotiate the terms of the performance improvement plan
38.5 with the commissioner.

38.6 (b) When the department determines that a county or service delivery authority does
38.7 not meet the minimum performance threshold for a given measure, the commissioner
38.8 must advise the county or service delivery authority that fiscal penalties may result if the
38.9 performance does not improve. The department must offer technical assistance to the
38.10 county or service delivery authority. Within 30 days of the initial advisement from the
38.11 department, the county or service delivery authority may claim and the department may
38.12 approve an extenuating circumstance that relieves the county or service delivery authority
38.13 of any further remedy. If a county or service delivery authority has a small number of
38.14 participants in an essential human services program such that reliable measurement is
38.15 not possible, the commissioner may approve extenuating circumstances ~~or may average~~
38.16 ~~performance over three years.~~

38.17 (c) If there are no extenuating circumstances, the county or service delivery authority
38.18 must submit a performance improvement plan to the commissioner within 60 days of the
38.19 initial advisement from the department. The term of the performance improvement plan
38.20 must be two years, starting with the date the plan is approved by the commissioner. This
38.21 plan must include a target level for improvement for each measure that did not meet the
38.22 minimum performance threshold. The commissioner must approve the performance
38.23 improvement plan within 60 days of submittal.

38.24 (d) The department must monitor the performance improvement plan for two
38.25 years. After two years, if the county or service delivery authority meets the minimum
38.26 performance threshold, there is no further remedy. If the county or service delivery
38.27 authority fails to meet the minimum performance threshold, but meets the improvement
38.28 target in the performance improvement plan, the county or service delivery authority shall
38.29 modify the performance improvement plan for further improvement and the department
38.30 shall continue to monitor the plan.

38.31 (e) If, after two years of monitoring, the county or service delivery authority fails to
38.32 meet both the minimum performance threshold and the improvement target identified in
38.33 the performance improvement plan, the next step of the remedies process shall be invoked
38.34 by the commissioner. This phase of the remedies process may include:

38.35 (1) fiscal penalties for the county or service delivery authority that do not exceed
38.36 one percent of the county's human services expenditures and that are negotiated in the

39.1 performance improvement plan, based on what is needed to improve outcomes. Counties
 39.2 or service delivery authorities must reinvest the amount of the fiscal penalty into the
 39.3 essential human services program that was underperforming. A county or service delivery
 39.4 authority shall not be required to pay more than three fiscal penalties in a year; and

39.5 (2) the department's provision of technical assistance to the county or service
 39.6 delivery authority that is targeted to address the specific performance issues.

39.7 The commissioner shall continue monitoring the performance improvement plan for a
 39.8 third year.

39.9 (f) If, after the third year of monitoring, the county or service delivery authority
 39.10 meets the minimum performance threshold, there is no further remedy. If the county or
 39.11 service delivery authority fails to meet the minimum performance threshold, but meets the
 39.12 improvement target for the performance improvement plan, the county or service delivery
 39.13 authority shall modify the performance improvement plan for further improvement and
 39.14 the department shall continue to monitor the plan.

39.15 (g) If, after the third year of monitoring, the county or service delivery authority fails
 39.16 to meet the minimum performance threshold and the improvement target identified in the
 39.17 performance improvement plan, the Human Services Performance Council shall review
 39.18 the situation and recommend a course of action to the commissioner.

39.19 (h) If the commissioner has determined that a program has a balanced set of program
 39.20 measures and a county or service delivery authority is subject to fiscal penalties for more
 39.21 than one-half of the measures for that program, the commissioner may apply further
 39.22 remedies as described in subdivisions 1 and 2.

39.23 **EFFECTIVE DATE.** This section is effective the day following final enactment.

39.24 Sec. 5. **ACTION PLAN TO INCREASE COMMUNITY INTEGRATION OF**
 39.25 **PEOPLE WITH DISABILITIES.**

39.26 The commissioners of human services, education, employment and economic
 39.27 development, and information technology shall develop a collaborative action plan in
 39.28 alignment with the state's Olmsted Plan to increase the community integration of people
 39.29 with disabilities, including housing, community living, and competitive employment.
 39.30 Priority must be given to actions that align policies and funding, streamline access to
 39.31 services, and increase efficiencies in interagency collaboration. Recommendations must
 39.32 include a proposed method to allow people with disabilities who access services from the
 39.33 state agencies identified in this section to access a unified record of the services they receive.
 39.34 This method must also allow people with disabilities to efficiently provide information to

40.1 multiple agencies regarding service choices and preferences. Recommendations must be
40.2 provided to the legislature by January 1, 2017, and include proposed statutory changes,
40.3 including any changes necessary to the data practices act to allow for data sharing, and
40.4 information technology solutions required to implement the actions.

40.5 **Sec. 6. HOUSING SUPPORT SERVICES.**

40.6 **Subdivision 1. Comprehensive housing support services.** The commissioner shall
40.7 design comprehensive housing services to support an individual's ability to obtain or
40.8 maintain stable housing.

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

40.11 (1) improve housing stability;

40.12 (2) increase opportunities for integrated community living;

40.13 (3) prevent and reduce homelessness

40.14 (4) increase overall health and well-being of people with housing instability; and

40.15 (5) reduce inefficient use of health care that may result from housing instability.

40.16 **Subd. 3. Housing support services benefit set proposal.** (a) The commissioner
40.17 shall develop a proposal for housing support services, including, but not limited to, the
40.18 following components:

40.19 (1) housing transition services that include, but are not limited to, tenant screening
40.20 and housing assessment; developing an individualized housing support plan; assisting with
40.21 housing search and application process; identifying resources to cover onetime moving
40.22 expenses; ensuring new living environment is safe and ready for move-in; assisting in
40.23 arranging for and supporting details of the move; developing a housing support crisis plan;
40.24 and payment for accessibility modifications to new housing; and

40.25 (2) housing and tenancy sustaining services that include, but are not limited to,
40.26 prevention and early identification of behaviors that may jeopardize continued housing;
40.27 training on the roles, rights, and responsibilities of tenant and landlord; coaching to
40.28 develop and maintain key relationships with landlords and property managers; advocacy
40.29 and linkage with community resources to prevent eviction when housing is at risk;
40.30 assistance with housing recertification processes; coordination with tenant to review;
40.31 update and modify housing support and crisis plan on a regular basis; and continuing
40.32 training on tenant responsibilities, lease compliance, or household management.

40.33 (b) The commissioner shall seek all federal authority and funding necessary to
40.34 implement the proposal.

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

41.3 Subd. 4. **Legislative update.** By February 1, 2017, the commissioner shall present
41.4 an update on the progress of the proposal to members of the legislative committees in the
41.5 house of representatives and senate with jurisdiction over health and human services
41.6 policy and finance on the progress of the proposal and shall make recommendations on
41.7 legislative changes and state appropriations necessary to implement the proposal.

41.8 Subd. 5. **Stakeholder input.** In developing the proposal, the commissioner shall
41.9 consult with stakeholders, including people who may utilize the service, advocates,
41.10 providers, counties, tribes, health plans, and landlords.

APPENDIX
Article locations in 16-4619

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