State of Minnesota

HOUSE OF REPRESENTATIVES

EIGHTY-NINTH SESSION

H. F. No. 3199

03/16/2016 Authored by Albright
The bill was read for the first time and referred to the Committee on Health and Human Services Reform

A bill for an act

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

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

ARTICLE 1

OMBUDSMAN FOR LONG-TERM CARE

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

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

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

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

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

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

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

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

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

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

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

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

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

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

256.9742 DUTIES AND POWERS OF THE OFFICE.

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

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

(2) mediate or advocate on behalf of clients;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(1) discharge or transfer from a facility;

(2) termination of service;

(3) restriction or prohibition of access to the facility or its residents;

(4) discharge from or termination of employment;

(5) demotion or reduction in remuneration for services; and

(6) any restriction of rights set forth in section 144.651, 144A.44, or 144A.751.

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

ARTICLE 2

CHEMICAL AND MENTAL HEALTH SERVICES

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

256B.0622 ~~INTENSIVE REHABILITATIVE MENTAL HEALTH SERVICES~~ ASSERTIVE COMMUNITY TREATMENT AND INTENSIVE RESIDENTIAL TREATMENT SERVICES.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(2) has a primary diagnosis of schizophrenia, schizoaffective disorder, major depressive disorder with psychotic features, other psychotic disorders, or bipolar disorder. Individuals with other psychiatric illnesses may qualify for assertive community treatment if they have a serious mental illness and meet the criteria outlined in clauses (3) and (4), but no more than ten percent of an ACT team's clients may be eligible based on this criteria. Individuals with a primary diagnosis of a substance use disorder, intellectual developmental disabilities, borderline personality disorder, antisocial personality disorder, traumatic brain injury, or an autism spectrum disorder are not eligible for assertive community treatment;

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

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

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

(iii) significant difficulty maintaining a safe living situation;

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

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

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

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

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

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

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

(vii) significant difficulty meeting basic survival needs;

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

(ix) significant impairment with social and interpersonal functioning such that basic needs are in jeopardy;

(x) coexisting mental health and physical health disorders lasting at least six months;

(xi) residing in an inpatient or supervised community residence but clinically assessed to be able to live in a more independent living situation if intensive services are provided;

(xii) requiring a residential placement if more intensive services are not available; or

(xiii) difficulty effectively using traditional office-based outpatient services;

(5) there are no indications that other available community-based services would be equally or more effective as evidenced by consistent and extensive efforts to treat the individual; and

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

Subd. 2b. **Continuing stay and discharge criteria for assertive community treatment.** (a) A client receiving assertive community treatment is eligible to continue receiving services if:

(1) the client has not achieved the desired outcomes of their individual treatment plan;

(2) the client's level of functioning has not been restored, improved, or sustained over the time frame outlined in the individual treatment plan;

(3) the client continues to be at risk for relapse based on current clinical assessment, history, or the tenuous nature of the functional gains; or

(4) the client is functioning effectively with this service and discharge would otherwise be indicated but without continued services the client's functioning would decline; and

(5) one of the following must also apply:

(i) the client has achieved current individual treatment plan goals but additional goals are indicated as evidenced by documented symptoms;

(ii) the client is making satisfactory progress toward meeting goals and there is documentation that supports that continuation of this service shall be effective in addressing the goals outlined in the individualized treatment plan;

(iii) the client is making progress, but the specific interventions in the individual treatment plan need to be modified so that greater gains, which are consistent with the client's potential level of functioning, are possible; or

(iv) the client fails to make progress or demonstrates regression in meeting goals through the interventions outlined in the individual treatment plan.

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

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

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

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

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

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

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

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

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

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

(1) is age 18 or older;

(2) is eligible for medical assistance;

(3) is diagnosed with a mental illness;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(8) submit information as required by the state;

(9) keep all necessary records required by law;

(10) comply with all applicable laws;

(11) be an enrolled Medicaid provider;

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

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

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

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

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

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

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

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

(2) not exceed 16 beds per site;

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

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

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

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

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

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

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

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

~~Subd. 6.~~ **~~Standards for intensive residential rehabilitative mental health services.~~** ~~(a) The provider of intensive residential services must have sufficient staff to provide 24-hour-per-day coverage to deliver the rehabilitative services described in the treatment plan and to safely supervise and direct the activities of recipients given the recipient's level of behavioral and psychiatric stability, cultural needs, and vulnerability. The provider must have the capacity within the facility to provide integrated services for chemical dependency, illness management services, and family education when appropriate.~~

~~(b) At a minimum:~~

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

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

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

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

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

Subd. 5a. **Standards for intensive residential rehabilitative mental health services.** (a) The standards in this subdivision apply to intensive residential mental health services.

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

(c) At a minimum:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(1) assertive engagement;

(2) benefits and finance support;

(3) co-occurring disorder treatment;

(4) crisis assessment and intervention;

(5) employment services;

(6) family psychoeducation and support;

(7) housing access support;

(8) medication assistance and support;

(9) medication education;

(10) mental health certified peer specialists services;

(11) physical health services;

(12) rehabilitative mental health services;

(13) symptom management;

(14) therapeutic interventions;

(15) wellness self-management and prevention; and

(16) other services based on client needs as identified in a client's assertive community treatment individual treatment plan.

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

Subd. 7b. **Assertive community treatment team staff requirements and roles.** (a) The required treatment staff qualifications and roles for an ACT team are:

(1) the team leader:

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

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

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

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

(2) the psychiatric care provider:

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

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

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

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

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

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

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

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

(3) the nursing staff:

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

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

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

(4) the co-occurring disorder specialist:

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

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

(5) the vocational specialist:

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

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

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

(6) the mental health certified peer specialist:

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

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

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

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

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

(8) additional staff:

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

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

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

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

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

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

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

(1) a small ACT team must:

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

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

(iii) ensure at least one full-time equivalent position for every eight clients served;

(iv) schedule ACT team staff for at least eight-hour shift coverage on weekdays and on-call duty to provide crisis services and deliver services after hours when staff are not working;

(v) provide crisis services during business hours if the small ACT team does not have sufficient staff numbers to operate an after-hours on-call system. During all other hours, the ACT team may arrange for coverage for crisis assessment and intervention services through a reliable crisis-intervention provider as long as there is a mechanism by which the ACT team communicates routinely with the crisis-intervention provider and the on-call ACT team staff are available to see clients face-to-face when necessary or if requested by the crisis-intervention services provider;

(vi) adjust schedules and provide staff to carry out the needed service activities in the evenings or on weekend days or holidays, when necessary;

(vii) arrange for and provide psychiatric backup during all hours the psychiatric care provider is not regularly scheduled to work. If availability of the ACT team's psychiatric care provider during all hours is not feasible, alternative psychiatric prescriber backup must be arranged and a mechanism of timely communication and coordination established in writing;

(viii) be composed of, at minimum, one full-time team leader, at least 16 hours each week per 50 clients of psychiatric provider time, or equivalent if fewer clients, one full-time equivalent nursing, one full-time substance abuse specialist, one full-time equivalent mental health certified peer specialist, one full-time vocational specialist, one full-time program assistant, and at least one additional full-time ACT team member who has mental health professional or practitioner status; and

(2) a midsize ACT team shall:

(i) be composed of, at minimum, one full-time team leader, at least 16 hours of psychiatry time for 51 clients, with an additional two hours for every six clients added to the team, 1.5 to two full-time equivalent nursing staff, one full-time substance abuse specialist, one full-time equivalent mental health certified peer specialist, one full-time vocational specialist, one full-time program assistant, and at least 1.5 to two additional full-time equivalent ACT members, with at least one dedicated full-time staff member with mental health professional status. Remaining team members may have mental health professional or practitioner status;

(ii) employ seven or more treatment team full-time equivalents, excluding the program assistant and the psychiatric care provider;

(iii) serve an annual average maximum caseload of 51 to 74 clients;

(iv) ensure at least one full-time equivalent position for every nine clients served;

(v) schedule ACT team staff for a minimum of ten-hour shift coverage on weekdays and six- to eight-hour shift coverage on weekends and holidays. In addition to these minimum specifications, staff are regularly scheduled to provide the necessary services on a client-by-client basis in the evenings and on weekends and holidays;

(vi) schedule ACT team staff on-call duty to provide crisis services and deliver services when staff are not working;

(vii) have the authority to arrange for coverage for crisis assessment and intervention services through a reliable crisis-intervention provider as long as there is a mechanism by which the ACT team communicates routinely with the crisis-intervention provider and the on-call ACT team staff are available to see clients face-to-face when necessary or if requested by the crisis-intervention services provider; and

(viii) arrange for and provide psychiatric backup during all hours the psychiatric care provider is not regularly scheduled to work. If availability of the psychiatric care provider during all hours is not feasible, alternative psychiatric prescriber backup must be arranged and a mechanism of timely communication and coordination established in writing;

(3) a large ACT team must:

(i) be composed of, at minimum, one full-time team leader, at least 32 hours each week per 100 clients, or equivalent of psychiatry time, three full-time equivalent nursing staff, one full-time substance abuse specialist, one full-time equivalent mental health certified peer specialist, one full-time vocational specialist, one full-time program assistant, and at least two additional full-time equivalent ACT team members, with at least one dedicated full-time staff member with mental health professional status. Remaining team members may have mental health professional or mental health practitioner status;

(ii) employ nine or more treatment team full-time equivalents, excluding the program assistant and psychiatric care provider;

(iii) serve an annual average maximum caseload of 75 to 100 clients;

(iv) ensure at least one full-time equivalent position for every nine individuals served;

(v) schedule staff to work two eight-hour shifts, with a minimum of two staff on the second shift providing services at least 12 hours per day weekdays. For weekends and holidays, the team must operate and schedule ACT team staff to work one eight-hour shift, with a minimum of two staff each weekend day and every holiday;

(vi) schedule ACT team staff on-call duty to provide crisis services and deliver services when staff are not working; and

(vii) arrange for and provide psychiatric backup during all hours the psychiatric care provider is not regularly scheduled to work. If availability of the ACT team psychiatric care

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Subd. 8. **Medical assistance payment for ~~intensive rehabilitative mental health services~~ assertive community treatment and intensive residential treatment services.** (a) Payment for intensive residential treatment services and assertive community treatment in this section shall be based on one daily rate per provider inclusive of the following services received by an eligible ~~recipient~~ client in a given calendar day: all rehabilitative services under this section, staff travel time to provide rehabilitative services under this section, and nonresidential crisis stabilization services under section 256B.0624.

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

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

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

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

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

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

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

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

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

(3) the number of service units;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(3) the side effects of medications.

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

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

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

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

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

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

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

(6) meets the following criteria:

(i) is at least 22 years of age;

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

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

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

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

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

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

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

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

(k) "Transition services" means:

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

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

(3) establishing communication between sending and receiving entities;

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

(5) establishing and enforcing procedures and schedules.

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

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

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

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

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

Subdivision 1. **Authorization of substance use disorder treatment system reform.** The commissioner shall design a reform of Minnesota's substance use disorder treatment system to ensure a full continuum of care for individuals with substance use disorders.

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

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

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

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

(4) build aftercare and recovery support services;

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

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

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

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

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

(2) mechanisms for direct reimbursement of credentialed professionals;

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

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

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

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

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

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

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

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

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

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

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

ARTICLE 3

MISCELLANEOUS

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

Subd. 2a. **Adult foster care and community residential setting license capacity.** (a) The commissioner shall issue adult foster care and community residential setting licenses with a maximum licensed capacity of four beds, including nonstaff roomers and boarders, except that the commissioner may issue a license with a capacity of five beds, including roomers and boarders, according to paragraphs (b) to (f).

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

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

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

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

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

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

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

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

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

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

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

(i) individualized plan of care;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(1) improve housing stability;

(2) increase opportunities for integrated community living;

(3) prevent and reduce homelessness

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

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

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

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

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

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

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

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

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

APPENDIX
Article locations in 16-4619