State of Minnesota

HOUSE OF REPRESENTATIVES

NINETIETH SESSION

H. F. No. 1245

02/14/2017 Authored by Schomacker
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 provisions governing children and families services, chemical and mental health services, operations, health care, and community supports; making various technical corrections; amending Minnesota Statutes 2016, sections 144D.04, subdivision 2, by adding a subdivision; 245.095; 245.462, subdivisions 6, 11; 245.464, subdivision 2; 245.466, subdivision 2; 245.470, subdivision 2; 245.4871, subdivisions 9a, 14, by adding a subdivision; 245.4875, subdivision 2; 245.488, subdivision 2; 245.735, subdivision 3; 245.8261, subdivision 1; 245A.02, subdivisions 5a, 8, 9, 12, by adding subdivisions; 245A.03, subdivisions 1, 7; 245A.04, subdivisions 2, 4, 6, 7, 10, 14, by adding a subdivision; 245A.05; 245A.07, subdivision 2; 245A.11, by adding subdivisions; 245D.02, subdivision 20; 245D.03, subdivision 1; 245D.04, subdivision 3; 245D.071, subdivisions 1, 3; 245D.09, subdivision 5a; 245D.11, subdivision 4; 245D.24, subdivision 3; 253B.02, subdivision 9; 254B.15, subdivisions 4, 5; 256.01, subdivision 29, by adding a subdivision; 256.045, subdivision 3; 256B.02, subdivision 7; 256B.04, subdivision 21; 256B.055, subdivision 12; 256B.0615; 256B.0616; 256B.0622, subdivisions 2, 2b, 7a; 256B.0623, subdivision 2; 256B.0624, subdivisions 1, 2, 3, 4; 256B.0625, subdivisions 35a, 43, 60a; 256B.064, subdivision 1b; 256B.0651, subdivision 17; 256B.0659, subdivisions 3, 12, 14, 21, 23, 24; 256B.0911, subdivision 3a; 256B.092, subdivisions 1a, 14; 256B.0943, subdivisions 1, 2, 4, 7, 9; 256B.0946, subdivisions 1, 1a, 4, 6; 256B.0947, subdivisions 3a, 7; 256B.49, subdivisions 13, 25; 256B.4912, by adding a subdivision; 256B.4913, by adding a subdivision; 256B.4914, subdivisions 3, 5, 8, 16; 256B.84; 256B.85, subdivision 12b; 256G.01, subdivision 4; 256G.02, subdivision 4; 256G.09, subdivision 2; 256G.10; 256N.02, subdivisions 10, 16, 17, 18; 256N.22, subdivision 1; 256N.23, subdivision 6; 256N.24, subdivisions 1, 8, 11, 12, 14; 256N.28, subdivision 6; 256P.08, subdivision 4; 270B.14, subdivision 1; 626.5572, subdivision 21; proposing coding for new law in Minnesota Statutes, chapters 245; 245A; repealing Minnesota Statutes 2016, sections 119B.125, subdivision 8; 245.469; 245.4879; 256B.0624, subdivisions 4a, 5, 6, 7, 8, 9, 10, 11; 256B.0944; Minnesota Rules, parts 9555.6255; 9555.7100; 9555.7200; 9555.7300; 9555.7600.

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

ARTICLE 1

CHILDREN AND FAMILIES SERVICES

Section 1. Minnesota Statutes 2016, section 256N.02, subdivision 10, is amended to read:

Subd. 10. **Financially responsible agency.** "Financially responsible agency" means the agency that is financially responsible for a child. These agencies include both local social service agencies under section 393.07 and tribal social service agencies authorized in section 256.01, subdivision 14b, as part of the American Indian Child Welfare Initiative, and Minnesota tribes who assume financial responsibility of children from other states. Under Northstar Care for Children, the agency that is financially responsible at the time of placement for foster care continues to be responsible under section 256N.27 for the local share of any maintenance payments, even after finalization of the adoption ~~of~~ or transfer of permanent legal and physical custody of a child.

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

Sec. 2. Minnesota Statutes 2016, section 256N.02, subdivision 16, is amended to read:

Subd. 16. **Permanent legal and physical custody.** "Permanent legal and physical custody" means (1) a full transfer of permanent legal and physical custody ordered by a Minnesota juvenile court under section 260C.515, subdivision 4, to a relative ~~ordered by a Minnesota juvenile court under section 260C.515, subdivision 4~~ who is not a parent as defined in section 260C.007, subdivision 25, or (2) for a child under jurisdiction of a tribal court, a judicial determination under a similar provision in tribal code which means that a relative will assume the duty and authority to provide care, control, and protection of a child who is residing in foster care, and to make decisions regarding the child's education, health care, and general welfare until adulthood. For purposes of establishing eligibility for Northstar kinship assistance, permanent legal and physical custody shall not include joint legal custody, joint physical custody, or joint legal and physical custody between a child's parent and relative custodian.

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

Sec. 3. Minnesota Statutes 2016, section 256N.02, subdivision 17, is amended to read:

Subd. 17. **Reassessment.** "Reassessment" means an update of a previous assessment through the process under section 256N.24 for a child who has been continuously eligible for Northstar Care for Children, or when a child identified as an at-risk child (Level A) under ~~guardianship or~~ adoption assistance has manifested the disability upon which eligibility

for the agreement was based according to section 256N.25, subdivision 3, paragraph (b). A reassessment may be used to update an initial assessment, a special assessment, or a previous reassessment.

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

Sec. 4. Minnesota Statutes 2016, section 256N.02, subdivision 18, is amended to read:

Subd. 18. **Relative.** "Relative," as described in section 260C.007, subdivision 27, means a person related to the child by blood, marriage, or adoption~~,~~; the legal parent, guardian, or custodian of the child's sibling; or an individual who is an important friend with whom the child has resided or had significant contact. For an Indian child, relative, as described in section 260C.007, subdivision 26b, means a person who is a member of the Indian child's family as defined in the Indian Child Welfare Act of 1978, United States Code, title 25, section 1903, paragraphs (2), (6), and (9).

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

Sec. 5. Minnesota Statutes 2016, section 256N.22, subdivision 1, is amended to read:

Subdivision 1. **General eligibility requirements.** (a) To be eligible for Northstar kinship assistance under this section, there must be a judicial determination under section 260C.515, subdivision 4, that a transfer of permanent legal and physical custody to a relative who is not a parent is in the child's best interest. For a child under jurisdiction of a tribal court, a judicial determination under a similar provision in tribal code indicating that a relative will assume the duty and authority to provide care, control, and protection of a child who is residing in foster care, and to make decisions regarding the child's education, health care, and general welfare until adulthood, and that this is in the child's best interest is considered equivalent. A child whose parent shares legal, physical, or legal and physical custody with a relative custodian is not eligible for Northstar kinship assistance. Additionally, a child must:

(1) have been removed from the child's home pursuant to a voluntary placement agreement or court order;

(2)(i) have resided with the prospective relative custodian who has been a licensed child foster parent for at least six consecutive months; or

(ii) have received from the commissioner an exemption from the requirement in item (i) that the prospective relative custodian has been a licensed child foster parent for at least six consecutive months, based on a determination that:

(A) an expedited move to permanency is in the child's best interest;

(B) expedited permanency cannot be completed without provision of Northstar kinship assistance;

(C) the prospective relative custodian is uniquely qualified to meet the child's needs, as defined in section 260C.212, subdivision 2, on a permanent basis;

(D) the child and prospective relative custodian meet the eligibility requirements of this section; and

(E) efforts were made by the legally responsible agency to place the child with the prospective relative custodian as a licensed child foster parent for six consecutive months before permanency, or an explanation why these efforts were not in the child's best interests;

(3) meet the agency determinations regarding permanency requirements in subdivision 2;

(4) meet the applicable citizenship and immigration requirements in subdivision 3;

(5) have been consulted regarding the proposed transfer of permanent legal and physical custody to a relative, if the child is at least 14 years of age or is expected to attain 14 years of age prior to the transfer of permanent legal and physical custody; and

(6) have a written, binding agreement under section 256N.25 among the caregiver or caregivers, the financially responsible agency, and the commissioner established prior to transfer of permanent legal and physical custody.

(b) In addition to the requirements in paragraph (a), the child's prospective relative custodian or custodians must meet the applicable background study requirements in subdivision 4.

(c) To be eligible for title IV-E Northstar kinship assistance, a child must also meet any additional criteria in section 473(d) of the Social Security Act. The sibling of a child who meets the criteria for title IV-E Northstar kinship assistance in section 473(d) of the Social Security Act is eligible for title IV-E Northstar kinship assistance if the child and sibling are placed with the same prospective relative custodian or custodians, and the legally responsible agency, relatives, and commissioner agree on the appropriateness of the arrangement for the sibling. A child who meets all eligibility criteria except those specific to title IV-E Northstar kinship assistance is entitled to Northstar kinship assistance paid through funds other than title IV-E.

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

Sec. 6. Minnesota Statutes 2016, section 256N.23, subdivision 6, is amended to read:

Subd. 6. **Exclusions.** The commissioner must not enter into an adoption assistance agreement with the following individuals:

(1) a child's biological parent or stepparent;

(2) a child's relative under section 260C.007, subdivision 26b or 27, with whom the child resided immediately prior to child welfare involvement unless:

(i) the child was in the custody of a Minnesota county or tribal agency pursuant to an order under chapter 260C or equivalent provisions of tribal code and the agency had placement and care responsibility for permanency planning for the child; and

(ii) the child is under guardianship of the commissioner of human services according to the requirements of section 260C.325, subdivision 1 or 3, or is a ward of a Minnesota tribal court after termination of parental rights, suspension of parental rights, or a finding by the tribal court that the child cannot safely return to the care of the parent;

(3) an individual adopting a child who is the subject of a direct adoptive placement under section 259.47 or the equivalent in tribal code;

(4) a child's legal custodian or guardian who is now adopting the child, except for a relative custodian as defined in section 256N.02, subdivision 19, who is currently receiving Northstar kinship assistance benefits; or

(5) an individual who is adopting a child who is not a citizen or resident of the United States and was either adopted in another country or brought to the United States for the purposes of adoption.

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

Sec. 7. Minnesota Statutes 2016, section 256N.24, subdivision 1, is amended to read:

Subdivision 1. **Assessment.** (a) Each child eligible under sections 256N.21, 256N.22, and 256N.23, must be assessed to determine the benefits the child may receive under section 256N.26, in accordance with the assessment tool, process, and requirements specified in subdivision 2.

(b) If an agency applies the emergency foster care rate for initial placement under section 256N.26, the agency may wait up to 30 days to complete the initial assessment.

(c) Unless otherwise specified in paragraph (d), a child must be assessed at the basic level, level B, or one of ten supplemental difficulty of care levels, levels C to L.

(d) An assessment must not be completed for:

(1) a child eligible for Northstar ~~kinship assistance under section 256N.22 or~~ adoption assistance under section 256N.23 who is determined to be an at-risk child. A child under this clause must be assigned level A under section 256N.26, subdivision 1; and

(2) a child transitioning into Northstar Care for Children under section 256N.28, subdivision 7, unless the commissioner determines an assessment is appropriate.

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

Sec. 8. Minnesota Statutes 2016, section 256N.24, subdivision 8, is amended to read:

Subd. 8. **Completing the special assessment.** (a) The special assessment must be completed in consultation with the child's caregiver. Face-to-face contact with the caregiver is not required to complete the special assessment.

(b) If a new special assessment is required prior to the effective date of the Northstar kinship assistance agreement, it must be completed by the financially responsible agency, in consultation with the legally responsible agency if different. If the prospective relative custodian is unable or unwilling to cooperate with the special assessment process, the child shall be assigned the basic level, level B under section 256N.26, subdivision 3~~, unless the child is known to be an at-risk child, in which case, the child shall be assigned level A under section 256N.26, subdivision 1~~.

(c) If a special assessment is required prior to the effective date of the adoption assistance agreement, it must be completed by the financially responsible agency, in consultation with the legally responsible agency if different. If there is no financially responsible agency, the special assessment must be completed by the agency designated by the commissioner. If the prospective adoptive parent is unable or unwilling to cooperate with the special assessment process, the child must be assigned the basic level, level B under section 256N.26, subdivision 3, unless the child is known to be an at-risk child, in which case, the child shall be assigned level A under section 256N.26, subdivision 1.

(d) Notice to the prospective relative custodians or prospective adoptive parents must be provided as specified in subdivision 13.

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

Sec. 9. Minnesota Statutes 2016, section 256N.24, subdivision 11, is amended to read:

Subd. 11. **Completion of reassessment.** (a) The reassessment must be completed in consultation with the child's caregiver. Face-to-face contact with the caregiver is not required to complete the reassessment.

(b) For foster children eligible under section 256N.21, reassessments must be completed by the financially responsible agency, in consultation with the legally responsible agency if different.

(c) If reassessment is required after the effective date of the Northstar kinship assistance agreement, the reassessment must be completed by the financially responsible agency.

(d) If a reassessment is required after the effective date of the adoption assistance agreement, it must be completed by the financially responsible agency or, if there is no financially responsible agency, the agency designated by the commissioner.

(e) If the child's caregiver is unable or unwilling to cooperate with the reassessment, the child must be assessed at level B under section 256N.26, subdivision 3, unless the child has ~~an~~ a Northstar adoption assistance ~~or Northstar kinship assistance~~ agreement in place and is known to be an at-risk child, in which case the child must be assessed at level A under section 256N.26, subdivision 1.

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

Sec. 10. Minnesota Statutes 2016, section 256N.24, subdivision 12, is amended to read:

Subd. 12. **Approval of initial assessments, special assessments, and reassessments.** (a) Any agency completing initial assessments, special assessments, or reassessments must designate one or more supervisors or other staff to examine and approve assessments completed by others in the agency under subdivision 2. The person approving an assessment must not be the case manager or staff member completing that assessment.

(b) In cases where a special assessment or reassessment for ~~guardian~~ Northstar kinship assistance and adoption assistance is required under subdivision 8 or 11, the commissioner shall review and approve the assessment as part of the eligibility determination process outlined in section 256N.22, subdivision 7, for Northstar kinship assistance, or section 256N.23, subdivision 7, for adoption assistance. The assessment determines the maximum for the negotiated agreement amount under section 256N.25.

(c) The new rate is effective the calendar month that the assessment is approved, or the effective date of the agreement, whichever is later.

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

Sec. 11. Minnesota Statutes 2016, section 256N.24, subdivision 14, is amended to read:

Subd. 14. **Assessment tool determines rate of benefits.** The assessment tool established by the commissioner in subdivision 2 determines the monthly benefit level for children in foster care. The monthly payment for ~~guardian~~ Northstar kinship assistance or adoption assistance may be negotiated up to the monthly benefit level under foster care for those children eligible for a payment under section 256N.26, subdivision 1.

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

Sec. 12. Minnesota Statutes 2016, section 256N.28, subdivision 6, is amended to read:

Subd. 6. **Appeals and fair hearings.** (a) A caregiver has the right to appeal to the commissioner under section 256.045 when eligibility for Northstar Care for Children is denied, and when payment or the agreement for an eligible child is modified or terminated.

(b) ~~A relative custodian or adoptive parent has additional rights to appeal to the commissioner pursuant to section 256.045. These rights include when the commissioner terminates or modifies the Northstar kinship assistance or adoption assistance agreement or when the commissioner denies an application for Northstar kinship assistance or adoption assistance. A prospective relative custodian or adoptive parent who disagrees with a decision by the commissioner before transfer of permanent legal and physical custody or finalization of the adoption may request review of the decision by the commissioner or may appeal the decision under section 256.045. A Northstar kinship assistance or adoption assistance agreement must be signed and in effect before the court order that transfers permanent legal and physical custody or the adoption finalization; however, in some cases, there may be extenuating circumstances as to why an agreement was not entered into before finalization of permanency for the child.~~ Caregivers who believe that extenuating circumstances exist as to why an agreement was not entered into before finalization of permanency in the case of their child may request a fair hearing. Caregivers have the responsibility of proving that extenuating circumstances exist. Caregivers must be required to provide written documentation of each eligibility criterion at the fair hearing. ~~Examples of extenuating circumstances include: relevant facts regarding the child were known by the placing agency and not presented to the caregivers before transfer of permanent legal and physical custody or finalization of the adoption, or failure by the commissioner or a designee to advise potential caregivers about the availability of Northstar kinship assistance or adoption assistance for children in the state foster care system.~~ If a human services judge finds through

the fair hearing process that extenuating circumstances existed and that the child met all other eligibility criteria at the time the transfer of permanent legal and physical custody was ordered or the adoption was finalized, the effective date ~~and any associated federal financial participation~~ shall be retroactive from the date of the request for a fair hearing.

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

ARTICLE 2

CHEMICAL AND MENTAL HEALTH SERVICES

Section 1. Minnesota Statutes 2016, section 245.462, subdivision 6, is amended to read:

Subd. 6. **Community support services program.** "Community support services program" means services, other than inpatient or residential treatment services, provided or coordinated by an identified program and staff under the clinical supervision of a mental health professional designed to help adults with serious and persistent mental illness to function and remain in the community. A community support services program includes:

(1) client outreach~~,~~;

(2) medication monitoring~~,~~;

(3) assistance in independent living skills~~,~~;

(4) development of employability and work-related opportunities~~,~~;

(5) crisis ~~assistance,~~ planning to develop a written plan identifying warning signs of a crisis, available resources, and actions to mitigate the crisis;

(6) psychosocial rehabilitation~~,~~;

(7) help in applying for government benefits~~,~~; and

(8) housing support services.

The community support services program must be coordinated with the case management services specified in section 245.4711. Crisis planning shall be coordinated with crisis services under section 245.991.

EFFECTIVE DATE. This section is effective August 1, 2017.

Sec. 2. Minnesota Statutes 2016, section 245.462, subdivision 11, is amended to read:

Subd. 11. **Emergency services.** "Emergency services" means an immediate response service available on a 24-hour, seven-day-a-week basis for persons having a psychiatric crisis, a mental health crisis, or emergency as defined in section 245.991.

EFFECTIVE DATE. This section is effective August 1, 2017.

Sec. 3. Minnesota Statutes 2016, section 245.464, subdivision 2, is amended to read:

Subd. 2. **Priorities.** By January 1, 1990, the commissioner shall require that each of the treatment services and management activities described in sections ~~245.469 to 245.477~~ 245.470 to 245.477 and 245.991 are developed for adults with mental illness within available resources based on the following ranked priorities:

(1) the provision of locally available emergency services;

(2) the provision of locally available services to all adults with serious and persistent mental illness and all adults with acute mental illness;

(3) the provision of specialized services regionally available to meet the special needs of all adults with serious and persistent mental illness and all adults with acute mental illness;

(4) the provision of locally available services to adults with other mental illness; and

(5) the provision of education and preventive mental health services targeted at high-risk populations.

EFFECTIVE DATE. This section is effective August 1, 2017.

Sec. 4. Minnesota Statutes 2016, section 245.466, subdivision 2, is amended to read:

Subd. 2. **Adult mental health services.** The adult mental health service system developed by each county board must include the following services:

(1) education and prevention services in accordance with section 245.468;

(2) ~~emergency~~ crisis services in accordance with section ~~245.469~~ 245.991;

(3) outpatient services in accordance with section 245.470;

(4) community support program services in accordance with section 245.4711;

(5) residential treatment services in accordance with section 245.472;

(6) acute care hospital inpatient treatment services in accordance with section 245.473;

(7) regional treatment center inpatient services in accordance with section 245.474;

(8) screening in accordance with section 245.476; and

(9) case management in accordance with sections 245.462, subdivision 3; and 245.4711.

EFFECTIVE DATE. This section is effective August 1, 2017.

Sec. 5. Minnesota Statutes 2016, section 245.470, subdivision 2, is amended to read:

Subd. 2. **Specific requirements.** The county board shall require that all service providers of outpatient services:

(1) meet the professional qualifications contained in sections 245.461 to 245.486;

(2) use a multidisciplinary mental health professional staff including at a minimum, arrangements for psychiatric consultation, licensed psychologist consultation, and other necessary multidisciplinary mental health professionals;

(3) develop individual treatment plans;

(4) provide initial appointments within three weeks, except in emergencies where there must be immediate access as described in section ~~245.469~~ 245.991; and

(5) establish fee schedules approved by the county board that are based on a client's ability to pay.

EFFECTIVE DATE. This section is effective August 1, 2017.

Sec. 6. Minnesota Statutes 2016, section 245.4871, subdivision 9a, is amended to read:

Subd. 9a. **Crisis ~~assistance~~ planning.** "Crisis ~~assistance~~ planning" means ~~assistance to the child, the child's family, and all providers of services to the child to: recognize factors precipitating a mental health crisis, identify behaviors related to the crisis, and be informed of available resources to resolve the crisis. Crisis assistance requires the development of a plan which addresses prevention and intervention strategies to be used in a potential crisis. Other interventions include: (1) arranging for admission to acute care hospital inpatient treatment; (2) crisis placement; (3) community resources for follow-up; and (4) emotional support to the family during crisis. Crisis assistance does not include services designed to secure the safety of a child who is at risk of abuse or neglect or necessary emergency services.~~ the development of a written plan to assist a child's family to contend with a potential crisis and is distinct from the immediate provision of intervention services as defined in section 245.991, subdivision 2, paragraph (g). The plan addresses prevention and intervention strategies to be used in a crisis. The plan identifies factors that might precipitate a crisis and behaviors related to the emergence of a crisis, and the resources available to resolve a crisis.

EFFECTIVE DATE. This section is effective August 1, 2017.

Sec. 7. Minnesota Statutes 2016, section 245.4871, subdivision 14, is amended to read:

Subd. 14. **Emergency services.** "Emergency services" means an immediate response service available on a 24-hour, seven-day-a-week basis for each child having a psychiatric crisis, a mental health crisis, or a mental health emergency as defined in section 245.991.

EFFECTIVE DATE. This section is effective August 1, 2017.

Sec. 8. Minnesota Statutes 2016, section 245.4875, subdivision 2, is amended to read:

Subd. 2. **Children's mental health services.** The children's mental health service system developed by each county board must include the following services:

(1) education and prevention services according to section 245.4877;

(2) mental health identification and intervention services according to section 245.4878;

(3) emergency services according to section ~~245.4879~~ 245.991;

(4) outpatient services according to section 245.488;

(5) family community support services according to section 245.4881;

(6) day treatment services according to section 245.4884, subdivision 2;

(7) residential treatment services according to section 245.4882;

(8) acute care hospital inpatient treatment services according to section 245.4883;

(9) screening according to section 245.4885;

(10) case management according to section 245.4881;

(11) therapeutic support of foster care according to section 245.4884, subdivision 4;

(12) professional home-based family treatment according to section 245.4884, subdivision 4; and

(13) mental health crisis services according to section 245.488, subdivision 3.

EFFECTIVE DATE. This section is effective August 1, 2017.

Sec. 9. Minnesota Statutes 2016, section 245.488, subdivision 2, is amended to read:

Subd. 2. **Specific requirements.** The county board shall require that a service provider of outpatient services to children:

(1) meets the professional qualifications contained in sections 245.487 to 245.4889;

(2) uses a multidisciplinary mental health professional staff including, at a minimum, arrangements for psychiatric consultation, licensed psychologist consultation, and other necessary multidisciplinary mental health professionals;

(3) develops individual treatment plans; and

(4) provides initial appointments within three weeks, except in emergencies where there must be immediate access as described in section ~~245.4879~~ 245.991.

EFFECTIVE DATE. This section is effective August 1, 2017.

Sec. 10. Minnesota Statutes 2016, section 245.735, subdivision 3, is amended to read:

Subd. 3. **Certified community behavioral health clinics.** (a) The commissioner shall establish a state certification process for certified community behavioral health clinics (CCBHCs) to be eligible for the prospective payment system in paragraph (f). Entities that choose to be CCBHCs must:

(1) comply with the CCBHC criteria published by the United States Department of Health and Human Services;

(2) employ or contract for clinic staff who have backgrounds in diverse disciplines, including licensed mental health professionals, and staff who are culturally and linguistically trained to serve the needs of the clinic's patient population;

(3) ensure that clinic services are available and accessible to patients of all ages and genders and that crisis management services are available 24 hours per day;

(4) establish fees for clinic services for nonmedical assistance patients using a sliding fee scale that ensures that services to patients are not denied or limited due to a patient's inability to pay for services;

(5) comply with quality assurance reporting requirements and other reporting requirements, including any required reporting of encounter data, clinical outcomes data, and quality data;

(6) provide crisis mental health services, withdrawal management services, emergency crisis intervention services, and stabilization services; screening, assessment, and diagnosis services, including risk assessments and level of care determinations; patient-centered treatment planning; outpatient mental health and substance use services; targeted case management; psychiatric rehabilitation services; peer support and counselor services and family support services; and intensive community-based mental health services, including mental health services for members of the armed forces and veterans;

(7) provide coordination of care across settings and providers to ensure seamless transitions for patients across the full spectrum of health services, including acute, chronic, and behavioral needs. Care coordination may be accomplished through partnerships or formal contracts with:

(i) counties, health plans, pharmacists, pharmacies, rural health clinics, federally qualified health centers, inpatient psychiatric facilities, substance use and detoxification facilities, or community-based mental health providers; and

(ii) other community services, supports, and providers, including schools, child welfare agencies, juvenile and criminal justice agencies, Indian health services clinics, tribally licensed health care and mental health facilities, urban Indian health clinics, Department of Veterans Affairs medical centers, outpatient clinics, drop-in centers, acute care hospitals, and hospital outpatient clinics;

(8) be certified as mental health clinics under section 245.69, subdivision 2;

(9) be certified to provide integrated treatment for co-occurring mental illness and substance use disorders in adults or children under Minnesota Rules, chapter 9533, effective July 1, 2017;

(10) comply with standards relating to mental health services in Minnesota Rules, parts 9505.0370 to 9505.0372;

(11) be licensed to provide chemical dependency treatment under Minnesota Rules, parts 9530.6405 to 9530.6505;

(12) be certified to provide children's therapeutic services and supports under section 256B.0943;

(13) be certified to provide adult rehabilitative mental health services under section 256B.0623;

(14) be enrolled to provide mental health crisis response services under section ~~256B.0624~~ 245.991;

(15) be enrolled to provide mental health targeted case management under section 256B.0625, subdivision 20;

(16) comply with standards relating to mental health case management in Minnesota Rules, parts 9520.0900 to 9520.0926; and

(17) provide services that comply with the evidence-based practices described in paragraph (e).

(b) If an entity is unable to provide one or more of the services listed in paragraph (a), clauses (6) to (17), the commissioner may certify the entity as a CCBHC, if the entity has a current contract with another entity that has the required authority to provide that service and that meets federal CCBHC criteria as a designated collaborating organization, or, to the extent allowed by the federal CCBHC criteria, the commissioner may approve a referral arrangement. The CCBHC must meet federal requirements regarding the type and scope of services to be provided directly by the CCBHC.

(c) Notwithstanding any other law that requires a county contract or other form of county approval for certain services listed in paragraph (a), clause (6), a clinic that otherwise meets CCBHC requirements may receive the prospective payment under paragraph (f) for those services without a county contract or county approval. There is no county share when medical assistance pays the CCBHC prospective payment. As part of the certification process in paragraph (a), the commissioner shall require a letter of support from the CCBHC's host county confirming that the CCBHC and the county or counties it serves have an ongoing relationship to facilitate access and continuity of care, especially for individuals who are uninsured or who may go on and off medical assistance.

(d) When the standards listed in paragraph (a) or other applicable standards conflict or address similar issues in duplicative or incompatible ways, the commissioner may grant variances to state requirements if the variances do not conflict with federal requirements. If standards overlap, the commissioner may substitute all or a part of a licensure or certification that is substantially the same as another licensure or certification. The commissioner shall consult with stakeholders, as described in subdivision 4, before granting variances under this provision.

(e) The commissioner shall issue a list of required evidence-based practices to be delivered by CCBHCs, and may also provide a list of recommended evidence-based practices. The commissioner may update the list to reflect advances in outcomes research and medical services for persons living with mental illnesses or substance use disorders. The commissioner shall take into consideration the adequacy of evidence to support the efficacy of the practice, the quality of workforce available, and the current availability of the practice in the state. At least 30 days before issuing the initial list and any revisions, the commissioner shall provide stakeholders with an opportunity to comment.

(f) The commissioner shall establish standards and methodologies for a prospective payment system for medical assistance payments for services delivered by certified community behavioral health clinics, in accordance with guidance issued by the Centers for Medicare and Medicaid Services. During the operation of the demonstration project,

payments shall comply with federal requirements for an enhanced federal medical assistance percentage. The commissioner may include quality bonus payment in the prospective payment system based on federal criteria and on a clinic's provision of the evidence-based practices in paragraph (e). The prospective payment system does not apply to MinnesotaCare. Implementation of the prospective payment system is effective July 1, 2017, or upon federal approval, whichever is later.

(g) The commissioner shall seek federal approval to continue federal financial participation in payment for CCBHC services after the federal demonstration period ends for clinics that were certified as CCBHCs during the demonstration period and that continue to meet the CCBHC certification standards in paragraph (a). Payment for CCBHC services shall cease effective July 1, 2019, if continued federal financial participation for the payment of CCBHC services cannot be obtained.

(h) The commissioner may certify at least one CCBHC located in an urban area and at least one CCBHC located in a rural area, as defined by federal criteria. To the extent allowed by federal law, the commissioner may limit the number of certified clinics so that the projected claims for certified clinics will not exceed the funds budgeted for this purpose. The commissioner shall give preference to clinics that:

(1) provide a comprehensive range of services and evidence-based practices for all age groups, with services being fully coordinated and integrated; and

(2) enhance the state's ability to meet the federal priorities to be selected as a CCBHC demonstration state.

(i) The commissioner shall recertify CCBHCs at least every three years. The commissioner shall establish a process for decertification and shall require corrective action, medical assistance repayment, or decertification of a CCBHC that no longer meets the requirements in this section or that fails to meet the standards provided by the commissioner in the application and certification process.

EFFECTIVE DATE. This section is effective August 1, 2017.

Sec. 11. Minnesota Statutes 2016, section 245.8261, subdivision 1, is amended to read:

Subdivision 1. **Scope.** (a) This section applies to providers of the following mental health services for children:

(1) emergency services as defined in sections 245.4871, subdivision 14, and ~~245.4879~~ 245.991;

(2) family community support services as defined in section 245.4871, subdivision 17;

(3) day treatment services as defined in section 245.4871, subdivision 10;

(4) therapeutic support of foster care as defined in section 245.4871, subdivision 34;

(5) professional home-based family treatment as defined in sections 245.4871, subdivision 31, and 245.4884, subdivision 3; and

(6) mental health crisis services as defined in sections 245.4871, subdivision 24a, and 245.488, subdivision 3.

(b) Providers of mental health services for children under paragraph (a) must meet the requirements of this section before using a restrictive procedure with a child.

EFFECTIVE DATE. This section is effective August 1, 2017.

Sec. 12. **[245.991] MENTAL HEALTH CRISIS SERVICES.**

Subdivision 1. **Availability of crisis services.** (a) By August 1, 2017, a county board must provide or contract for crisis services within the county to meet the needs of children and adults in the county experiencing a crisis 24 hours a day, seven days a week. The provider entity shall seek reimbursement under available health insurance for the recipient. If the recipient lacks insurance that covers this service, or cannot afford the cost-sharing, a provider entity may require a recipient to pay a fee according to section 245.481. A provider entity shall not delay the timely provision of crisis services because of delays in determining this fee or because of the unwillingness or inability of the recipient to pay the fee. Crisis services must include screening, assessment, intervention services, and appropriate case disposition, including stabilization services. A tribal authority that accepts crisis grant funding has the same responsibilities within the tribal authority's designated service area.

(b) Crisis services must:

(1) promote the safety and emotional stability of a recipient;

(2) minimize further deterioration of a recipient;

(3) help a recipient to obtain ongoing care and treatment;

(4) prevent a recipient's placement in a setting that is more intensive, costly, or restrictive than necessary and appropriate to meet a recipient's needs when clinically appropriate; and

(5) provide support, psychoeducation, and referrals to third parties, including family members, friends, or service providers, for a recipient in need of crisis services.

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

(a) "Adult" means a recipient 18 years of age or older.

(b) "Assessment" means an immediate face-to-face assessment by a mental health practitioner under the clinical supervision of a mental health professional, a physician, or a mental health professional.

(c) "Certified family peer specialist" is an individual qualified to provide services under section 256B.0616 and who is under the supervision of a mental health professional.

(d) "Certified peer specialist" is an individual qualified to provide services under section 256B.0615 and who is under the supervision of a mental health professional.

(e) "Commissioner" means the commissioner of human services.

(f) "Crisis" is a behavioral, emotional, or psychiatric situation that without the provision of crisis response services, would likely result in significantly reduced levels of functioning in primary activities of daily living, or in an emergency situation, or in the placement of the recipient in a more restrictive setting, including, but not limited to, inpatient hospitalization. Crisis includes a behavioral, emotional, or psychiatric situation that causes an immediate need for mental health services consistent with section 62Q.55. A crisis is not limited to the standards for emergency admission or transportation in section 253B.05.

(g) "Intervention services" means face-to-face, short-term intensive mental health services initiated during a crisis to help the recipient cope with immediate stressors, identify and utilize available resources and strengths, engage in voluntary treatment, and begin to return to the recipient's baseline level of functioning.

(h) "Mental health practitioner" is a crisis team member defined by section 245.462, subdivision 17, or 245.4871, subdivision 26, and is under the clinical supervision of a mental health professional on the team.

(i) "Mental health professional" has the meaning given in section 245.462, subdivision 18, clauses (1) to (6), or 245.4871, subdivision 27, clauses (1) to (6).

(j) "Screening" is the process by which a provider entity gathers information, determines if a potential crisis exists, identifies parties involved, and determines an appropriate response.

(k) "Stabilization services" means individualized mental health services provided to a recipient following intervention services that are designed to restore the recipient to the

recipient's prior functional level. Stabilization services does not include inpatient, partial hospitalization, or day treatment. Stabilization services include family psychoeducation.

(l) "Warm handoff" means a referral or transfer of a recipient to other services, facilitated by outreach performed by the crisis team. A warm handoff includes follow-up with the target provider entity or recipient.

Subd. 3. **Eligibility.** (a) Crisis services are available to recipients of all ages.

(b) For the purposes of an assessment, an eligible recipient is an individual who is screened as potentially experiencing a crisis.

(c) For the purpose of intervention services, an eligible recipient is an individual who is assessed as experiencing a crisis and for whom intervention services are necessary.

(d) For the purpose of stabilization services, an eligible recipient is an individual who is assessed as experiencing a crisis and for whom stabilization services are necessary.

(e) For the purpose of residential stabilization services, an eligible recipient is an adult who is assessed as experiencing a crisis and for whom residential stabilization services are necessary.

Subd. 4. **Provider entity standards.** (a) The commissioner shall establish a certification process and recertification process to determine whether a provider entity meets the requirements in this section. A certification may be valid for up to three years, or a shorter period as determined by the commissioner.

(b) The commissioner shall establish a process for decertification of a provider entity and shall require corrective action, medical assistance repayment, or decertification of a provider entity 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.

(c) A provider entity is an entity that is:

(1) operated by a county board;

(2) under a provider contract with the county board in the county where the potential crisis occurs. To provide services under this clause, the provider entity must directly provide the service or, if the service is subcontracted, maintain responsibility for the service and billing; or

(3) an Indian health service facility or facility owned and operated by a tribe or tribal organization operating under United States Code, title 25, section 450f.

(d) The commissioner must certify that a provider entity has the ability to:

(1) recruit, hire, manage, and train mental health professionals, mental health practitioners, certified peer specialists, and rehabilitation workers;

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

(3) ensure adequate preservice and in-service training;

(4) ensure that staff are skilled in delivering crisis services to any recipient, regardless of the recipient's age, a recipient's needs within a family system, and in engaging a recipient's legal guardian or family as applicable;

(5) ensure that staff are capable of implementing culturally responsive treatment identified in the treatment plan that is meaningful and appropriate as determined by the recipient's culture, beliefs, values, and language;

(6) ensure coordination with live interpreter and written translation services to provide care and treatment plans that are accessible to the recipient;

(7) ensure a flexible response to the recipient's changing intervention and care needs as identified by the recipient;

(8) ensure that a mental health practitioner and a mental health professional have communication tools to promptly communicate and consult about assessment and intervention services as services occur;

(9) coordinate with and recommend the use of crisis services by other responders, including community hospitals, ambulance services, transportation services, social services, law enforcement, and schools through regularly scheduled interagency meetings;

(10) ensure that screening, assessment, and intervention services are available in the designated service area 24 hours a day, seven days a week;

(11) coordinate services with detoxification or withdrawal management services to ensure a recipient receives care that is responsive to chemical and mental health needs;

(12) ensure that services are coordinated with other mental health service providers, county mental health authorities, or federally recognized American Indian authorities and others as necessary, with the consent of the adult. Services must also be coordinated with the recipient's case manager if the adult is receiving case management services;

(13) ensure that services are provided consistent with sections 245.461 to 245.486 and 245.487 to 245.4887;

(14) submit information as required by the state;

(15) maintain staff training and personnel files, including documentation of staff completion of required training modules;

(16) establish and maintain a quality assurance and evaluation plan to evaluate the outcomes of services and recipient satisfaction;

(17) maintain records as required by applicable laws;

(18) comply with all applicable laws and statutes;

(19) demonstrate that the provider entity is enrolled as a medical assistance provider;

(20) develop and maintain written policies and procedures regarding service provision and administration of the provider entity, including safety of staff and recipients in a high-risk situation;

(21) directly provide or connect a recipient through a warm handoff to stabilization services or other ongoing supports as indicated in a recipient's treatment plan;

(22) respond to a call for crisis services in a designated service area, or according to a written agreement with the local mental health authority for an adjacent area;

(23) document protocol used when delivering services by telemedicine, as provided by sections 62A.67 to 62A.672, including responsibilities of the originating site, means to promote recipient safety, timeliness for connection and response, and steps to be taken in the event of lost connection; and

(24) develop and publicly post a written policy containing criteria for providing services, and the response to a call for a person who is ineligible for service.

(e) A crisis provider that is certified to provide crisis services before August 1, 2017, may continue to operate according to standards in Minnesota Statutes 2016, sections 245.469, 245.4879, 256B.0624, and 256B.0944, until certified by the commissioner under this section or January 1, 2019, whichever comes first. This paragraph expires January 1, 2019.

Subd. 5. **Crisis team.** (a) A crisis team is comprised of at least two members, one of whom must be qualified as a mental health professional. A second member must be qualified as a mental health professional or mental health practitioner. Additional staff should be added to reflect the needs of the area served.

(b) Staff for a crisis team must be qualified to provide services in the following ways:

(1) mental health professional;

(2) mental health practitioner;

(3) certified peer specialist; or

(4) certified family peer specialist.

(c) Assessment and intervention services must be led by a mental health professional, or a mental health practitioner under the supervision of a mental health professional as described in subdivision 11.

(d) At least one member of the crisis team must provide assessment and intervention services when needed. Crisis team members must have experience in assessments, crisis intervention techniques, treatment engagement strategies, working with families, and clinical decision making under emergency conditions, and have knowledge of local services and resources.

Subd. 6. **Screening standards.** (a) A crisis team shall conduct a screening for a recipient to determine the need for further services. A screening must be available by telephone and may be performed by alternate means as clinically appropriate.

(b) In conducting a screening, a provider entity shall:

(1) employ evidence-based practices as identified by the commissioner to reduce the risk of the recipient's suicide and self-injurious behavior;

(2) work with the recipient to establish a plan and time frame for responding to the crisis, including immediate needs for support by telephone or text message until a face-to-face response can arrive;

(3) coordinate response with other emergency responders as appropriate;

(4) consider other available services to determine which intervention service would best address the recipient's needs and circumstances;

(5) document significant factors related to the determination of a crisis, including prior calls to the crisis team, recent presentation at an emergency department, known calls to 911 or law enforcement, or the presence of third parties with knowledge of a potential recipient's history or current needs;

(6) screen for the needs of a third-party caller, including a recipient who primarily identifies as a family member or a caregiver but also presents signs of a crisis; and

(7) provide psychoeducation to third-party callers, including education on the available means for reducing self-harm.

(c) A provider entity shall consider the following to indicate a positive screening unless the provider entity documents specific evidence to show why crisis response was clinically inappropriate:

(1) the recipient presented in an emergency department or urgent care setting, and the health care team at that location requested crisis services; or

(2) a peace officer requested crisis services for a recipient who may be subject to transportation under section 253B.05 for a mental health crisis.

(d) Direct contact with the recipient is not required before initiating an assessment or intervention service. A crisis team may gather relevant information from a third party at the scene to establish the need for services and potential safety factors.

(e) A crisis team that receives a call for services outside of the team's coverage area shall offer to connect the recipient with a crisis team serving the recipient's location.

(f) A crisis team shall consider input from a recipient whenever possible in determining if a potential crisis exists and face-to-face assessment is necessary.

Subd. 7. **Assessment.** (a) If screening indicates a potential crisis, an assessment must be completed. An assessment evaluates any immediate needs for services and, as time permits, the recipient's current life situation, sources of stress, mental health problems and symptoms, strengths, cultural considerations, support network, vulnerabilities, current functioning, and the recipient's preferences as communicated directly by the recipient, or as communicated in a health care directive as described in chapters 145C and 253B, the treatment plan described under subdivision 8, paragraph (b); a crisis prevention plan; or wellness recovery action plan. An assessment includes, when feasible, assessing whether the recipient is willing to voluntarily accept treatment, determining whether the recipient has an advance directive, and obtaining information and history from an involved family member or caregiver.

(b) An assessment is provided face-to-face by a crisis team outside of an inpatient hospital setting. A service must be provided promptly and respond to the recipient's location whenever possible, including community or clinical settings. As clinically appropriate, a crisis team must coordinate a response with other health care providers if a recipient requires detoxification, withdrawal management, or medical stabilization services in addition to crisis services.

(c) A crisis team shall consider input from a recipient whenever possible in determining if a crisis exists.

(d) If after an assessment, a crisis provider entity refers a recipient to an acute setting, including an emergency department, in-patient hospitalization, or crisis residential treatment, a crisis team member who performed or conferred on the assessment must contact the provider entity and consult with the triage nurse or other staff responsible for intake. The crisis team member must convey key findings or concerns that led to the referral. This consultation shall occur with the recipient's consent, the recipient's legal guardian's consent, or as allowed by section 144.293, subdivision 5.

Subd. 8. **Intervention.** (a) If the assessment determines intervention services are needed, the intervention services must be provided promptly. At least one crisis team member must provide the intervention services face-to-face with a recipient. If a mental health practitioner is providing in-person services, the mental health practitioner must seek clinical supervision as required under subdivision 11, including obtaining approval before acting as a health officer as defined in section 253B.02.

(b) The crisis team must develop a crisis intervention treatment plan as soon as appropriate but no later than 24 hours after the initial face-to-face intervention. The crisis intervention treatment plan must:

(1) address the recipient's needs and problems noted in the assessment;

(2) include measurable short-term goals;

(3) address cultural considerations;

(4) specify the frequency and type of services to be provided to achieve the recipient's goals and reduce or eliminate the crisis; and

(5) be updated as needed to reflect current goals and services.

(c) If the crisis team refers a recipient to an acute setting, as described in subdivision 7, paragraph (d), a crisis team member must send a copy of the crisis intervention treatment plan by secure electronic transmission to the provider entity to which the recipient was referred. This release shall occur with the recipient's consent, the recipient's legal guardian's consent, or as allowed by section 144.293, subdivision 5.

(d) The crisis team must document when short-term goals are met and when no further crisis services are required.

(e) If the recipient's crisis is stabilized, but the recipient needs a referral to another service, the crisis team must provide a warm handoff to those services. If the recipient has a case manager, planning for other services must be coordinated with the case manager.

(f) If the recipient's crisis is stabilized and the recipient does not have an advance directive, the case manager or crisis team shall offer to work with the recipient to develop one.

Subd. 9. **Stabilization service.** (a) Stabilization services must be provided by qualified staff. Stabilization services may be provided in the recipient's home, the home of a family member or friend of the recipient, another community setting, or a short-term supervised, licensed residential program. Stabilization services include family psychoeducation and must meet the following requirements:

(1) include a stabilization treatment plan that meets the criteria in subdivision 13;

(2) staff must be qualified as defined in subdivision 10; and

(3) service must be delivered according to the treatment plan and include face-to-face contact with the recipient by qualified staff for further assessment, help with referrals, updating of the stabilization treatment plan, supportive counseling, skills training, and collaboration with other service providers in the community.

(b) If stabilization services are provided to an adult in a supervised, licensed residential setting, the adult must have daily face-to-face contact with a qualified mental health practitioner or professional. The program must have 24-hour-a-day residential staffing that may include staff who do not meet the qualifications in subdivision 10. The residential staff must have 24-hour-a-day immediate direct or telephone access to a qualified mental health professional or practitioner.

(c) If stabilization services are provided to an adult in a supervised, licensed residential setting that serves no more than four adult residents, and one or more adults are present at the setting to receive stabilization services, the residential staff must include, for at least eight hours per day, at least one staff member who meets the qualifications in subdivision 10.

(d) If stabilization services are provided to an adult in a supervised, licensed residential setting that serves more than four adult residents, and one or more are adults receiving stabilization services, the residential staff must include, for 24 hours a day, at least one staff member who meets the qualifications in subdivision 10. During the first 48 hours that an adult is in the residential program, the residential program must have at least two staff members working 24 hours a day. After the first 48 hours that an adult is in the residential program, staff levels may be adjusted according to the needs of the adult as specified in the stabilization treatment plan.

Subd. 10. **Stabilization staff qualifications.** (a) Stabilization services must be provided by a qualified individual staff member. A qualified individual staff member includes:

(1) a mental health professional;

(2) a mental health practitioner;

(3) a certified peer specialist;

(4) a certified family peer specialist; or

(5) a mental health rehabilitation worker who meets the criteria in section 256B.0623, subdivision 5, clause (4), and works under the clinical supervision of a mental health professional or under the direction of a mental health practitioner.

(b) Except for a mental health professional, a stabilization staff member must have completed at least 30 hours of training in intervention and stabilization services during the past two years.

Subd. 11. **Supervision.** A mental health practitioner may provide assessment and intervention services if the following clinical supervision requirements are met:

(1) the qualified provider entity accepts full responsibility for any service provided;

(2) the mental health professional who is an employee or under contract with the qualified provider, must be immediately available in person or by telephone for clinical supervision;

(3) the mental health professional is consulted, in person or by telephone, during the first three hours when a mental health practitioner provides on-site service;

(4) the mental health professional must:

(i) review and approve the assessment and crisis intervention treatment plan;

(ii) document the consultation; and

(iii) sign the assessment and crisis intervention treatment plan within the next business day;

(5) if the intervention services continue into a second calendar day, a mental health professional must contact the recipient face-to-face on the second day to provide service and update the crisis intervention treatment plan;

(6) the on-site observation must be documented in the recipient's record and signed by the mental health professional; and

(7) specific consultation and approval must be obtained from the mental health professional before a mental health practitioner acts as a health officer as defined in section 253B.02, subdivision 9.

Subd. 12. **Recipient file.** (a) A provider entity must maintain for each assessment, intervention, or stabilization recipient a file that complies with the requirements established by the commissioner. The file must contain the following information:

(1) the crisis intervention treatment plan signed by the recipient or the recipient's legal guardian, mental health professional, and mental health practitioner who developed the crisis treatment plan, or if the recipient or the recipient's legal guardian refused to sign the plan, the date, and the reason as to why the recipient or the recipient's legal guardian would not sign the plan, as stated by the recipient or the recipient's legal guardian;

(2) signed release forms;

(3) recipient's health information and current medications;

(4) emergency contacts for the recipient;

(5) case records that document the date of service, place of service delivery, signature of the provider entity of the service, and the nature, extent, and units of service;

(6) documentation of in-person and telephone contact with the recipient's family or other supporters;

(7) documentation of required clinical supervision by a mental health professional;

(8) a summary of consultation between crisis team members;

(9) any written information by the recipient or the recipient's legal guardian that the recipient or the recipient's legal guardian wants in the file; and

(10) the recipient's advance directive if available.

(b) For a recipient of crisis stabilization services, a provider entity must also maintain a copy of the stabilization treatment plan as defined in subdivision 13. If a recipient was referred to crisis stabilization from a different provider entity, an assessment or referral may be substituted for the crisis intervention treatment plan in clause (1).

Subd. 13. **Stabilization treatment plan.** (a) A written stabilization treatment plan must be completed within 24 hours of beginning services for the recipient. A stabilization treatment plan must be developed by a mental health professional or mental health practitioner under the clinical supervision of a mental health professional. The stabilization treatment plan must include, at a minimum:

(1) problems identified in the assessment;

(2) the recipient's strengths and resources;

(3) concrete, measurable short-term goals to be achieved, including time frames for achievement;

(4) specific objectives directed toward achieving each goal;

(5) planned frequency and type of service initiated;

(6) a crisis response action plan;

(7) progress notes on the outcome of goals;

(8) each specific provider, when applicable; and

(9) a documentation of the participants involved in the service planning. The recipient, if possible, must be a participant.

(b) The recipient or the recipient's legal guardian must sign the stabilization treatment plan or if the recipient or the recipient's legal guardian refused to sign the plan, the date and the reason why the recipient or the recipient's legal guardian would not sign the plan, as stated by the recipient or the recipient's legal guardian. A copy of the plan must be given to the recipient and the recipient's legal guardian. The mental health professional must approve and sign any treatment plan. If a treatment plan completed by a referring entity, such as an in-patient hospital, meets the criteria in this subdivision, it may be adopted by the crisis team for the purpose of stabilization services.

Subd. 14. **Crisis service infrastructure.** The commissioner must:

(1) develop a central phone number to route calls to the appropriate crisis service;

(2) provide telephone consultation 24 hours a day to a crisis team that is serving a person with a traumatic brain injury or an intellectual disability and who is experiencing a crisis;

(3) expand crisis services across the state, including rural areas of the state;

(4) examine access to crisis service by population; and

(5) establish and implement state standards for crisis services.

EFFECTIVE DATE. This section is effective August 1, 2017.

Sec. 13. Minnesota Statutes 2016, section 245D.02, subdivision 20, is amended to read:

Subd. 20. **Mental health crisis intervention team.** "Mental health crisis intervention team" means a mental health crisis response provider as identified in section ~~256B.0624,~~

~~subdivision 2, paragraph (d), for adults, and in section 256B.0944, subdivision 1, paragraph (d), for children~~ 245.991.

EFFECTIVE DATE. This section is effective August 1, 2017.

Sec. 14. Minnesota Statutes 2016, section 253B.02, subdivision 9, is amended to read:

Subd. 9. **Health officer.** "Health officer" means:

(1) a licensed physician;

(2) a ~~licensed psychologist~~ mental health professional as defined in section 245.462, subdivision 18, clauses (1) to (6);

~~(3) a licensed social worker;~~

~~(4)~~ (3) a registered nurse working in an emergency room of a hospital;

~~(5)~~ (4) a psychiatric or public health nurse as defined in section 145A.02, subdivision 18;

~~(6)~~ (5) an advanced practice registered nurse (APRN) as defined in section 148.171, subdivision 3;

~~(7)~~ (6) a mental health practitioner as defined in section 245.462, subdivision 17, with the consultation and approval by a mental health professional providing ~~mental health mobile~~ crisis ~~intervention~~ services as described under section ~~256B.0624~~ 245.991; or

~~(8)~~ (7) a formally designated member of a prepetition screening unit established by section 253B.07.

EFFECTIVE DATE. This section is effective August 1, 2017.

Sec. 15. Minnesota Statutes 2016, section 256B.0615, is amended to read:

256B.0615 MENTAL HEALTH CERTIFIED PEER SPECIALIST.

Subdivision 1. **Scope.** Medical assistance covers mental health certified peer specialist services, as established in subdivision 2, subject to federal approval, if provided to recipients who are eligible for services under sections 256B.0622, 256B.0623, and 256B.0624 and are provided by a certified peer specialist who has completed the training under subdivision 5.

Subd. 2. **Establishment.** The commissioner of human services shall establish a certified peer specialist program model, which:

(1) provides nonclinical peer support ~~counseling~~ services by certified peer specialists;

(2) provides a part of a wraparound continuum of services in conjunction with other community mental health services;

(3) is individualized to the consumer; and

(4) promotes socialization, recovery, self-sufficiency, self-advocacy, development of natural supports, and maintenance of skills learned in other support services.

Subd. 3. **Eligibility.** Peer support services may be made available to consumers of (1) intensive residential treatment services under section 256B.0622; (2) adult rehabilitative mental health services under section 256B.0623; and (3) crisis stabilization and mental health mobile crisis intervention services under section 256B.0624.

Subd. 4. **Peer support specialist ~~program~~ service providers.** The commissioner shall develop a process to certify peer support ~~specialist programs~~ specialists, in accordance with the federal guidelines, in order for the program to bill for reimbursable services. ~~Peer support programs may be freestanding or within existing mental health community provider centers.~~

Subd. 5. **Certified peer specialist training and certification.** The commissioner of human services shall develop a training and certification process for certified peer specialists, who must be at least 21 years of age and have a high school diploma or its equivalent. The candidates must have had a primary diagnosis of mental illness, be a current or former consumer of mental health services, and must demonstrate leadership and advocacy skills and a strong dedication to recovery. The training curriculum must teach participating consumers specific skills relevant to providing peer support to other consumers. In addition to initial training and certification, the commissioner shall develop ongoing continuing educational workshops on pertinent issues related to peer support ~~counseling~~ services.

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

Sec. 16. Minnesota Statutes 2016, section 256B.0616, is amended to read:

256B.0616 MENTAL HEALTH CERTIFIED FAMILY PEER SPECIALIST.

Subdivision 1. **Scope.** Medical assistance covers mental health certified family peer specialists services, as established in subdivision 2, subject to federal approval, if provided to recipients who have an emotional disturbance or severe emotional disturbance under chapter 245, and are provided by a certified family peer specialist who has completed the training under subdivision 5. A family peer specialist cannot provide services to the peer specialist's family.

Subd. 2. **Establishment.** The commissioner of human services shall establish a certified family peer ~~specialists program model~~ support specialist service which increases the child's ability to function within the child's home, school, and community by:

(1) ~~provides~~ providing nonclinical family peer support ~~counseling~~, building on the strengths of families ~~and helping~~ to help them achieve desired outcomes;

(2) ~~collaborates~~ collaborating with ~~others~~ other services that are providing care or support to the family;

(3) ~~provides nonadversarial advocacy~~ teaching the family self-advocacy skills;

(4) ~~promotes~~ supporting the individual family culture in the treatment milieu;

(5) ~~links~~ linking parents to other parents in the community;

~~(6) offers support and encouragement;~~

~~(7) assists~~ (6) assisting parents ~~in developing~~ to develop coping mechanisms and problem-solving skills;

~~(8) promotes~~ (7) promoting resiliency, ~~self-advocacy,~~ development of natural supports, and maintenance of skills learned in other support services;

~~(9) establishes~~ (8) establishing and ~~provides~~ providing peer-led parent support groups; and

~~(10) increases the child's ability to function better within the child's home, school, and community by~~ (9) educating parents on community resources~~, assisting with problem solving,~~ and ~~educating parents on~~ mental illnesses.

Subd. 3. **Eligibility.** Family peer support services may be ~~located~~ provided in inpatient hospitalization, partial hospitalization, residential treatment, treatment foster care, day treatment, children's therapeutic services and supports, ~~or~~ and crisis services.

Subd. 4. **Peer support specialist ~~program~~ providers.** The commissioner shall develop a process to certify family peer support ~~specialist programs~~ specialists, in accordance with the federal guidelines, in order for the program to bill for reimbursable services. ~~Family peer support programs must operate within an existing mental health community provider or center.~~

Subd. 5. **Certified family peer specialist training and certification.** The commissioner shall develop a training and certification process for certified family peer specialists who must be at least 21 years of age and have a high school diploma or its equivalent. The candidates must have raised or be currently raising a child with a mental illness, have had

experience navigating the children's mental health system, and must demonstrate leadership and advocacy skills and a strong dedication to family-driven and family-focused services. The training curriculum must teach ~~participating family peer specialists~~ specific skills ~~relevant~~ to ~~providing~~ provide peer support to other parents. In addition to initial training and certification, the commissioner shall develop ongoing continuing educational workshops on pertinent issues related to family peer support ~~counseling~~ services.

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

Sec. 17. Minnesota Statutes 2016, section 256B.0622, subdivision 2, is amended to read:

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.

(c) "Assertive community treatment" means intensive nonresidential treatment and rehabilitative mental health services provided according to the 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.

(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)~~ 245.991, subdivisions 7 to 9.

(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.

(n) "Intensive residential treatment services" means short-term, time-limited services provided in a residential setting to 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.

(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.

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

(r) "Mental health certified peer specialist 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.

EFFECTIVE DATE. This section is effective August 1, 2017.

Sec. 18. Minnesota Statutes 2016, section 256B.0622, subdivision 7a, is amended to read:

Subd. 7a. **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 certified by the American Osteopathic Board of Neurology and Psychiatry 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 lead mental health professional:

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

(ii) is responsible for the provision of individual supportive therapy, symptom management, and empirically supported psychotherapy as specified in a person's treatment plan and must use empirically supported techniques to address a wide range of clinical and behavioral needs for this population;

(iii) conduct comprehensive assessment of psychiatric history including but not limited to onset, course and effect of illness, past treatment and responses, and risk behaviors; mental status; and diagnosis and educate the ACT team in identifying and choosing the appropriate interventions for psychiatric needs; and

(iv) provide direct clinical services including individual supportive therapy and psychotherapy to clients on an individual, group, and family basis to teach behavioral symptom-management techniques to alleviate and manage symptoms not reduced with medication and promote personal growth and development by assisting clients to adapt and cope with internal and external stresses;

~~(3)~~ (4) 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)~~ (5) 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)~~ (6) 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)~~ (7) 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)~~ (8) 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)~~ (9) 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 individual 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.

Sec. 19. Minnesota Statutes 2016, section 256B.0623, subdivision 2, is amended to read:

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

(a) "Adult rehabilitative mental health services" means mental health services which are rehabilitative and enable the recipient 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. Adult rehabilitative mental health services are also appropriate when provided to enable a recipient to retain stability and functioning, if the recipient would be at risk of significant functional decompensation or more restrictive service settings without these services.

(1) Adult rehabilitative mental health services instruct, assist, and support the recipient in areas such as: interpersonal communication skills, community resource utilization and integration skills, crisis ~~assistance~~ planning as defined in section 245.462, subdivision 6, relapse prevention skills, health care directives, budgeting and shopping skills, healthy lifestyle skills and practices, cooking and nutrition skills, transportation skills, medication education and monitoring, mental illness symptom management skills, household management skills, employment-related skills, parenting skills, and transition to community living services.

(2) These services shall be provided to the recipient on a one-to-one basis in the recipient's home or another community setting or in groups.

(b) "Medication education services" means services provided individually or in groups which focus on educating the recipient about mental illness and symptoms; the role and effects of medications in treating symptoms of mental illness; and 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, physician assistants, or registered nurses.

(c) "Transition to community living services" means services which maintain continuity of contact between the rehabilitation services provider and the recipient and which facilitate discharge from a hospital, residential treatment program under Minnesota Rules, chapter 9505, board and lodging facility, or nursing home. Transition to community living services are not intended to provide other areas of adult rehabilitative mental health services.

EFFECTIVE DATE. This section is effective August 1, 2017.

Sec. 20. Minnesota Statutes 2016, section 256B.0624, subdivision 1, is amended to read:

Subdivision 1. **Scope.** Medical assistance covers ~~adult~~ mental health crisis response services as defined in ~~subdivision 2, paragraphs (c) to (e)~~ section 245.991, subject to federal approval, if provided to a recipient as defined in subdivision 3 and provided by a qualified provider entity as defined in this section and by a qualified individual provider working within the provider's scope of practice and ~~as defined in this subdivision and~~ identified in the recipient's individual crisis treatment plan as defined in ~~subdivision 11~~ section 245.991 and if determined to be medically necessary.

EFFECTIVE DATE. This section is effective August 1, 2017.

Sec. 21. Minnesota Statutes 2016, section 256B.0624, subdivision 2, is amended to read:

Subd. 2. **Definitions.** ~~For purposes of this section,~~ The ~~following~~ terms used in this section have the meanings given them in section 245.991, subdivision 2.

~~(a) "Mental health crisis" is an adult behavioral, emotional, or psychiatric situation which, but for the provision of crisis response services, would likely result in significantly reduced levels of functioning in primary activities of daily living, or in an emergency situation, or in the placement of the recipient in a more restrictive setting, including, but not limited to, inpatient hospitalization.~~

~~(b) "Mental health emergency" is an adult behavioral, emotional, or psychiatric situation which causes an immediate need for mental health services and is consistent with section 62Q.55.~~

~~A mental health crisis or emergency is determined for medical assistance service reimbursement by a physician, a mental health professional, or crisis mental health practitioner with input from the recipient whenever possible.~~

~~(c) "Mental health crisis assessment" means an immediate face-to-face assessment by a physician, a mental health professional, or mental health practitioner under the clinical supervision of a mental health professional, following a screening that suggests that the adult may be experiencing a mental health crisis or mental health emergency situation. It includes, when feasible, assessing whether the person might be willing to voluntarily accept treatment, determining whether the person has an advance directive, and obtaining information and history from involved family members or caretakers.~~

~~(d) "Mental health mobile crisis intervention services" means face-to-face, short-term intensive mental health services initiated during a mental health crisis or mental health emergency to help the recipient cope with immediate stressors, identify and utilize available resources and strengths, engage in voluntary treatment, and begin to return to the recipient's baseline level of functioning. The services, including screening and treatment plan recommendations, must be culturally and linguistically appropriate.~~

~~(1) This service is provided on site by a mobile crisis intervention team outside of an inpatient hospital setting. Mental health mobile crisis intervention services must be available 24 hours a day, seven days a week.~~

~~(2) The initial screening must consider other available services to determine which service intervention would best address the recipient's needs and circumstances.~~

~~(3) The mobile crisis intervention team must be available to meet promptly face-to-face with a person in mental health crisis or emergency in a community setting or hospital emergency room.~~

~~(4) The intervention must consist of a mental health crisis assessment and a crisis treatment plan.~~

~~(5) The team must be available to individuals who are experiencing a co-occurring substance use disorder, who do not need the level of care provided in a detoxification facility.~~

~~(6) The treatment plan must include recommendations for any needed crisis stabilization services for the recipient, including engagement in treatment planning and family psychoeducation.~~

~~(e) "Mental health crisis stabilization services" means individualized mental health services provided to a recipient following crisis intervention services which are designed to restore the recipient to the recipient's prior functional level. Mental health crisis stabilization services may be provided in the recipient's home, the home of a family member or friend of the recipient, another community setting, or a short-term supervised, licensed residential program. Mental health crisis stabilization does not include partial hospitalization or day treatment. Mental health crisis stabilization services includes family psychoeducation.~~

EFFECTIVE DATE. This section is effective August 1, 2017.

Sec. 22. Minnesota Statutes 2016, section 256B.0624, subdivision 3, is amended to read:

Subd. 3. **Eligibility.** ~~An eligible recipient is an individual who:~~

~~(1) is age 18 or older;~~

~~(2) is screened as possibly experiencing a mental health crisis or emergency where a mental health crisis assessment is needed; and~~

~~(3) is assessed as experiencing a mental health crisis or emergency, and mental health crisis intervention or crisis intervention and stabilization services are determined to be medically necessary.~~

(a) An eligible adult recipient is an individual who:

(1) is eligible for medical assistance;

(2) is 18 years of age or older;

(3) for the purposes of an assessment, is screened as potentially experiencing a crisis;

(4) for the purposes of intervention services, is assessed as experiencing a crisis and for whom intervention services are necessary;

(5) for the purposes of stabilization services, is assessed as experiencing a crisis and for whom stabilization services are necessary; and

(6) for the purposes of residential stabilization services, is assessed as experiencing a crisis and for whom residential stabilization services are necessary.

(b) An eligible child recipient is an individual who:

(1) is eligible for medical assistance;

(2) is younger than 18 years of age;

(3) for the purposes of an assessment, is screened as potentially experiencing a crisis;

(4) for the purposes of intervention services, is assessed as experiencing a crisis and for whom intervention services are necessary; and

(5) for the purposes of stabilization services, is assessed as experiencing a crisis and for whom stabilization services are necessary.

(c) A crisis is determined for medical assistance service reimbursement by a physician, a mental health professional, or a mental health practitioner who is a member of the crisis team with input from the recipient whenever possible.

EFFECTIVE DATE. This section is effective August 1, 2017.

Sec. 23. Minnesota Statutes 2016, section 256B.0624, subdivision 4, is amended to read:

Subd. 4. **Provider entity standards.** ~~(a)~~ A provider entity is an entity that meets the standards listed in ~~paragraph (b) and:~~ section 245.991, subdivision 4, and is a currently enrolled medical assistance provider.

~~(1) is a county board operated entity; or~~

~~(2) is a provider entity that is under contract with the county board in the county where the potential crisis or emergency is occurring. To provide services under this section, the provider entity must directly provide the services; or if services are subcontracted, the provider entity must maintain responsibility for services and billing.~~

~~(b) The adult mental health crisis response services provider entity must have the capacity to meet and carry out the following standards:~~

~~(1) has the capacity to recruit, hire, and manage and train mental health professionals, practitioners, and rehabilitation workers;~~

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

~~(3) is able to ensure adequate preservice and in-service training;~~

~~(4) is able to ensure that staff providing these services are skilled in the delivery of mental health crisis response services to recipients;~~

~~(5) is able to ensure that staff are capable of implementing culturally specific treatment identified in the individual treatment plan that is meaningful and appropriate as determined by the recipient's culture, beliefs, values, and language;~~

~~(6) is able to ensure enough flexibility to respond to the changing intervention and care needs of a recipient as identified by the recipient during the service partnership between the recipient and providers;~~

~~(7) is able to ensure that mental health professionals and mental health practitioners have the communication tools and procedures to communicate and consult promptly about crisis assessment and interventions as services occur;~~

~~(8) is able to coordinate these services with county emergency services, community hospitals, ambulance, transportation services, social services, law enforcement, and mental health crisis services through regularly scheduled interagency meetings;~~

~~(9) is able to ensure that mental health crisis assessment and mobile crisis intervention services are available 24 hours a day, seven days a week;~~

~~(10) is able to ensure that services are coordinated with other mental health service providers, county mental health authorities, or federally recognized American Indian authorities and others as necessary, with the consent of the adult. Services must also be coordinated with the recipient's case manager if the adult is receiving case management services;~~

~~(11) is able to ensure that crisis intervention services are provided in a manner consistent with sections 245.461 to 245.486;~~

~~(12) is able to submit information as required by the state;~~

~~(13) maintains staff training and personnel files;~~

~~(14) is able to establish and maintain a quality assurance and evaluation plan to evaluate the outcomes of services and recipient satisfaction;~~

~~(15) is able to keep records as required by applicable laws;~~

~~(16) is able to comply with all applicable laws and statutes;~~

~~(17) is an enrolled medical assistance provider; and~~

~~(18) develops and maintains written policies and procedures regarding service provision and administration of the provider entity, including safety of staff and recipients in high-risk situations.~~

EFFECTIVE DATE. This section is effective August 1, 2017.

Sec. 24. Minnesota Statutes 2016, section 256B.0625, subdivision 35a, is amended to read:

Subd. 35a. **Children's mental health crisis response services.** Medical assistance covers children's mental health crisis response services according to section ~~256B.0944~~ 256B.0624.

EFFECTIVE DATE. This section is effective August 1, 2017.

Sec. 25. Minnesota Statutes 2016, section 256B.092, subdivision 14, is amended to read:

Subd. 14. **Reduce avoidable behavioral crisis emergency room admissions, psychiatric inpatient hospitalizations, and commitments to institutions.** (a) Persons receiving home and community-based services authorized under this section who have had two or more admissions within a calendar year to an emergency room, psychiatric unit, or institution must receive consultation from a mental health professional as defined in section

245.462, subdivision 18, or a behavioral professional as defined in the home and community-based services state plan within 30 days of discharge. The mental health professional or behavioral professional must:

(1) conduct a functional assessment of the crisis incident as defined in section 245D.02, subdivision 11, which led to the hospitalization with the goal of developing proactive strategies as well as necessary reactive strategies to reduce the likelihood of future avoidable hospitalizations due to a behavioral crisis;

(2) use the results of the functional assessment to amend the coordinated service and support plan set forth in section 245D.02, subdivision 4b, to address the potential need for additional staff training, increased staffing, ~~access to crisis mobility services,~~ mental health services, use of technology, and crisis ~~stabilization~~ services in section ~~256B.0624, subdivision 7~~ 245.991; and

(3) identify the need for additional consultation, testing, ~~and mental health crisis intervention team services as defined in section 245D.02, subdivision 20,~~ psychotropic medication use and monitoring under section 245D.051, and the frequency and duration of ongoing consultation.

(b) For the purposes of this subdivision, "institution" includes, but is not limited to, the Anoka-Metro Regional Treatment Center and the Minnesota Security Hospital.

EFFECTIVE DATE. This section is effective August 1, 2017.

Sec. 26. Minnesota Statutes 2016, section 256B.0943, subdivision 1, is amended to read:

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

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

(b) "Clinical supervision" means the overall responsibility of the mental health professional for the control and direction of individualized treatment planning, service delivery, and treatment review for each client. A mental health professional who is an enrolled Minnesota health care program provider accepts full professional responsibility

for a supervisee's actions and decisions, instructs the supervisee in the supervisee's work, and oversees or directs the supervisee's work.

(c) "Clinical trainee" means a mental health practitioner who meets the qualifications specified in Minnesota Rules, part 9505.0371, subpart 5, item C.

(d) "Crisis planning" means the development of a written plan to assist a child's family to contend with a potential crisis and is distinct from the immediate provision of crisis intervention services. The plan addresses prevention and intervention strategies to be used in a crisis. It identifies factors that might precipitate a mental health crisis, identify behaviors related to the emergence of a crisis, and resources available to resolve a crisis.

~~(d) "Crisis assistance" has the meaning given in section 245.4871, subdivision 9a. Crisis assistance entails the development of a written plan to assist a child's family to contend with a potential crisis and is distinct from the immediate provision of crisis intervention services.~~

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

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

(g) "Diagnostic assessment" has the meaning given in Minnesota Rules, part 9505.0372, subpart 1.

(h) "Direct service time" means the time that a mental health professional, clinical trainee, mental health practitioner, or mental health behavioral aide spends face-to-face with a client and the client's family or providing covered telemedicine services. Direct service time includes time in which the provider obtains a client's history, develops a client's treatment plan, records individual treatment outcomes, or provides service components of children's therapeutic services and supports. Direct service time does not include time doing work before and after providing direct services, including scheduling or maintaining clinical records.

(i) "Direction of mental health behavioral aide" means the activities of a mental health professional or mental health practitioner in guiding the mental health behavioral aide in

providing services to a client. The direction of a mental health behavioral aide must be based on the client's individualized treatment plan and meet the requirements in subdivision 6, paragraph (b), clause (5).

(j) "Emotional disturbance" has the meaning given in section 245.4871, subdivision 15.

(k) "Individual behavioral plan" means a plan of intervention, treatment, and services for a child written by a mental health professional or mental health practitioner, under the clinical supervision of a mental health professional, to guide the work of the mental health behavioral aide. The individual behavioral plan may be incorporated into the child's individual treatment plan so long as the behavioral plan is separately communicable to the mental health behavioral aide.

(l) "Individual treatment plan" has the meaning given in Minnesota Rules, part 9505.0371, subpart 7.

(m) "Mental health behavioral aide services" means medically necessary one-on-one activities performed by a trained paraprofessional qualified as provided in subdivision 7, paragraph (b), clause (3), to assist a child retain or generalize psychosocial skills as previously trained by a mental health professional or mental health practitioner and as described in the child's individual treatment plan and individual behavior plan. Activities involve working directly with the child or child's family as provided in subdivision 9, paragraph (b), clause (4).

(n) "Mental health practitioner" means an individual as defined in Minnesota Rules, part 9505.0370, subpart 17.

(o) "Mental health professional" means an individual as defined in Minnesota Rules, part 9505.0370, subpart 18.

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

(1) the development, review, and revision of a child's individual treatment plan, as provided in Minnesota Rules, part 9505.0371, subpart 7, including involvement of the client or client's parents, primary caregiver, or other person authorized to consent to mental health services for the client, and including arrangement of treatment and support activities specified in the individual treatment plan; and

(2) administering standardized outcome measurement instruments, determined and updated by the commissioner, as periodically needed to evaluate the effectiveness of treatment for children receiving clinical services and reporting outcome measures, as required by the commissioner.

(q) "Mental illness," for persons at least age 18 but under age 21, has the meaning given in section 245.462, subdivision 20, paragraph (a).

(r) "Psychotherapy" means the treatment of mental or emotional disorders or maladjustment by psychological means. Psychotherapy may be provided in many modalities in accordance with Minnesota Rules, part 9505.0372, subpart 6, including patient and/or family psychotherapy; family psychotherapy; psychotherapy for crisis; group psychotherapy; or multiple-family psychotherapy. Beginning with the American Medical Association's Current Procedural Terminology, standard edition, 2014, the procedure "individual psychotherapy" is replaced with "patient and/or family psychotherapy," a substantive change that permits the therapist to work with the client's family without the client present to obtain information about the client or to explain the client's treatment plan to the family. Psychotherapy is appropriate for crisis response when a child has become dysregulated or experienced new trauma since the diagnostic assessment was completed and needs psychotherapy to address issues not currently included in the child's individual treatment plan.

(s) "Rehabilitative services" or "psychiatric rehabilitation services" means a series or multidisciplinary combination of psychiatric and psychosocial interventions to: (1) restore a child or adolescent to an age-appropriate developmental trajectory that had been disrupted by a psychiatric illness; or (2) enable the child to self-monitor, compensate for, cope with, counteract, or replace psychosocial skills deficits or maladaptive skills acquired over the course of a psychiatric illness. Psychiatric rehabilitation services for children combine psychotherapy to address internal psychological, emotional, and intellectual processing deficits, and skills training to restore personal and social functioning. Psychiatric rehabilitation services establish a progressive series of goals with each achievement building upon a prior achievement. Continuing progress toward goals is expected, and rehabilitative potential ceases when successive improvement is not observable over a period of time.

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

EFFECTIVE DATE. This section is effective August 1, 2017.

Sec. 27. Minnesota Statutes 2016, section 256B.0943, subdivision 2, is amended to read:

Subd. 2. **Covered service components of children's therapeutic services and supports.** (a) Subject to federal approval, medical assistance covers medically necessary children's therapeutic services and supports as defined in this section that an eligible provider entity certified under subdivision 4 provides to a client eligible under subdivision 3.

(b) The service components of children's therapeutic services and supports are:

(1) patient and/or family psychotherapy, family psychotherapy, psychotherapy for crisis, and group psychotherapy;

(2) individual, family, or group skills training provided by a mental health professional or mental health practitioner;

(3) crisis ~~assistance~~ planning;

(4) mental health behavioral aide services;

(5) direction of a mental health behavioral aide;

(6) mental health service plan development; and

(7) children's day treatment.

EFFECTIVE DATE. This section is effective August 1, 2017.

Sec. 28. Minnesota Statutes 2016, section 256B.0943, subdivision 4, is amended to read:

Subd. 4. **Provider entity certification.** (a) The commissioner shall establish an initial provider entity application and certification process and recertification process to determine whether a provider entity has an administrative and clinical infrastructure that meets the requirements in subdivisions 5 and 6. A provider entity must be certified for the three core rehabilitation services of psychotherapy, skills training, and crisis ~~assistance~~ planning. The commissioner shall recertify a provider entity at least every three years. The commissioner shall establish a process for decertification of a provider entity and shall require corrective action, medical assistance repayment, or decertification of a provider entity 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.

(b) For purposes of this section, a provider entity must be:

(1) an Indian health services facility or a facility owned and operated by a tribe or tribal organization operating as a 638 facility under ~~Public Law 93-638~~ United States Code, title 25, section 450f, certified by the state;

(2) a county-operated entity certified by the state; or

(3) a noncounty entity certified by the state.

EFFECTIVE DATE. This section is effective August 1, 2017.

Sec. 29. Minnesota Statutes 2016, section 256B.0943, subdivision 7, is amended to read:

Subd. 7. **Qualifications of individual and team providers.** (a) An individual or team provider working within the scope of the provider's practice or qualifications may provide service components of children's therapeutic services and supports that are identified as medically necessary in a client's individual treatment plan.

(b) An individual provider must be qualified as:

(1) a mental health professional as defined in subdivision 1, paragraph (o); or

(2) a mental health practitioner or clinical trainee. The mental health practitioner or clinical trainee must work under the clinical supervision of a mental health professional; or

(3) a mental health behavioral aide working under the clinical supervision of a mental health professional to implement the rehabilitative mental health services previously introduced by a mental health professional or practitioner and identified in the client's individual treatment plan and individual behavior plan.

(A) A level I mental health behavioral aide must:

(i) be at least 18 years old;

(ii) have a high school diploma or general equivalency diploma (GED) or two years of experience as a ~~primary~~ caregiver to a child with severe emotional disturbance within the previous ten years; and

(iii) meet ~~preservice~~ training and continuing education requirements under subdivision 8.

(B) A level II mental health behavioral aide must:

(i) be at least 18 years old;

(ii) have an associate or bachelor's degree or 4,000 hours of experience in delivering ~~clinical~~ services in the treatment of mental illness concerning children or adolescents or complete a certificate program established under subdivision 8a; and

(iii) meet ~~preservice~~ training and continuing education requirements in subdivision 8.

(c) A day treatment multidisciplinary team must include at least one mental health professional or clinical trainee and one mental health practitioner.

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

Sec. 30. Minnesota Statutes 2016, section 256B.0943, subdivision 9, is amended to read:

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

(1) each individual provider's caseload size permits the provider to deliver services to both clients with severe, complex needs and clients with less intensive needs. The provider's caseload size should reasonably enable the provider to play an active role in service planning, monitoring, and delivering services to meet the client's and client's family's needs, as specified in each client's individual treatment plan;

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

(3) a day treatment program is provided to a group of clients by a multidisciplinary team under the clinical supervision of a mental health professional. The day treatment program must be provided in and by: (i) an outpatient hospital accredited by the Joint Commission on Accreditation of Health Organizations and licensed under sections 144.50 to 144.55; (ii) a community mental health center under section 245.62; or (iii) an entity that is certified under subdivision 4 to operate a program that meets the requirements of section 245.4884, subdivision 2, and Minnesota Rules, parts 9505.0170 to 9505.0475. The day treatment program must stabilize the client's mental health status while developing and improving the client's independent living and socialization skills. The goal of the day treatment program must be to reduce or relieve the effects of mental illness and provide training to enable the client to live in the community. The program must be available year-round at least three to five days per week, two or three hours per day, unless the normal five-day school week is shortened by a holiday, weather-related cancellation, or other districtwide reduction in a school week. A child transitioning into or out of day treatment must receive a minimum treatment of one day a week for a two-hour time block. The two-hour time block must

include at least one hour of patient and/or family or group psychotherapy. The remainder of the structured treatment program may include patient and/or family or group psychotherapy, and individual or group skills training, if included in the client's individual treatment plan. Day treatment programs are not part of inpatient or residential treatment services. When a day treatment group that meets the minimum group size requirement temporarily falls below the minimum group size because of a member's temporary absence, medical assistance covers a group session conducted for the group members in attendance. A day treatment program may provide fewer than the minimally required hours for a particular child during a billing period in which the child is transitioning into, or out of, the program.

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

(1) patient and/or family, family, and group psychotherapy must be delivered as specified in Minnesota Rules, part 9505.0372, subpart 6. Psychotherapy to address the child's underlying mental health disorder must be documented as part of the child's ongoing treatment. A provider must deliver, or arrange for, medically necessary psychotherapy, unless the child's parent or caregiver chooses not to receive it. When a provider delivering other services to a child under this section deems it not medically necessary to provide psychotherapy to the child for a period of 90 days or longer, the provider entity must document the medical reasons why psychotherapy is not necessary. When a provider determines that a child needs psychotherapy but psychotherapy cannot be delivered due to a shortage of licensed mental health professionals in the child's community, the provider must document the lack of access in the child's medical record;

(2) individual, family, or group skills training must be provided by a mental health professional or a mental health practitioner who is delivering services that fall within the scope of the provider's practice and is supervised by a mental health professional who accepts full professional responsibility for the training. Skills training is subject to the following requirements:

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

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

(iii) the mental health professional delivering or supervising the delivery of skills training must document any underlying psychiatric condition and must document how skills training is being used in conjunction with psychotherapy to address the underlying condition;

(iv) skills training delivered to the child's family must teach skills needed by parents to enhance the child's skill development, to help the child utilize daily life skills taught by a mental health professional, clinical trainee, or mental health practitioner, and to develop or maintain a home environment that supports the child's progressive use of skills;

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

(A) one mental health professional or one clinical trainee or mental health practitioner under supervision of a licensed mental health professional must work with a group of three to eight clients; or

(B) two mental health professionals, two clinical trainees or mental health practitioners under supervision of a licensed mental health professional, or one mental health professional or clinical trainee and one mental health practitioner must work with a group of nine to 12 clients;

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

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

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

(4) mental health behavioral aide services must be medically necessary treatment services, identified in the child's individual treatment plan and individual behavior plan, which are performed minimally by a paraprofessional qualified according to subdivision 7, paragraph (b), clause (3), and which are designed to improve the functioning of the child in the progressive use of developmentally appropriate psychosocial skills. Activities involve working directly with the child, child-peer groupings, or child-family groupings to practice, repeat, reintroduce, and master the skills defined in subdivision 1, paragraph (t), as previously taught by a mental health professional, clinical trainee, or mental health practitioner including:

(i) providing cues or prompts in skill-building peer-to-peer or parent-child interactions so that the child progressively recognizes and responds to the cues independently;

(ii) performing as a practice partner or role-play partner;

(iii) reinforcing the child's accomplishments;

(iv) generalizing skill-building activities in the child's multiple natural settings;

(v) assigning further practice activities; and

(vi) intervening as necessary to redirect the child's target behavior and to de-escalate behavior that puts the child or other person at risk of injury.

To be eligible for medical assistance payment, mental health behavioral aide services must be delivered to a child who has been diagnosed with an emotional disturbance or a mental illness, as provided in subdivision 1, paragraph (a). The mental health behavioral aide must implement treatment strategies in the individual treatment plan and the individual behavior plan as developed by the mental health professional, clinical trainee, or mental health practitioner providing direction for the mental health behavioral aide. The mental health behavioral aide must document the delivery of services in written progress notes. Progress notes must reflect implementation of the treatment strategies, as performed by the mental health behavioral aide and the child's responses to the treatment strategies;

(5) direction of a mental health behavioral aide must include the following:

(i) ongoing face-to-face observation of the mental health behavioral aide delivering services to a child by a mental health professional or mental health practitioner for at least a total of one hour during every 40 hours of service provided to a child; and

(ii) immediate accessibility of the mental health professional, clinical trainee, or mental health practitioner to the mental health behavioral aide during service provision;

(6) mental health service plan development must be performed in consultation with the child's family and, when appropriate, with other key participants in the child's life by the child's treating mental health professional or clinical trainee or by a mental health practitioner and approved by the treating mental health professional. Treatment plan drafting consists of development, review, and revision by face-to-face or electronic communication. The provider must document events, including the time spent with the family and other key participants in the child's life to review, revise, and sign the individual treatment plan; and

(7) to be eligible for payment, a diagnostic assessment must be complete with regard to all required components, including multiple assessment appointments required for an extended diagnostic assessment and the written report. Dates of the multiple assessment appointments must be noted in the client's clinical record.

EFFECTIVE DATE. This section is effective August 1, 2017.

Sec. 31. Minnesota Statutes 2016, section 256B.0946, subdivision 1, is amended to read:

Subdivision 1. **Required covered service components.** (a) Effective May 23, 2013, and subject to federal approval, medical assistance covers medically necessary intensive treatment services described under paragraph (b) that are provided by a provider entity eligible under subdivision 3 to a client eligible under subdivision 2 who is placed in a foster home licensed under Minnesota Rules, parts 2960.3000 to 2960.3340, or placed in a foster home licensed under the regulations established by a federally recognized Minnesota tribe.

(b) Intensive treatment services to children with mental illness residing in foster family settings that comprise specific required service components provided in clauses (1) to (5) are reimbursed by medical assistance when they meet the following standards:

(1) psychotherapy provided by a mental health professional as defined in Minnesota Rules, part 9505.0371, subpart 5, item A, or a clinical trainee, as defined in Minnesota Rules, part 9505.0371, subpart 5, item C;

(2) crisis ~~assistance~~ planning provided according to standards for children's therapeutic services and supports in section 256B.0943;

(3) individual, family, and group psychoeducation services, defined in subdivision 1a, paragraph (q), provided by a mental health professional or a clinical trainee;

(4) clinical care consultation, as defined in subdivision 1a, and provided by a mental health professional or a clinical trainee; and

(5) service delivery payment requirements as provided under subdivision 4.

EFFECTIVE DATE. This section is effective August 1, 2017.

Sec. 32. Minnesota Statutes 2016, section 256B.0946, subdivision 1a, is amended to read:

Subd. 1a. **Definitions.** For the purposes of this section, the following terms have the meanings given them.

(a) "Clinical care consultation" means communication from a treating clinician to other providers working with the same client to inform, inquire, and instruct regarding the client's symptoms, strategies for effective engagement, care and intervention needs, and treatment expectations across service settings, including but not limited to the client's school, social services, day care, probation, home, primary care, medication prescribers, disabilities services, and other mental health providers and to direct and coordinate clinical service components provided to the client and family.

(b) "Clinical supervision" means the documented time a clinical supervisor and supervisee spend together to discuss the supervisee's work, to review individual client cases, and for the supervisee's professional development. It includes the documented oversight and supervision responsibility for planning, implementation, and evaluation of services for a client's mental health treatment.

(c) "Clinical supervisor" means the mental health professional who is responsible for clinical supervision.

(d) "Clinical trainee" has the meaning given in Minnesota Rules, part 9505.0371, subpart 5, item C;

(e) "Crisis ~~assistance~~ planning" has the meaning given in section 245.4871, subdivision 9a, including the development of a plan that addresses prevention and intervention strategies to be used in a potential crisis, but does not include actual crisis intervention.

(f) "Culturally appropriate" means providing mental health services in a manner that incorporates the child's cultural influences, as defined in Minnesota Rules, part 9505.0370, subpart 9, into interventions as a way to maximize resiliency factors and utilize cultural strengths and resources to promote overall wellness.

(g) "Culture" means the distinct ways of living and understanding the world that are used by a group of people and are transmitted from one generation to another or adopted by an individual.

(h) "Diagnostic assessment" has the meaning given in Minnesota Rules, part 9505.0370, subpart 11.

(i) "Family" means a person who is identified by the client or the client's parent or guardian as being important to the client's mental health treatment. Family may include, but is not limited to, parents, foster parents, children, spouse, committed partners, former spouses, persons related by blood or adoption, persons who are a part of the client's permanency plan, or persons who are presently residing together as a family unit.

(j) "Foster care" has the meaning given in section 260C.007, subdivision 18.

(k) "Foster family setting" means the foster home in which the license holder resides.

(l) "Individual treatment plan" has the meaning given in Minnesota Rules, part 9505.0370, subpart 15.

(m) "Mental health practitioner" has the meaning given in Minnesota Rules, part 9505.0370, subpart 17.

(n) "Mental health professional" has the meaning given in Minnesota Rules, part 9505.0370, subpart 18.

(o) "Mental illness" has the meaning given in Minnesota Rules, part 9505.0370, subpart 20.

(p) "Parent" has the meaning given in section 260C.007, subdivision 25.

(q) "Psychoeducation services" means information or demonstration provided to an individual, family, or group to explain, educate, and support the individual, family, or group in understanding a child's symptoms of mental illness, the impact on the child's development, and needed components of treatment and skill development so that the individual, family, or group can help the child to prevent relapse, prevent the acquisition of comorbid disorders, and achieve optimal mental health and long-term resilience.

(r) "Psychotherapy" has the meaning given in Minnesota Rules, part 9505.0370, subpart 27.

(s) "Team consultation and treatment planning" means the coordination of treatment plans and consultation among providers in a group concerning the treatment needs of the child, including disseminating the child's treatment service schedule to all members of the service team. Team members must include all mental health professionals working with the child, a parent, the child unless the team lead or parent deem it clinically inappropriate, and at least two of the following: an individualized education program case manager; probation agent; children's mental health case manager; child welfare worker, including adoption or guardianship worker; primary care provider; foster parent; and any other member of the child's service team.

EFFECTIVE DATE. This section is effective August 1, 2017.

Sec. 33. Minnesota Statutes 2016, section 256B.0946, subdivision 4, is amended to read:

Subd. 4. **Service delivery payment requirements.** (a) To be eligible for payment under this section, a provider must develop and practice written policies and procedures for intensive treatment in foster care, consistent with subdivision 1, paragraph (b), and comply with the following requirements in paragraphs (b) to (n).

(b) A qualified clinical supervisor, as defined in and performing in compliance with Minnesota Rules, part 9505.0371, subpart 5, item D, must supervise the treatment and provision of services described in this section.

(c) Each client receiving treatment services must receive an extended diagnostic assessment, as described in Minnesota Rules, part 9505.0372, subpart 1, item C, within 30 days of enrollment in this service unless the client has a previous extended diagnostic assessment that the client, parent, and mental health professional agree still accurately describes the client's current mental health functioning.

(d) Each previous and current mental health, school, and physical health treatment provider must be contacted to request documentation of treatment and assessments that the eligible client has received. This information must be reviewed and incorporated into the diagnostic assessment and team consultation and treatment planning review process.

(e) Each client receiving treatment must be assessed for a trauma history, and the client's treatment plan must document how the results of the assessment will be incorporated into treatment.

(f) Each client receiving treatment services must have an individual treatment plan that is reviewed, evaluated, and signed every 90 days using the team consultation and treatment planning process, as defined in subdivision 1a, paragraph (s).

(g) Care consultation, as defined in subdivision 1a, paragraph (a), must be provided in accordance with the client's individual treatment plan.

(h) Each client must have a crisis ~~assistance~~ plan within ten days of initiating services and must have access to clinical phone support 24 hours per day, seven days per week, during the course of treatment. The crisis plan must demonstrate coordination with the local or regional ~~mobile~~ crisis ~~intervention team~~ provider entity as defined in section 245.991, subdivision 4.

(i) Services must be delivered and documented at least three days per week, equaling at least six hours of treatment per week, unless reduced units of service are specified on the treatment plan as part of transition or on a discharge plan to another service or level of care. Documentation must comply with Minnesota Rules, parts 9505.2175 and 9505.2197.

(j) Location of service delivery must be in the client's home, day care setting, school, or other community-based setting that is specified on the client's individualized treatment plan.

(k) Treatment must be developmentally and culturally appropriate for the client.

(l) Services must be delivered in continual collaboration and consultation with the client's medical providers and, in particular, with prescribers of psychotropic medications, including those prescribed on an off-label basis. Members of the service team must be aware of the medication regimen and potential side effects.

(m) Parents, siblings, foster parents, and members of the child's permanency plan must be involved in treatment and service delivery unless otherwise noted in the treatment plan.

(n) Transition planning for the child must be conducted starting with the first treatment plan and must be addressed throughout treatment to support the child's permanency plan and postdischarge mental health service needs.

EFFECTIVE DATE. This section is effective August 1, 2017.

Sec. 34. Minnesota Statutes 2016, section 256B.0946, subdivision 6, is amended to read:

Subd. 6. **Excluded services.** (a) Services in clauses (1) to (7) are not covered under this section and are not eligible for medical assistance payment as components of intensive treatment in foster care services, but may be billed separately:

(1) inpatient psychiatric hospital treatment;

(2) mental health targeted case management;

(3) partial hospitalization;

(4) medication management;

(5) children's mental health day treatment services;

(6) crisis response services under section ~~256B.0944~~ 256B.0624; and

(7) transportation.

(b) Children receiving intensive treatment in foster care services are not eligible for medical assistance reimbursement for the following services while receiving intensive treatment in foster care:

(1) psychotherapy and skills training components of children's therapeutic services and supports under section 256B.0625, subdivision 35b;

(2) mental health behavioral aide services as defined in section 256B.0943, subdivision 1, paragraph (m);

(3) home and community-based waiver services;

(4) mental health residential treatment; and

(5) room and board costs as defined in section 256I.03, subdivision 6.

EFFECTIVE DATE. This section is effective August 1, 2017.

Sec. 35. Minnesota Statutes 2016, section 256B.0947, subdivision 3a, is amended to read:

Subd. 3a. **Required service components.** (a) Subject to federal approval, medical assistance covers all medically necessary intensive nonresidential rehabilitative mental health services and supports, as defined in this section, under a single daily rate per client. Services and supports must be delivered by an eligible provider under subdivision 5 to an eligible client under subdivision 3.

(b) Intensive nonresidential rehabilitative mental health services, supports, and ancillary activities covered by the single daily rate per client must include the following, as needed by the individual client:

(1) individual, family, and group psychotherapy;

(2) individual, family, and group skills training, as defined in section 256B.0943, subdivision 1, paragraph (t);

(3) crisis ~~assistance~~ planning as defined in section 245.4871, subdivision 9a, which includes recognition of factors precipitating a mental health crisis, identification of behaviors related to the crisis, and the development of a plan to address prevention, intervention, and follow-up strategies to be used in the lead-up to or onset of, and conclusion of, a mental health crisis; crisis ~~assistance~~ planning does not mean crisis response services or ~~crisis~~ intervention services provided in section ~~256B.0944~~ 245.991;

(4) medication management provided by a physician or an advanced practice registered nurse with certification in psychiatric and mental health care;

(5) mental health case management as provided in section 256B.0625, subdivision 20;

(6) medication education services as defined in this section;

(7) care coordination by a client-specific lead worker assigned by and responsible to the treatment team;

(8) psychoeducation of and consultation and coordination with the client's biological, adoptive, or foster family and, in the case of a youth living independently, the client's immediate nonfamilial support network;

(9) clinical consultation to a client's employer or school or to other service agencies or to the courts to assist in managing the mental illness or co-occurring disorder and to develop client support systems;

(10) coordination with, or performance of, ~~crisis~~ intervention and stabilization services as defined in section ~~256B.0944~~ 245.991, subdivision 2;

(11) assessment of a client's treatment progress and effectiveness of services using standardized outcome measures published by the commissioner;

(12) transition services as defined in this section;

(13) integrated dual disorders treatment as defined in this section; and

(14) housing access support.

(c) The provider shall ensure and document the following by means of performing the required function or by contracting with a qualified person or entity:

(1) client access to crisis intervention services, as defined in section ~~256B.0944~~ 245.991, and available 24 hours per day and seven days per week;

(2) completion of an extended diagnostic assessment, as defined in Minnesota Rules, part 9505.0372, subpart 1, item C; and

(3) determination of the client's needed level of care using an instrument approved and periodically updated by the commissioner.

EFFECTIVE DATE. This section is effective August 1, 2017.

Sec. 36. Minnesota Statutes 2016, section 256B.0947, subdivision 7, is amended to read:

Subd. 7. **Medical assistance payment and rate setting.** (a) Payment for services in this section must be based on one daily encounter rate per provider inclusive of the following services received by an eligible client in a given calendar day: all rehabilitative services,

supports, and ancillary activities under this section, staff travel time to provide rehabilitative services under this section, and crisis response services under section ~~256B.0944~~ 256B.0624.

(b) Payment must not be made to more than one entity for each 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 shall determine how to distribute the payment among the members.

(c) The commissioner shall establish regional cost-based rates for entities that will bill medical assistance for nonresidential intensive rehabilitative mental health services. In developing these rates, the commissioner shall consider:

(1) the cost for similar services in the health care trade area;

(2) actual costs incurred by entities providing the services;

(3) the intensity and frequency of services to be provided to each client;

(4) the degree to which 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 a provider must not exceed the rate charged by that provider for the same service to other payers.

EFFECTIVE DATE. This section is effective August 1, 2017.

Sec. 37. Minnesota Statutes 2016, section 256B.49, subdivision 25, is amended to read:

Subd. 25. **Reduce avoidable behavioral crisis emergency room admissions, psychiatric inpatient hospitalizations, and commitments to institutions.** (a) Persons receiving home and community-based services authorized under this section who have two or more admissions within a calendar year to an emergency room, psychiatric unit, or institution must receive consultation from a mental health professional as defined in section 245.462, subdivision 18, or a behavioral professional as defined in the home and community-based services state plan within 30 days of discharge. The mental health professional or behavioral professional must:

(1) conduct a functional assessment of the crisis incident as defined in section 245D.02, subdivision 11, which led to the hospitalization with the goal of developing proactive strategies as well as necessary reactive strategies to reduce the likelihood of future avoidable hospitalizations due to a behavioral crisis;

(2) use the results of the functional assessment to amend the coordinated service and support plan in section 245D.02, subdivision 4b, to address the potential need for additional staff training, increased staffing, ~~access to crisis mobility services,~~ mental health services, use of technology, and crisis ~~stabilization~~ services in section ~~256B.0624, subdivision 7~~ 245.991; and

(3) identify the need for additional consultation, testing, ~~mental health crisis intervention team services as defined in section 245D.02, subdivision 20,~~ psychotropic medication use and monitoring under section 245D.051, and the frequency and duration of ongoing consultation.

(b) For the purposes of this subdivision, "institution" includes, but is not limited to, the Anoka-Metro Regional Treatment Center and the Minnesota Security Hospital.

EFFECTIVE DATE. This section is effective August 1, 2017.

Sec. 38. Minnesota Statutes 2016, section 256B.84, is amended to read:

256B.84 AMERICAN INDIAN CONTRACTING PROVISIONS.

Notwithstanding other state laws or rules, Indian health services and agencies operated by Indian tribes are not required to have a county contract or county certification to enroll as providers of adult rehabilitative mental health services under section 256B.0623; and adult mental health crisis response services under section ~~256B.0624~~ 245.991. In order to enroll as providers of these services, Indian health services and agencies operated by Indian tribes must meet the vendor of medical care requirements in section 256B.02, subdivision 7.

EFFECTIVE DATE. This section is effective August 1, 2017.

Sec. 39. **REVISOR'S INSTRUCTION.**

The revisor shall make necessary cross-reference changes and remove statutory cross-references in Minnesota Statutes and Minnesota Rules to conform with the recodification and repealer in this article. The revisor may make technical and other necessary changes to sentence structure to preserve the meaning of the text. The revisor may alter the statutory coding in this article to incorporate statutory changes made by other laws during the 2017 regular legislative session. If a provision repealed by this article is also amended by other law during the 2017 regular legislative session, the revisor shall merge the amendment into the recodification, notwithstanding Minnesota Statutes, section 645.30.

EFFECTIVE DATE. This section is effective August 1, 2017.

Sec. 40. **REPEALER.**

Minnesota Statutes 2016, sections 245.469; 245.4879; 256B.0624, subdivisions 4a, 5, 6, 7, 8, 9, 10, and 11; and 256B.0944, are repealed.

EFFECTIVE DATE. This section is effective August 1, 2017.

ARTICLE 3

OPERATIONS

Section 1. Minnesota Statutes 2016, section 245.095, is amended to read:

245.095 LIMITS ON RECEIVING PUBLIC FUNDS.

Subdivision 1. **Prohibition.** (a) If a provider, vendor, or individual enrolled, licensed, ~~or~~ receiving funds under a grant contract, or registered in any program administered by the commissioner, including under the commissioner's powers and authorities in section 256.01, is excluded from ~~any~~ that program ~~administered by the commissioner, including under the commissioner's powers and authorities in section 256.01~~, the commissioner shall:

(1) prohibit the excluded provider, vendor, or individual from enrolling ~~or~~, becoming licensed, receiving grant funds, or registering in any other program administered by the commissioner~~.~~; and

(2) disenroll, revoke or suspend a license, disqualify, or debar the excluded provider, vendor, or individual in any other program administered by the commissioner.

(b) The duration of this prohibition, disenrollment, revocation, suspension, disqualification, or debarment must last for the longest applicable sanction or disqualifying period in effect for the provider, vendor, or individual permitted by state or federal law.

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

(b) "Excluded" means disenrolled, subject to license revocation or suspension, disqualified, or subject to vendor debarment under Minnesota Rules, part 1230.1150, or excluded pursuant to section 256B.064, subdivision 3.

(c) "Individual" means a natural person providing products or services as a provider or vendor.

(d) "Provider" means an owner, controlling individual, license holder, director, or managerial official.

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

Sec. 2. Minnesota Statutes 2016, section 245A.02, is amended by adding a subdivision to read:

Subd. 3b. **Authorized agent.** "Authorized agent" means the controlling individual designated by the license holder to be responsible for communicating with the commissioner of human services on all matters provided for in this chapter and on whom service of all notices and orders must be made, pursuant to section 245A.04, subdivision 1.

EFFECTIVE DATE. This section is effective August 1, 2017.

Sec. 3. Minnesota Statutes 2016, section 245A.02, subdivision 5a, is amended to read:

Subd. 5a. **Controlling individual.** (a) "Controlling individual" means ~~a public body, governmental agency, business entity, officer, owner, or managerial official whose responsibilities include the direction of the management or policies of a program. For purposes of this subdivision, owner means an individual who has direct or indirect ownership interest in a corporation, partnership, or other business association issued a license under this chapter.~~ the owner of a program or service licensed under this chapter and the following individuals, if applicable:

(1) each officer of the organization, including the chief executive officer and chief financial officer;

(2) the individual designated as the authorized agent pursuant to section 245A.04, subdivision 1;

(3) the individual designated as the compliance officer pursuant to section 256B.04, subdivision 21; and

(4) each managerial official whose responsibilities include the direction of the management or policies of a program.

~~For purposes of this subdivision, managerial official means those individuals who have the decision-making authority related to the operation of the program, and the responsibility for the ongoing management of or direction of the policies, services, or employees of the program. A site director who has no ownership interest in the program is not considered to be a managerial official for purposes of this definition.~~

(b) Controlling individual does not include:

(1) a bank, savings bank, trust company, savings association, credit union, industrial loan and thrift company, investment banking firm, or insurance company unless the entity operates a program directly or through a subsidiary;

(2) an individual who is a state or federal official, or state or federal employee, or a member or employee of the governing body of a political subdivision of the state or federal government that operates one or more programs, unless the individual is also an officer, owner, or managerial official of the program, receives remuneration from the program, or owns any of the beneficial interests not excluded in this subdivision;

(3) an individual who owns less than five percent of the outstanding common shares of a corporation:

(i) whose securities are exempt under section 80A.45, clause (6); or

(ii) whose transactions are exempt under section 80A.46, clause (2); or

(4) an individual who is a member of an organization exempt from taxation under section 290.05, unless the individual is also an officer, owner, or managerial official of the program or owns any of the beneficial interests not excluded in this subdivision. This clause does not exclude from the definition of controlling individual an organization that is exempt from taxation.

(c) For purposes of this subdivision, "managerial official" means those individuals who have the decision-making authority related to the operation of the program, and the responsibility for the ongoing management of or direction of the policies, services, or employees of the program. A site director who has no ownership interest in the program is not considered to be a managerial official for purposes of this definition.

EFFECTIVE DATE. This section is effective August 1, 2017.

Sec. 4. Minnesota Statutes 2016, section 245A.02, subdivision 8, is amended to read:

Subd. 8. **License.** "License" means a certificate issued by the commissioner under section 245A.04 authorizing the license holder to provide a specified program for a specified period of time and in accordance with the terms of the license and the rules of the commissioner.

EFFECTIVE DATE. This section is effective August 1, 2017.

Sec. 5. Minnesota Statutes 2016, section 245A.02, subdivision 9, is amended to read:

Subd. 9. **License holder.** "License holder" means ~~an individual, corporation, partnership, voluntary association, or other~~ an individual, organization, or government entity that is legally responsible for the operation of the program or service, and has been granted a license by the commissioner under this chapter ~~or chapter 245D~~ and the rules of the commissioner~~, and is a controlling individual~~.

EFFECTIVE DATE. This section is effective August 1, 2017.

Sec. 6. Minnesota Statutes 2016, section 245A.02, is amended by adding a subdivision to read:

Subd. 10b. **Organization.** "Organization" means a domestic or foreign corporation, nonprofit corporation, limited liability company, partnership, limited partnership, limited liability partnership, association, voluntary association, and any other legal or commercial entity. For purposes of this chapter, organization does not include a government entity.

EFFECTIVE DATE. This section is effective August 1, 2017.

Sec. 7. Minnesota Statutes 2016, section 245A.02, subdivision 12, is amended to read:

Subd. 12. **Private agency.** "Private agency" means ~~an individual, corporation, partnership, voluntary association~~ an individual or ~~other~~ organization~~, other than a county agency, or a court with jurisdiction,~~ that places persons who cannot remain in their own homes in residential programs, foster care, or adoptive homes.

EFFECTIVE DATE. This section is effective August 1, 2017.

Sec. 8. Minnesota Statutes 2016, section 245A.02, is amended by adding a subdivision to read:

Subd. 12a. **Provisional license.** "Provisional license" means a license of limited duration not to exceed 15 months issued under section 245A.04, subdivision 7, paragraph (g), or 245A.045.

EFFECTIVE DATE. This section is effective August 1, 2017.

Sec. 9. Minnesota Statutes 2016, section 245A.03, subdivision 1, is amended to read:

Subdivision 1. **License required.** Unless licensed by the commissioner under this chapter, an individual, ~~corporation, partnership, voluntary association, other~~ organization, or ~~controlling individual~~ government entity must not:

(1) operate a residential or a nonresidential program;

(2) receive a child or adult for care, supervision, or placement in foster care or adoption;

(3) help plan the placement of a child or adult in foster care or adoption or engage in placement activities as defined in section 259.21, subdivision 9, in this state, whether or not the adoption occurs in this state; or

(4) advertise a residential or nonresidential program.

EFFECTIVE DATE. This section is effective August 1, 2017.

Sec. 10. Minnesota Statutes 2016, section 245A.04, subdivision 2, is amended to read:

Subd. 2. **Notification of affected municipality.** The commissioner must not issue a license under this chapter without giving 30 calendar days' written notice to the affected municipality or other political subdivision unless the program is considered a permitted single-family residential use under sections 245A.11 and 245A.14. The commissioner may provide the notice through electronic communication. The notification must be given before the first issuance of a license under this chapter and annually after that time if annual notification is requested in writing by the affected municipality or other political subdivision. State funds must not be made available to or be spent by an agency or department of state, county, or municipal government for payment to a residential or nonresidential program licensed under this chapter until the provisions of this subdivision have been complied with in full. The provisions of this subdivision shall not apply to programs located in hospitals.

EFFECTIVE DATE. This section is effective August 1, 2017.

Sec. 11. Minnesota Statutes 2016, section 245A.04, subdivision 4, is amended to read:

Subd. 4. **Inspections; waiver.** (a) Before issuing ~~an initial~~ a license under this chapter, the commissioner shall conduct an inspection of the program. The inspection must include but is not limited to:

(1) an inspection of the physical plant;

(2) an inspection of records and documents;

(3) an evaluation of the program by consumers of the program; and

(4) observation of the program in operation.

For the purposes of this subdivision, "consumer" means a person who receives the services of a ~~licensed~~ program licensed under this chapter, the person's legal guardian, or the parent or individual having legal custody of a child who receives the services of a ~~licensed~~ program licensed under this chapter.

(b) The evaluation required in paragraph (a), clause (3) or the observation in paragraph (a), clause (4) is not required prior to issuing ~~an initial~~ a license under subdivision 7. If the commissioner issues ~~an initial~~ a license under ~~subdivision 7~~ this chapter, these requirements must be completed within one year after the issuance of ~~an initial~~ the license.

EFFECTIVE DATE. This section is effective August 1, 2017.

Sec. 12. Minnesota Statutes 2016, section 245A.04, subdivision 6, is amended to read:

Subd. 6. **Commissioner's evaluation.** (a) Before issuing, denying, suspending, revoking, or making conditional a license, the commissioner shall evaluate information gathered under this section. The commissioner's evaluation shall consider the requirements of statutes and rules applicable to the program or services for which the applicant is seeking to be licensed, including the disqualification standards set forth in chapter 245C, and shall evaluate facts, conditions, or circumstances concerning:

(1) the program's operation~~,~~;

(2) the well-being of persons served by the program~~,~~;

(3) available consumer evaluations of the program~~, and~~;

(4) information about the qualifications of the personnel employed by the applicant or license holder~~.~~; and

(5) the applicant's ability to demonstrate competent knowledge of the applicable laws and rules including but not limited to this chapter and chapters 119B and 245C.

(b) The commissioner shall also evaluate the results of the study required in subdivision 3 and determine whether a risk of harm to the persons served by the program exists. In conducting this evaluation, the commissioner shall apply the disqualification standards set forth in chapter 245C.

EFFECTIVE DATE. This section is effective August 1, 2017.

Sec. 13. Minnesota Statutes 2016, section 245A.04, subdivision 7, is amended to read:

Subd. 7. **Grant of license; license extension.** (a) If the commissioner determines that the program complies with all applicable rules and laws, the commissioner shall issue a license consistent with this section or, if applicable, a temporary change of ownership license under section 245A.043, or a provisional license under section 245A.045. At minimum, the license shall state:

(1) the name of the license holder;

(2) the address of the program;

(3) the effective date and expiration date of the license;

(4) the type of license;

(5) the maximum number and ages of persons that may receive services from the program; and

(6) any special conditions of licensure.

(b) The commissioner may issue ~~an initial~~ a license for a period not to exceed two years if:

(1) the commissioner is unable to conduct the evaluation or observation required by subdivision 4, paragraph (a), clauses (3) and (4), because the program is not yet operational;

(2) certain records and documents are not available because persons are not yet receiving services from the program; and

(3) the applicant complies with applicable laws and rules in all other respects.

(c) A decision by the commissioner to issue a license does not guarantee that any person or persons will be placed or cared for in the licensed program. ~~A license shall not be transferable to another individual, corporation, partnership, voluntary association, other organization, or controlling individual or to another location.~~

~~(d) A license holder must notify the commissioner and obtain the commissioner's approval before making any changes that would alter the license information listed under paragraph (a).~~

~~(e)~~ (d) Except as provided in paragraphs ~~(g)~~ (f) and ~~(h)~~ (g), the commissioner shall not issue or reissue a license if the applicant, license holder, or controlling individual has:

(1) been disqualified and the disqualification was not set aside and no variance has been granted;

(2) been denied a license under this chapter, including a license following the expiration of a provisional license under section 245A.045, within the past two years;

(3) had a license issued under this chapter revoked within the past five years;

(4) an outstanding debt related to a license fee, licensing fine, or settlement agreement for which payment is delinquent; or

(5) failed to submit the information required of an applicant under subdivision 1, paragraph (f) or (g), after being requested by the commissioner.

When a license issued under this chapter is revoked under clause (1) or (3), the license holder and controlling individual may not hold any license under chapter 245A or 245D for

five years following the revocation, and other licenses held by the applicant, license holder, or controlling individual shall also be revoked.

~~(f)~~ (e) The commissioner shall not issue or reissue a license under this chapter if an individual living in the household where the ~~licensed~~ services will be provided as specified under section 245C.03, subdivision 1, has been disqualified and the disqualification has not been set aside and no variance has been granted.

~~(g)~~ (f) Pursuant to section 245A.07, subdivision 1, paragraph (b), and section 245A.045, subdivision 2, when a license issued under this chapter has been suspended or revoked and the suspension or revocation is under appeal, the program may continue to operate pending a final order from the commissioner. If the license under suspension or revocation will expire before a final order is issued, a temporary provisional license may be issued provided any applicable license fee is paid before the temporary provisional license is issued.

~~(h)~~ (g) Notwithstanding paragraph ~~(g)~~ (f), when a revocation is based on the disqualification of a controlling individual or license holder, and the controlling individual or license holder is ordered under section 245C.17 to be immediately removed from direct contact with persons receiving services or is ordered to be under continuous, direct supervision when providing direct contact services, the program may continue to operate only if the program complies with the order and submits documentation demonstrating compliance with the order. If the disqualified individual fails to submit a timely request for reconsideration, or if the disqualification is not set aside and no variance is granted, the order to immediately remove the individual from direct contact or to be under continuous, direct supervision remains in effect pending the outcome of a hearing and final order from the commissioner.

~~(i)~~ (h) For purposes of reimbursement for meals only, under the Child and Adult Care Food Program, Code of Federal Regulations, title 7, subtitle B, chapter II, subchapter A, part 226, relocation within the same county by a licensed family day care provider, shall be considered an extension of the license for a period of no more than 30 calendar days or until the new license is issued, whichever occurs first, provided the county agency has determined the family day care provider meets licensure requirements at the new location.

~~(j)~~ (i) Unless otherwise specified by statute, all licenses issued under this chapter expire at 12:01 a.m. on the day after the expiration date stated on the license. A license holder must apply for and be granted a new license to operate the program or the program must not be operated after the expiration date.

~~(k)~~ (j) The commissioner shall not issue or reissue a license under this chapter if it has been determined that a tribal licensing authority has established jurisdiction to license the program or service.

EFFECTIVE DATE. This section is effective August 1, 2017.

Sec. 14. Minnesota Statutes 2016, section 245A.04, is amended by adding a subdivision to read:

Subd. 7a. **Notification required.** (a) A license holder must notify the commissioner and obtain the commissioner's approval before making any change that would alter the license information listed under subdivision 7, paragraph (a).

(b) At least 30 days before the effective date of a change, the license holder must notify the commissioner in writing of any:

(1) change to the license holder's authorized agent as defined in section 245A.02, subdivision 3b;

(2) change to the license holder's controlling individual as defined in section 245A.02, subdivision 5a;

(3) change to license holder information on file with the secretary of state;

(4) change to a program's business structure;

(5) change in the location of the program or service licensed under this chapter; and

(6) change in the federal or state tax identification number associated with the license holder.

(c) When a license holder notifies the commissioner of a change to the business structure governing the licensed program or services but is not selling the business, the license holder must provide amended articles of incorporation and other documentation of the change and any other information requested by the commissioner.

EFFECTIVE DATE. This section is effective August 1, 2017.

Sec. 15. Minnesota Statutes 2016, section 245A.04, subdivision 10, is amended to read:

Subd. 10. **Adoption agency; additional requirements.** In addition to the other requirements of this section, an individual~~, corporation, partnership, voluntary association, other~~ or organization~~, or controlling individual~~ applying for a license to place children for adoption must:

(1) incorporate as a nonprofit corporation under chapter 317A;

(2) file with the application for licensure a copy of the disclosure form required under section 259.37, subdivision 2;

(3) provide evidence that a bond has been obtained and will be continuously maintained throughout the entire operating period of the agency, to cover the cost of transfer of records to and storage of records by the agency which has agreed, according to rule established by the commissioner, to receive the applicant agency's records if the applicant agency voluntarily or involuntarily ceases operation and fails to provide for proper transfer of the records. The bond must be made in favor of the agency which has agreed to receive the records; and

(4) submit a certified audit to the commissioner each year the license is renewed as required under section 245A.03, subdivision 1.

EFFECTIVE DATE. This section is effective August 1, 2017.

Sec. 16. **[245A.043] LICENSE APPLICATION AFTER A CHANGE OF OWNERSHIP.**

Subdivision 1. **Transfer prohibited.** A license issued under this chapter is only valid for a premises and individual, organization, or government entity identified by the commissioner on the license. A license is not transferable or assignable.

Subd. 2. **Change of ownership.** If the commissioner determines that there will be a change in ownership, the commissioner shall require submission of a new license application. A change in ownership occurs when:

(1) the license holder sells or transfers 100 percent of the property, stock, or assets;

(2) the license holder merges with another organization;

(3) the license holder consolidates with two or more organizations, resulting in the creation of a new organization;

(4) there is a change in the federal tax identification number associated with the license holder; or

(5) there is a turnover of each controlling individual associated with the license within a 12-month period. A change to the license holder's controlling individuals, including a change due to a transfer of stock, is not a change in ownership if at least one controlling individual who was listed on the license for at least 12 consecutive months continues to be a controlling individual after the reported change.

Subd. 3. **Sale of a program.** (a) A license holder who intends to change the ownership of the program or service as defined in subdivision 2 to a party that intends to assume operation without an interruption in service longer than 60 days after acquiring the program or service must provide the commissioner with written notice of the proposed sale or change on a form provided by the commissioner, at least 60 days before the anticipated date of the change in program owner. For purposes of this subdivision and subdivision 4, "party" means the party that intends to operate the service or program.

(b) The party must submit a license application under this chapter on the form and in the manner prescribed by the commissioner at least 30 days before the change of program ownership is complete, and must include documentation to support the upcoming change. The party must comply with background study requirements under chapter 245C and shall pay the application fee required in section 245A.10. A party that intends to assume operation without an interruption in service longer than 60 days after acquiring the program or service is exempt from the requirements of Minnesota Rules, part 9530.6800.

(c) The commissioner may develop streamlined application procedures for when the party is an existing license holder under this chapter and is acquiring a program licensed under this chapter or service in the same service class as one or more licensed programs or services it operates and those licenses are in substantial compliance according to the licensing standards in this chapter and applicable rules. For purposes of this subdivision, "substantial compliance" means the commissioner did not issue, within the past 12 months, a sanction under section 245A.045 or 245A.07 against a license held by the party or made a license held by the party conditional according to section 245A.06 within the past 12 months.

(d) Except when a temporary change of ownership license is issued pursuant to subdivision 5, the existing license holder is solely responsible for operating the program according to applicable rules and statutes until a license under this chapter is issued to the party.

(e) If a licensing inspection of the program or service was conducted within the previous 12 months and the existing license holder's license record demonstrates substantial compliance with the applicable licensing requirements, the commissioner may waive the party's inspection required by section 245A.04, subdivision 4. The party must submit to the commissioner proof that the premises was inspected by a fire marshal or that the fire marshal deemed that an inspection was not warranted and proof that the premises was inspected for compliance with the building code or that no inspection was deemed warranted.

(f) If the party is seeking a license for a program or service that has an outstanding correction order, the party must submit a letter identifying how the party will resolve the outstanding correction order and come into full compliance with the licensing requirements.

(g) Any action taken under section 245A.06 or 245A.07 against the existing license holder's license at the time the party is applying for a license, including when the existing license holder is operating under a conditional license or is subject to a revocation, shall remain in effect until the commissioner determines that the grounds for the action are corrected or no longer exist.

(h) The commissioner shall evaluate the application of the party according to section 245A.04, subdivision 6. Pursuant to section 245A.04, subdivision 7, if the commissioner determines that the party complies with applicable laws and rules, the commissioner may issue a license or a temporary change of ownership license.

(i) The commissioner may deny an application as provided in section 245A.05. An applicant whose application was denied by the commissioner may appeal the denial according to section 245A.05.

(j) This subdivision does not apply to a licensed program or service located in a home where the license holder resides.

Subd. 4. **Temporary change of ownership license.** (a) After receiving the party's application pursuant to subdivision 4, upon the written request of the existing license holder and the party, the commissioner may issue a temporary change of ownership license to the party while the commissioner evaluates the party's application. Until a decision is made to grant or deny a license under this chapter, the existing license holder and the party shall both be responsible for operating the program or service according to applicable laws and rules, and the sale or transfer of the license holder's ownership interest in the licensed program or service does not terminate the existing license.

(b) The commissioner may establish criteria to issue a temporary change of ownership license when a license holder's death, divorce, or other event affecting the ownership of the program when an applicant seeks to assume operation of the program or service to ensure continuity of the program or service while a license application is evaluated. This subdivision applies to any program or service licensed under this chapter.

EFFECTIVE DATE. This section is effective August 1, 2017.

Sec. 17. **[245A.045] PROVISIONAL LICENSE.**

Subdivision 1. **When a provisional license shall be required.** (a) Before issuing a license under section 245A.04, subdivision 7, the commissioner shall issue a provisional license for a period of up to 15 months if the applicant or license holder:

(1) is not currently licensed under this chapter;

(2) is licensed but does not hold a license in the same service class for which a license application was submitted;

(3) was licensed in the same service class for less than 12 months at the time the application was submitted;

(4) was in substantial, but not complete, compliance with applicable requirements for licensure under section 245A.04 but demonstrates the potential to comply with all applicable laws and rules by the end of the provisional license term, if the commissioner determines that the deficiencies identified do not adversely affect the health, welfare, or safety of a client; or

(5) is identified as the buyer of a program that (i) was licensed under this chapter for less than 12 months, (ii) has an outstanding correction order violation, (iii) is operating under a conditional license, (iv) was issued a revocation order, or (v) is buying a program that is currently operating under a provisional license.

(b) The commissioner may place terms and conditions on the provisional license as the commissioner determines necessary until the applicant achieves full compliance with applicable statutes and rules before the expiration of the provisional license. The decision to issue a provisional license under this section instead of a license under section 245A.04, subdivision 7, is not appealable.

(c) Before the expiration of the provisional license, the commissioner shall conduct at least one unannounced inspection of the program. At least 60 days before the expiration of the provisional license, the license holder of a provisional license must apply for a license under section 245A.04, subdivision 7, in a manner prescribed by the commissioner. The commissioner may grant or deny the application to convert a provisional license according to section 245A.05. An applicant whose application is denied by the commissioner may appeal the denial according to section 245A.05.

Subd. 2. **Sanctions for provisional license.** (a) The commissioner may issue the following sanctions against a program or service of a license holder who does not comply with an applicable law or rule:

(1) a fine or temporary immediate suspension under section 245A.07; or

(2) a revocation under this section.

(b) The commissioner may revoke a provisional license if the commissioner identifies any of the following:

(1) a license holder failed to fully comply with applicable laws or rules including chapters 119B, 245A, and 245C;

(2) a license holder, a controlling individual, or an individual living in the household where the licensed services are provided or is otherwise subject to a background study has a disqualification that was not set aside under section 245C.22;

(3) a license holder knowingly withheld relevant information from or gave false or misleading information to the commissioner in connection with an application for a license or the background study status of an individual, during an investigation, or regarding compliance with applicable laws or rules;

(4) a license holder or controlling individual is prohibited from becoming licensed pursuant to section 245.095;

(5) a license holder adds or removes a controlling individual identified in the license application within the first 12 months of operation; or

(6) a license holder fails to demonstrate competency in licensing statutes and rules.

(c) When revoking a provisional license under this section, the commissioner shall consider facts, conditions, or circumstances concerning the program's operation, the well-being of persons served by the program, available consumer evaluations of the program, information about the qualifications of the personnel employed by the license holder, and the program's overall development of competency in demonstrating compliance with applicable statutes and rules.

(d) The commissioner must notify by certified mail or personal service a license holder when the license holder's provisional license is revoked. If mailed, the notice must be mailed to the address shown on the application or the last known address of the license holder. The notice must state the reason for revocation.

(e) If a provisional license is revoked, the notice must inform the license holder of the right to a contested case hearing under chapter 14 and Minnesota Rules, parts 1400.8505 to 1400.8612. The license holder may appeal a revocation order. The appeal of a revocation order must be made in writing by certified mail or personal service. If mailed, the appeal

must be postmarked and sent to the commissioner within ten calendar days after the license holder receives notice. If a request is made by personal service, it must be received by the commissioner within ten calendar days after the license holder received notice. Except as provided in subdivision 2, paragraph (c), if a license holder submits a timely appeal of a revocation order, the license holder may continue to operate the program as provided in section 245A.04, subdivision 7, paragraphs (f) and (g), until the commissioner issues a final order on the revocation. The hearing must be conducted according to section 245A.08.

Subd. 3. **Exclusions.** This section does not apply to the following programs or services: family child care, child foster care, adult day services, adult foster care, and community residential settings.

EFFECTIVE DATE. This section is effective August 1, 2017.

Sec. 18. Minnesota Statutes 2016, section 245A.05, is amended to read:

245A.05 DENIAL OF APPLICATION.

(a) The commissioner may deny a license if an applicant or controlling individual:

(1) fails to submit a substantially complete application after receiving notice from the commissioner under section 245A.04, subdivision 1;

(2) fails to comply with applicable laws or rules;

(3) knowingly withholds relevant information from or gives false or misleading information to the commissioner in connection with an application for a license or during an investigation;

(4) has a disqualification that has not been set aside under section 245C.22 and no variance has been granted;

(5) has an individual living in the household who received a background study under section 245C.03, subdivision 1, paragraph (a), clause (2), who has a disqualification that has not been set aside under section 245C.22, and no variance has been granted;

(6) is associated with an individual who received a background study under section 245C.03, subdivision 1, paragraph (a), clause (6), who may have unsupervised access to children or vulnerable adults, and who has a disqualification that has not been set aside under section 245C.22, and no variance has been granted; ~~or~~

(7) fails to comply with section 245A.04, subdivision 1, paragraph (f) or (g)~~.~~;

(8) fails to demonstrate competent knowledge as required by section 245A.04, subdivision 6;

(9) has a history of noncompliance as a license holder or controlling individual with applicable laws or rules including but not limited to this chapter and chapters 199B and 245C; or

(10) is prohibited from holding a license according to section 245.095.

(b) An applicant whose application has been denied by the commissioner must be given notice of the denial. Notice must be given by certified mail or personal service. The notice must state the reasons the application was denied and must inform the applicant of the right to a contested case hearing under chapter 14 and Minnesota Rules, parts 1400.8505 to 1400.8612. The applicant may appeal the denial by notifying the commissioner in writing by certified mail or personal service. If mailed, the appeal must be postmarked and sent to the commissioner within 20 calendar days after the applicant received the notice of denial. If an appeal request is made by personal service, it must be received by the commissioner within 20 calendar days after the applicant received the notice of denial. Section 245A.08 applies to hearings held to appeal the commissioner's denial of an application.

EFFECTIVE DATE. This section is effective August 1, 2017.

Sec. 19. Minnesota Statutes 2016, section 245A.07, subdivision 2, is amended to read:

Subd. 2. **Temporary immediate suspension.** (a) The commissioner shall act immediately to temporarily suspend a license issued under this chapter if:

(1) the license holder's actions or failure to comply with applicable law or rule, or the actions of other individuals or conditions in the program, pose an imminent risk of harm to the health, safety, or rights of persons served by the program; or

(2) while the program continues to operate pending an appeal of an order of revocation, the commissioner identifies one or more subsequent violations of law or rule which may adversely affect the health or safety of persons served by the program.

(b) No state funds shall be made available or be expended by any agency or department of state, county, or municipal government for use by a license holder regulated under this chapter while a license issued under this chapter is under immediate suspension. A notice stating the reasons for the immediate suspension and informing the license holder of the right to an expedited hearing under chapter 14 and Minnesota Rules, parts 1400.8505 to 1400.8612, must be delivered by personal service to the address shown on the application or the last known address of the license holder. The license holder may appeal an order

immediately suspending a license. The appeal of an order immediately suspending a license must be made in writing by certified mail ~~or personal service~~, by person service, or by other means expressly set forth in the commissioner's order. If mailed, the appeal must be postmarked and sent to the commissioner within five calendar days after the license holder receives notice that the license has been immediately suspended. If a request is made by personal service, it must be received by the commissioner within five calendar days after the license holder received the order. A license holder and any controlling individual shall discontinue operation of the program upon receipt of the commissioner's order to immediately suspend the license.

EFFECTIVE DATE. This section is effective August 1, 2017.

Sec. 20. Minnesota Statutes 2016, section 256.01, is amended by adding a subdivision to read:

Subd. 2c. **Program Simplification and Uniformity Advisory Committee.** (a) The Program Simplification and Uniformity Advisory Committee shall advise the commissioner on policies and procedures to create a human services delivery system that simplifies and aligns agency programs. The committee shall meet at least quarterly and may meet more frequently as required by the commissioner. The committee shall annually elect a chair from its members, who shall work with the commissioner to establish the agenda for each meeting. The commissioner, or the commissioner's designee, shall attend each advisory committee meeting.

(b) The Program Simplification and Uniformity Advisory Committee shall advise and make recommendations to the commissioner on the development of policies, strategies, and approaches to simplify, align, and unify programs that will:

(1) promote client-centered programs;

(2) reduce program redundancies and duplication;

(3) prepare for and facilitate the development and implementation of new information technology eligibility systems;

(4) ensure program integrity by preventing waste, fraud, abuse, and to improve program efficiency; and

(5) promote the development and implementation of an integrated human service eligibility and delivery system.

(c) The Program Simplification and Uniformity Advisory Committee consists of:

(1) four voting members who represent county and social service administrators, at least two of whom must represent a county other than Anoka, Carver, Chisago, Dakota, Hennepin, Isanti, Ramsey, Scott, Sherburne, Washington, and Wright;

(2) two voting members who represent tribal social service agencies;

(3) four voting members of agencies and organizations who represent public assistance recipients, including persons with physical and developmental disabilities, persons with mental illness, seniors, parents or legal guardians of children, or low-income individuals;

(4) four voting members who are users of public human services programs, including persons with physical and developmental disabilities, persons with mental illness, seniors, parents or legal guardians of children, or low-income individuals;

(5) two voting members who represent county financial and eligibility workers;

(6) two voting members of the house of representatives, one from the majority party appointed by the speaker of the house and one from the minority party appointed by the minority leader, and two voting members from the senate, one from the majority party appointed by the senate majority leader and one from the minority party appointed by the senate minority leader;

(7) four at-large voting members as determined by the members under clauses (1), (2), (3), and (4);

(8) up to four nonvoting members appointed by the commissioner who are program policy experts to provide technical support to the committee;

(9) one nonvoting member appointed by the commissioner of health who is a program policy expert to provide technical support to the committee;

(10) one nonvoting member appointed by the commissioner of employment and economic development who is a program policy expert to provide technical support to the committee; and

(11) one nonvoting member appointed by the commissioner of commerce who is a program policy expert to provide technical support to the committee.

(d) A voting committee member shall not be employed by the state of Minnesota except for voting members appointed under clause (6). A committee member shall not receive compensation for committee work.

EFFECTIVE DATE. This section is effective the day following final enactment and expires June 30, 2020.

Sec. 21. Minnesota Statutes 2016, section 256B.02, subdivision 7, is amended to read:

Subd. 7. **Vendor of medical care.** (a) "Vendor of medical care" means any person or persons furnishing, within the scope of the vendor's respective license, any or all of the following goods or services: medical, surgical, hospital, ambulatory surgical center services, optical, visual, dental and nursing services; drugs and medical supplies; appliances; laboratory, diagnostic, and therapeutic services; nursing home and convalescent care; screening and health assessment services provided by public health nurses as defined in section 145A.02, subdivision 18; health care services provided at the residence of the patient if the services are performed by a public health nurse and the nurse indicates in a statement submitted under oath that the services were actually provided; and such other medical services or supplies provided or prescribed by persons authorized by state law to give such services and supplies, including services under section 256B.4912. For purposes of this chapter, the term includes a person or entity that furnishes a good or service eligible for medical assistance or federally approved waiver plan payments under this chapter. The term includes, but is not limited to, directors and officers of corporations or members of partnerships who, either individually or jointly with another or others, have the legal control, supervision, or responsibility of submitting claims for reimbursement to the medical assistance program. The term only includes directors and officers of corporations who personally receive a portion of the distributed assets upon liquidation or dissolution, and their liability is limited to the portion of the claim that bears the same proportion to the total claim as their share of the distributed assets bears to the total distributed assets.

(b) "Vendor of medical care" also includes any person who is credentialed as a health professional under standards set by the governing body of a federally recognized Indian tribe authorized under an agreement with the federal government according to United States Code, title 25, section 450f, to provide health services to its members, and who through a tribal facility provides covered services to American Indian people within a contract health service delivery area of a Minnesota reservation, as defined under Code of Federal Regulations, title 42, section 36.22.

(c) A federally recognized Indian tribe that intends to implement standards for credentialing health professionals must submit the standards to the commissioner of human services, along with evidence of meeting, exceeding, or being exempt from corresponding state standards. The commissioner shall maintain a copy of the standards and supporting evidence, and shall use those standards to enroll tribal-approved health professionals as medical assistance providers. For purposes of this section, "Indian" and "Indian tribe" mean persons or entities that meet the definition in United States Code, title 25, section 450b.

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

Sec. 22. Minnesota Statutes 2016, section 256B.04, subdivision 21, is amended to read:

Subd. 21. **Provider enrollment.** (a) If the commissioner or the Centers for Medicare and Medicaid Services determines that a provider is designated "high-risk," the commissioner may withhold payment from providers within that category upon initial enrollment for a 90-day period. The withholding for each provider must begin on the date of the first submission of a claim.

(b) An enrolled provider that is also licensed by the commissioner under chapter 245A, or is licensed as a home care provider by the Department of Health under chapter 144A and has a home and community-based services designation on the home care license under section 144A.484, must designate an individual as the entity's compliance officer. The compliance officer must:

(1) develop policies and procedures to assure adherence to medical assistance laws and regulations and to prevent inappropriate claims submissions;

(2) train the employees of the provider entity, and any agents or subcontractors of the provider entity including billers, on the policies and procedures under clause (1);

(3) respond to allegations of improper conduct related to the provision or billing of medical assistance services, and implement action to remediate any resulting problems;

(4) use evaluation techniques to monitor compliance with medical assistance laws and regulations;

(5) promptly report to the commissioner any identified violations of medical assistance laws or regulations; and

(6) within 60 days of discovery by the provider of a medical assistance reimbursement overpayment, report the overpayment to the commissioner and make arrangements with the commissioner for the commissioner's recovery of the overpayment.

The commissioner may require, as a condition of enrollment in medical assistance, that a provider within a particular industry sector or category establish a compliance program that contains the core elements established by the Centers for Medicare and Medicaid Services.

(c) The commissioner may revoke the enrollment of an ordering or rendering provider for a period of not more than one year, if the provider fails to maintain and, upon request from the commissioner, provide access to documentation relating to written orders or requests for payment for durable medical equipment, certifications for home health services, or

referrals for other items or services written or ordered by such provider, when the commissioner has identified a pattern of a lack of documentation. A pattern means a failure to maintain documentation or provide access to documentation on more than one occasion. Nothing in this paragraph limits the authority of the commissioner to sanction a provider under the provisions of section 256B.064.

(d) The commissioner shall terminate or deny the enrollment of any individual or entity if the individual or entity has been terminated from participation in Medicare or under the Medicaid program or Children's Health Insurance Program of any other state.

(e) As a condition of enrollment in medical assistance, the commissioner shall require that a provider designated "moderate" or "high-risk" by the Centers for Medicare and Medicaid Services or the commissioner permit the Centers for Medicare and Medicaid Services, its agents, or its designated contractors and the state agency, its agents, or its designated contractors to conduct unannounced on-site inspections of any provider location. The commissioner shall publish in the Minnesota Health Care Program Provider Manual a list of provider types designated "limited," "moderate," or "high-risk," based on the criteria and standards used to designate Medicare providers in Code of Federal Regulations, title 42, section 424.518. The list and criteria are not subject to the requirements of chapter 14. The commissioner's designations are not subject to administrative appeal.

(f) As a condition of enrollment in medical assistance, the commissioner shall require that a high-risk provider, or a person with a direct or indirect ownership interest in the provider of five percent or higher, consent to criminal background checks, including fingerprinting, when required to do so under state law or by a determination by the commissioner or the Centers for Medicare and Medicaid Services that a provider is designated high-risk for fraud, waste, or abuse.

(g)(1) Upon initial enrollment, reenrollment, and notification of revalidation, all durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) medical suppliers meeting the durable medical equipment provider and supplier definition in clause (3), operating in Minnesota and receiving Medicaid funds must purchase a surety bond that is annually renewed and designates the Minnesota Department of Human Services as the obligee, and must be submitted in a form approved by the commissioner. For purposes of this clause, the following medical suppliers are not required to obtain a surety bond: a federally qualified health center, a home health agency, the Indian Health Service, a pharmacy, and a rural health clinic.

(2) At the time of initial enrollment or reenrollment, durable medical equipment providers and suppliers defined in clause (3) must purchase a surety bond of $50,000. If a revalidating provider's Medicaid revenue in the previous calendar year is up to and including $300,000, the provider agency must purchase a surety bond of $50,000. If a revalidating provider's Medicaid revenue in the previous calendar year is over $300,000, the provider agency must purchase a surety bond of $100,000. ~~The surety bond must allow for recovery of costs and fees in pursuing a claim on the bond.~~ The surety bond must be in a form approved by the commissioner, renewed annually, and allow for recovery of the entire value of the bond for up to five years from the date of submission of a claim for medical assistance payment if the enrolled provider violates this chapter or Minnesota Rules, chapter 9505, regardless of the actual loss.

(3) "Durable medical equipment provider or supplier" means a medical supplier that can purchase medical equipment or supplies for sale or rental to the general public and is able to perform or arrange for necessary repairs to and maintenance of equipment offered for sale or rental.

(h) The Department of Human Services may require a provider to purchase a surety bond as a condition of initial enrollment, reenrollment, reinstatement, or continued enrollment if: (1) the provider fails to demonstrate financial viability, (2) the department determines there is significant evidence of or potential for fraud and abuse by the provider, or (3) the provider or category of providers is designated high-risk pursuant to paragraph (a) and as per Code of Federal Regulations, title 42, section 455.450. The surety bond must be in an amount of $100,000 or ten percent of the provider's payments from Medicaid during the immediately preceding 12 months, whichever is greater. The surety bond must name the Department of Human Services as an obligee and must allow for recovery of costs and fees in pursuing a claim on the bond. This paragraph does not apply if the provider currently maintains a surety bond under the requirements in section 256B.0659 or 256B.85.

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

Sec. 23. Minnesota Statutes 2016, section 256B.0625, subdivision 43, is amended to read:

Subd. 43. **Mental health provider travel time.** (a) Medical assistance covers provider travel time if a ~~recipient's individual treatment plan~~ recipient requires the provision of mental health services outside of the provider's ~~normal~~ usual place of business. ~~This does not include any travel time which is included in other billable services, and is only covered when the mental health service being provided to a recipient is covered under medical assistance.~~

(b) Mental health provider travel time under this subdivision covers the time the provider is in transit to deliver a mental health service to a recipient at a location that is not the provider's usual place of business or to the next location for delivery of a covered mental health service, and the time a provider is in transit returning from the location of the last recipient who received services on that day to the provider's usual place of business. A provider must travel the most direct route available. Mental health provider travel time does not include time for scheduled or unscheduled stops, meal breaks, or vehicle maintenance or repair, including refueling or vehicle emergencies. Recipient transport is not covered under this subdivision.

(c) Mental health provider travel time under this subdivision is only covered when the mental health service being provided is covered under medical assistance and only when the covered service is delivered and billed. Mental health provider travel time is not covered when the mental health service being provided otherwise includes provider travel time or when the service is site based.

(d) If the first occurrence of mental health provider travel time in a day begins at a location other than the provider's usual place of business, the provider shall bill for the lesser of the travel time between the location and the recipient and the travel time between the provider's usual place of business and the recipient.

(e) Mental health provider travel time may be billed for not more than one round trip per recipient per day.

(f) As a condition of payment, a provider must document each occurrence of mental health provider travel time according to this subdivision. Program funds paid for mental health provider travel time that is not documented according to this subdivision shall be recovered by the department. The documentation may be collected and maintained electronically or in paper form but must be made available and produced upon request. A provider must compile records that meet the following requirements for each occurrence:

(1) the record must be in English and must be legible according to the standard of a reasonable person;

(2) the recipient's name and date of birth or individual identification number must be on each page of the record;

(3) the reason the provider must travel to provide services, if not otherwise documented in the recipient's individual treatment plan; and

(4) each entry in the record must document:

(i) the date on which the entry is made;

(ii) the date the travel occurred;

(iii) the printed last name, first name, and middle initial of the provider and the provider's identification number, if the provider has one;

(iv) the signature of the traveling provider stating that the provider understands that it is a federal crime to provide false information on service billings for medical assistance payments;

(v) the location of the provider's usual place of business;

(vi) the address, or the description if the address is not available, of both the origination site and destination site and the travel time for the most direct route from the origination site to the destination site;

(vii) any unusual travel conditions that may cause a need to bill for additional time over and above what an electronic source document shows the mileage and time necessary to travel from the origination site to destination site;

(viii) the time the provider left the origination site and the time the provider arrived at the destination site, with a.m. and p.m. designations; and

(ix) the electronic source documentation used to calculate the most direct route detailing driving directions, mileage, and time.

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

Sec. 24. Minnesota Statutes 2016, section 256B.064, subdivision 1b, is amended to read:

Subd. 1b. **Sanctions available.** The commissioner may impose the following sanctions for the conduct described in subdivision 1a: suspension or withholding of payments to a vendor and suspending or terminating participation in the program, or imposition of a fine under subdivision 2, paragraph (f). When imposing sanctions under this section, the commissioner shall consider the nature, chronicity, or severity of the conduct and the effect of the conduct on the health and safety of persons served by the vendor. The commissioner shall suspend a vendor's participation in the program for a minimum of five years if the vendor is convicted of a crime, received a stay of adjudication, or entered a court-ordered diversion program for an offense related to provision of a health service under medical assistance or health care fraud. Regardless of imposition of sanctions, the commissioner may make a referral to the appropriate state licensing board.

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

Sec. 25. Minnesota Statutes 2016, section 256B.0651, subdivision 17, is amended to read:

Subd. 17. **Recipient protection.** (a) Providers of home care services must provide each recipient with a copy of the home care bill of rights under section 144A.44 at least 30 days prior to terminating services to a recipient, if the termination results from provider sanctions under section 256B.064, such as a payment withhold, a suspension of participation, or a termination of participation. If a home care provider determines it is unable to continue providing services to a recipient, the provider must notify the recipient, the recipient's responsible party, and the commissioner 30 days prior to terminating services to the recipient because of an action under section 256B.064, and must assist the commissioner and lead agency in supporting the recipient in transitioning to another home care provider of the recipient's choice.

(b) In the event of a payment withhold from a home care provider, a suspension of participation, or a termination of participation of a home care provider under section 256B.064, the commissioner may inform the Office of Ombudsman for Long-Term Care and the lead agencies for all recipients with active service agreements with the provider. At the commissioner's request, the lead agencies must contact recipients to ensure that the recipients are continuing to receive needed care, and that the recipients have been given free choice of provider if they transfer to another home care provider. In addition, the commissioner or the commissioner's delegate may directly notify recipients who receive care from the provider that payments have been or will be withheld or that the provider's participation in medical assistance has been or will be suspended or terminated, if the commissioner determines that notification is necessary to protect the welfare of the recipients. For purposes of this subdivision, "lead agencies" means counties, tribes, and managed care organizations.

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

Sec. 26. Minnesota Statutes 2016, section 256B.0659, subdivision 3, is amended to read:

Subd. 3. ~~**Noncovered**~~ **Personal care assistance services not covered.** (a) Personal care assistance services are not eligible for medical assistance payment under this section when provided:

(1) by the recipient's spouse, parent of a recipient under the age of 18, paid legal guardian, licensed foster provider, except as allowed under section 256B.0652, subdivision 10, or responsible party;

(2) in order to meet staffing or license requirements in a residential or child care setting;

(3) solely as a child care or babysitting service; ~~or~~

(4) without authorization by the commissioner or the commissioner's designee~~.~~; or

(5) on dates not within the frequency requirements of subdivision 14, paragraph (c), and subdivision 19, paragraph (a).

(b) The following personal care services are not eligible for medical assistance payment under this section when provided in residential settings:

(1) when the provider of home care services who is not related by blood, marriage, or adoption owns or otherwise controls the living arrangement, including licensed or unlicensed services; or

(2) when personal care assistance services are the responsibility of a residential or program license holder under the terms of a service agreement and administrative rules.

(c) Other specific tasks not covered under paragraph (a) or (b) that are not eligible for medical assistance reimbursement for personal care assistance services under this section include:

(1) sterile procedures;

(2) injections of fluids and medications into veins, muscles, or skin;

(3) home maintenance or chore services;

(4) homemaker services not an integral part of assessed personal care assistance services needed by a recipient;

(5) application of restraints or implementation of procedures under section 245.825;

(6) instrumental activities of daily living for children under the age of 18, except when immediate attention is needed for health or hygiene reasons integral to the personal care services and the need is listed in the service plan by the assessor; and

(7) assessments for personal care assistance services by personal care assistance provider agencies or by independently enrolled registered nurses.

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

Sec. 27. Minnesota Statutes 2016, section 256B.0659, subdivision 12, is amended to read:

Subd. 12. **Documentation of personal care assistance services provided.** (a) Personal care assistance services for a recipient must be documented daily by each personal care assistant, on a time sheet form approved by the commissioner. All documentation may be

Web-based, electronic, or paper documentation. The completed form must be submitted on a monthly basis to the provider and kept in the recipient's health record.

(b) The activity documentation must correspond to the personal care assistance care plan and be reviewed by the qualified professional.

(c) The personal care assistant time sheet must be on a form approved by the commissioner documenting time the personal care assistant provides services in the home. The following criteria must be included in the time sheet:

(1) full name of personal care assistant and individual provider number;

(2) provider name and telephone numbers;

(3) full name of recipient and either the recipient's medical assistance identification number or date of birth;

(4) consecutive dates, including month, day, and year, and arrival and departure times with a.m. or p.m. notations;

(5) signatures of recipient or the responsible party;

(6) personal signature of the personal care assistant;

(7) any shared care provided, if applicable;

(8) a statement that it is a federal crime to provide false information on personal care service billings for medical assistance payments; and

(9) dates and location of recipient stays in a hospital, care facility, or incarceration.

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

Sec. 28. Minnesota Statutes 2016, section 256B.0659, subdivision 14, is amended to read:

Subd. 14. **Qualified professional; duties.** (a) Effective January 1, 2010, all personal care assistants must be supervised by a qualified professional.

(b) Through direct training, observation, return demonstrations, and consultation with the staff and the recipient, the qualified professional must ensure and document that the personal care assistant is:

(1) capable of providing the required personal care assistance services;

(2) knowledgeable about the plan of personal care assistance services before services are performed; and

(3) able to identify conditions that should be immediately brought to the attention of the qualified professional.

(c) The qualified professional shall evaluate the personal care assistant within the first 14 days of starting to provide regularly scheduled services for a recipient, or sooner as determined by the qualified professional, except for the personal care assistance choice option under subdivision 19, paragraph (a), clause (4). For the initial evaluation, the qualified professional shall evaluate the personal care assistance services for a recipient through direct observation of a personal care assistant's work. The qualified professional may conduct additional training and evaluation visits, based upon the needs of the recipient and the personal care assistant's ability to meet those needs. Subsequent visits to evaluate the personal care assistance services provided to a recipient do not require direct observation of each personal care assistant's work and shall occur:

(1) at least every 90 days thereafter for the first year of a recipient's services;

(2) every 120 days after the first year of a recipient's service or whenever needed for response to a recipient's request for increased supervision of the personal care assistance staff; and

(3) after the first 180 days of a recipient's service, supervisory visits may alternate between unscheduled phone or Internet technology and in-person visits, unless the in-person visits are needed according to the care plan.

(d) Communication with the recipient is a part of the evaluation process of the personal care assistance staff.

(e) At each supervisory visit, the qualified professional shall evaluate personal care assistance services including the following information:

(1) satisfaction level of the recipient with personal care assistance services;

(2) review of the month-to-month plan for use of personal care assistance services;

(3) review of documentation of personal care assistance services provided;

(4) whether the personal care assistance services are meeting the goals of the service as stated in the personal care assistance care plan and service plan;

(5) a written record of the results of the evaluation and actions taken to correct any deficiencies in the work of a personal care assistant; and

(6) revision of the personal care assistance care plan as necessary in consultation with the recipient or responsible party, to meet the needs of the recipient.

(f) The qualified professional shall complete the required documentation in the agency recipient and employee files and the recipient's home, including the following documentation:

(1) the personal care assistance care plan based on the service plan and individualized needs of the recipient;

(2) a month-to-month plan for use of personal care assistance services;

(3) changes in need of the recipient requiring a change to the level of service and the personal care assistance care plan;

(4) evaluation results of supervision visits and identified issues with personal care assistance staff with actions taken;

(5) all communication with the recipient and personal care assistance staff; ~~and~~

(6) hands-on training or individualized training for the care of the recipient~~.~~;

(7) the month, day, and year, and arrival and departure times with a.m. or p.m. designations of each visit or call to the recipient when services are provided; and

(8) the total amount of time of each service visit with the recipient.

(g) The documentation in paragraph (f) must be done on agency templates.

(h) The services that are not eligible for payment as qualified professional services include:

(1) direct professional nursing tasks that could be assessed and authorized as skilled nursing tasks;

(2) the time spent documenting services;

~~(2)~~ (3) agency administrative activities;

~~(3)~~ (4) training other than the individualized training required to provide care for a recipient; and

~~(4)~~ (5) any other activity that is not described in this section.

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

Sec. 29. Minnesota Statutes 2016, section 256B.0659, subdivision 21, is amended to read:

Subd. 21. **Requirements for provider enrollment of personal care assistance provider agencies.** (a) All personal care assistance provider agencies must provide, at the time of enrollment, reenrollment, and revalidation as a personal care assistance provider agency in

a format determined by the commissioner, information and documentation that includes, but is not limited to, the following:

(1) the personal care assistance provider agency's current contact information including address, telephone number, and e-mail address;

(2) proof of surety bond coverage. Upon new enrollment, or if the provider's Medicaid revenue in the previous calendar year is up to and including $300,000, the provider agency must purchase a surety bond of $50,000. If the Medicaid revenue in the previous year is over $300,000, the provider agency must purchase a surety bond of $100,000. The surety bond must be in a form approved by the commissioner, must be renewed annually, and must allow for recovery of ~~costs and fees in pursuing a claim on the bond~~ the entire value of the bond for up to five years from the date of submission of a claim for medical assistance payment if the enrolled provider violates this chapter or Minnesota Rules, chapter 9505, regardless of the actual loss;

(3) proof of fidelity bond coverage in the amount of $20,000;

(4) proof of workers' compensation insurance coverage;

(5) proof of liability insurance;

(6) a description of the personal care assistance provider agency's organization identifying the names of all owners, managing employees, staff, board of directors, and the affiliations of the directors, owners, or staff to other service providers;

(7) a copy of the personal care assistance provider agency's written policies and procedures including: hiring of employees; training requirements; service delivery; and employee and consumer safety including process for notification and resolution of consumer grievances, identification and prevention of communicable diseases, and employee misconduct;

(8) copies of all other forms the personal care assistance provider agency uses in the course of daily business including, but not limited to:

(i) a copy of the personal care assistance provider agency's time sheet if the time sheet varies from the standard time sheet for personal care assistance services approved by the commissioner, and a letter requesting approval of the personal care assistance provider agency's nonstandard time sheet;

(ii) the personal care assistance provider agency's template for the personal care assistance care plan; and

(iii) the personal care assistance provider agency's template for the written agreement in subdivision 20 for recipients using the personal care assistance choice option, if applicable;

(9) a list of all training and classes that the personal care assistance provider agency requires of its staff providing personal care assistance services;

(10) documentation that the personal care assistance provider agency and staff have successfully completed all the training required by this section;

(11) documentation of the agency's marketing practices;

(12) disclosure of ownership, leasing, or management of all residential properties that is used or could be used for providing home care services;

(13) documentation that the agency will use the following percentages of revenue generated from the medical assistance rate paid for personal care assistance services for employee personal care assistant wages and benefits: 72.5 percent of revenue in the personal care assistance choice option and 72.5 percent of revenue from other personal care assistance providers. The revenue generated by the qualified professional and the reasonable costs associated with the qualified professional shall not be used in making this calculation; and

(14) effective May 15, 2010, documentation that the agency does not burden recipients' free exercise of their right to choose service providers by requiring personal care assistants to sign an agreement not to work with any particular personal care assistance recipient or for another personal care assistance provider agency after leaving the agency and that the agency is not taking action on any such agreements or requirements regardless of the date signed.

(b) Personal care assistance provider agencies shall provide the information specified in paragraph (a) to the commissioner at the time the personal care assistance provider agency enrolls as a vendor or upon request from the commissioner. The commissioner shall collect the information specified in paragraph (a) from all personal care assistance providers beginning July 1, 2009.

(c) All personal care assistance provider agencies shall require all employees in management and supervisory positions and owners of the agency who are active in the day-to-day management and operations of the agency to complete mandatory training as determined by the commissioner before enrollment of the agency as a provider. Employees in management and supervisory positions and owners who are active in the day-to-day operations of an agency who have completed the required training as an employee with a personal care assistance provider agency do not need to repeat the required training if they

are hired by another agency, if they have completed the training within the past three years. By September 1, 2010, the required training must be available with meaningful access according to title VI of the Civil Rights Act and federal regulations adopted under that law or any guidance from the United States Health and Human Services Department. The required training must be available online or by electronic remote connection. The required training must provide for competency testing. Personal care assistance provider agency billing staff shall complete training about personal care assistance program financial management. This training is effective July 1, 2009. Any personal care assistance provider agency enrolled before that date shall, if it has not already, complete the provider training within 18 months of July 1, 2009. Any new owners or employees in management and supervisory positions involved in the day-to-day operations are required to complete mandatory training as a requisite of working for the agency. Personal care assistance provider agencies certified for participation in Medicare as home health agencies are exempt from the training required in this subdivision. When available, Medicare-certified home health agency owners, supervisors, or managers must successfully complete the competency test.

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

Sec. 30. Minnesota Statutes 2016, section 256B.4912, is amended by adding a subdivision to read:

Subd. 11. **Service documentation and billing requirements.** (a) Only a service provided as specified in a federally approved waiver plan, as authorized under sections 256B.0913, 256B.0915, 256B.092, and 256B.49, is eligible for payment. As a condition of payment, a home and community-based waiver provider must document each time a service was provided to a recipient. Payment for a service not documented according to this subdivision or not specified in a federally approved waiver plan shall be recovered by the department under section 256B.064. For payment of a service, documentation must meet the standards in paragraphs (a) to (i).

(b) The service delivered to a recipient must be documented in the provider's record of service delivery.

(c) The recipient's name and recipient identification number must be entered on each document.

(d) The provider's record of service delivery must be in English and must be legible according to the standard of a reasonable person.

(e) The provider's record of service delivery must contain a statement that it is a federal crime to provide false information on service billings for medical assistance or services under a federally approved waiver plan, as authorized under sections 256B.0913, 256B.0915, 256B.092, and 256B.49.

(f) If an entry is a time-based service, each entry in the provider's record of service delivery must contain:

(1) the date that the entry was made;

(2) the day, month, and year when the service was provided;

(3) the service name or description of the service provided;

(4) the start and stop times with a.m. and p.m. designations, except for case management services as defined under section 256B.092, subdivision 1a, and 256B.49, subdivision 13;

(5) the name, signature, and title, if any, of the provider of service. If the service is provided by multiple staff members, the provider may designate a staff member responsible for verifying services and completing the documentation required by this paragraph.

(g) For all other services each record must contain:

(1) the date the entry of service delivery was made;

(2) the day, month, and year when the service was provided;

(3) a service name or description of the service provided; and

(4) the name, signature, and title, if any, of the person providing the service. If the service is provided by multiple staff, the provider may designate a staff person responsible for verifying services and completing the documentation required by this paragraph.

(h) If the service billed is transportation, each entry must contain the information from paragraphs (a) to (d) and (f). A provider must:

(1) maintain odometer and other records pursuant to section 256B.0625, subdivision 17b, clause (3), sufficient to distinguish an individual trip with a specific vehicle and driver for a transportation service that is billed by mileage, except if the provider is a common carrier as defined by Minnesota Rules, part 9505.0315, subpart 1, item B, or publicly operated transit systems. This documentation may be collected and maintained electronically or in paper form, but must be made available and produced upon request;

(2) maintain documentation demonstrating that a vehicle and a driver meets the standards determined by the Department of Human Services on vehicle and driver qualifications;

(3) only bill a waivered transportation service if the transportation is not to or from a health care service available through the Medicaid state plan; and

(4) only bill a waivered transportation service when the rate for waiver service does not include transportation.

(i) If the service provided is equipment or supplies, the documentation must contain the information from paragraphs (a) to (d) and:

(1) the recipient's assessed need for the equipment or supplies and the reason the equipment or supplies are not covered by the Medicaid state plan;

(2) the type and brand name of equipment or supplies delivered to or purchased by the recipient, including whether the equipment or supplies were rented or purchased;

(3) the quantity of supplies delivered or purchased;

(4) the shipping invoice or a delivery service tracking log or other documentation showing the date of delivery that proves the equipment or supplies were delivered to the recipient or a receipt if the equipment or supplies were purchased by the recipient; and

(5) the cost of equipment or supplies if the amount paid for the service depends on the cost.

(j) A service defined as "adult day care" under section 245A.02, subdivision 2a, must meet the documentation standards specified in paragraphs (a) to (e) and must comply with the following:

(1) individual recipient's service records must contain the following:

(i) the recipient's needs assessment and current plan of care according to section 245A.143, subdivisions 4 to 7, or Minnesota Rules, part 9555.9700, if applicable; and

(ii) the day, month, and year the service was provided, including arrival and departure times with a.m. and p.m. designations and the first and last name of the individual making the entry;

(2) entity records must contain the following:

(i) the monthly and quarterly program requirements in Minnesota Rules, part 9555.9710, subparts 1, items E and H, and 3, 4, and 6, if applicable;

(ii) the names and qualifications of the registered physical therapists, registered nurses, and registered dietitian who provide services to the adult day care or nonresidential program;

(iii) the location where the service was provided and, if the location is an alternate location than the primary place of service, the record must contain the address, or the description if the address is not available, of both the origin and destination location and the length of time at the alternate location with a.m. and p.m. designations, and a list of participants who went to the alternate location; and

(iv) documentation that the program is maintaining the appropriate staffing levels according to licensing standards and the federally approved waiver plan.

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

Sec. 31. Minnesota Statutes 2016, section 256G.01, subdivision 4, is amended to read:

Subd. 4. **Additional coverage.** The provisions in sections 256G.02, subdivision 4, paragraphs (a) to (d); 256G.02, subdivisions 5 to 8; 256G.03; 256G.04; 256G.05; and 256G.07, subdivisions 1 to 3, apply to the following financial assistance programs: the aid to families with dependent children program formerly codified in sections 256.72 to 256.87, Minnesota family investment program; medical assistance; general assistance; the family general assistance program formerly codified in sections 256D.01 to 256D.23; general assistance medical care formerly codified in chapter 256D; and Minnesota supplemental aid.

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

Sec. 32. Minnesota Statutes 2016, section 256G.02, subdivision 4, is amended to read:

Subd. 4. **County of financial responsibility.** (a) "County of financial responsibility" has the meanings in paragraphs (b) to (f).

(b) For an applicant who resides in the state and is not in a facility described in subdivision 6, it means the county in which the applicant resides at the time of application.

(c) For an applicant who resides in a facility described in subdivision 6, it means the county in which the applicant last resided in nonexcluded status immediately before entering the facility.

(d) For an applicant who has not resided in this state for any time other than the excluded time, and subject to the limitations in section 256G.03, subdivision 2, it means the county in which the applicant resides at the time of making application.

(e) For an individual already having a social service case open in one county, financial responsibility for any additional social services attaches to the case that has the earliest date

of application and has been open without interruption. This provision does not apply to financial assistance programs listed in section 256G.01, subdivision 4.

(f) Notwithstanding paragraphs (b) to (e), the county of financial responsibility for semi-independent living services provided under section 252.275, and chapter 245D, is the county of residence in nonexcluded status immediately before the placement into or request for those services.

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

Sec. 33. Minnesota Statutes 2016, section 256G.09, subdivision 2, is amended to read:

Subd. 2. **Financial disputes.** (a) If the county receiving the transmittal does not believe it is financially responsible, it ~~should provide~~ shall submit to the department and provide to the initially responsible county a request for department resolution of financial responsibility dispute form, with a statement of all facts and documents necessary for the department to make the requested determination of financial responsibility. The submission must clearly state the program area in dispute, the application date or commitment date for the program in dispute, and ~~must state~~ the specific basis upon which the submitting county is denying financial responsibility. If the receiving county fails to submit the dispute resolution form to the department, the initially responsible county may submit the form to the department and provide a copy to the receiving county.

(b) The ~~initially responsible~~ county responding to the dispute resolution request then has ~~15~~ 30 calendar days to submit its position and any supporting evidence to the department. The absence of a submission by the initially responsible county or the responding county does not limit the right of the department to issue a binding opinion based on the evidence actually submitted.

(c) The department shall not issue an advisory opinion. A county may not submit a case ~~must not be submitted~~ to the department under the dispute resolution process until the local agency taking the application or making the commitment has made an initial determination about eligibility and financial responsibility, and services have been initiated. This paragraph does not prohibit the submission of closed cases that otherwise meet the applicable statute of limitations.

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

Sec. 34. Minnesota Statutes 2016, section 256G.10, is amended to read:

256G.10 DERIVATIVE SETTLEMENT.

The residence of the parent of a minor child~~, with whom that child last lived in a nonexcluded time setting,~~ or guardian of a ward shall determine the residence of the child or ward for all social services governed by this chapter. If the child lived with each parent separately, then the residence of the parent with whom the child lived most recently shall determine the residence of the child for all social services governed by this chapter.

For purposes of this chapter, a minor child is defined as being under 18 years of age unless otherwise specified in a program administered by the commissioner.

Physical or legal custody has no bearing on residence determinations. This section does not, however, apply to situations involving another state, limit the application of an interstate compact, or apply to situations involving state wards where the commissioner is defined by law as the guardian.

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

Sec. 35. Minnesota Statutes 2016, section 270B.14, subdivision 1, is amended to read:

Subdivision 1. **Disclosure to commissioner of human services.** (a) On the request of the commissioner of human services, the commissioner shall disclose return information regarding taxes imposed by chapter 290, and claims for refunds under chapter 290A, to the extent provided in paragraph (b) and for the purposes set forth in paragraph (c).

(b) Data that may be disclosed are limited to data relating to the identity, whereabouts, employment, income, and property of a person owing or alleged to be owing an obligation of child support.

(c) The commissioner of human services may request data only for the purposes of carrying out the child support enforcement program and to assist in the location of parents who have, or appear to have, deserted their children. Data received may be used only as set forth in section 256.978.

(d) The commissioner shall provide the records and information necessary to administer the supplemental housing allowance to the commissioner of human services.

(e) At the request of the commissioner of human services, the commissioner of revenue shall electronically match the Social Security numbers and names of participants in the telephone assistance plan operated under sections 237.69 to 237.71, with those of property tax refund filers, and determine whether each participant's household income is within the eligibility standards for the telephone assistance plan.

(f) The commissioner may provide records and information collected under sections 295.50 to 295.59 to the commissioner of human services for purposes of the Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991, Public Law 102-234. Upon the written agreement by the United States Department of Health and Human Services to maintain the confidentiality of the data, the commissioner may provide records and information collected under sections 295.50 to 295.59 to the Centers for Medicare and Medicaid Services section of the United States Department of Health and Human Services for purposes of meeting federal reporting requirements.

(g) The commissioner may provide records and information to the commissioner of human services as necessary to administer the early refund of refundable tax credits.

(h) The commissioner may disclose information to the commissioner of human services as necessary ~~to verify~~ for income verification for eligibility and premium payment under the MinnesotaCare program, under section 256L.05, subdivision 2, and the medical assistance program under chapter 256B.

(i) The commissioner may disclose information to the commissioner of human services necessary to verify whether applicants or recipients for the Minnesota family investment program, general assistance, food support, Minnesota supplemental aid program, and child care assistance have claimed refundable tax credits under chapter 290 and the property tax refund under chapter 290A, and the amounts of the credits.

(j) The commissioner may disclose information to the commissioner of human services necessary to verify income for purposes of calculating parental contribution amounts under section 252.27, subdivision 2a.

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

ARTICLE 4

HEALTH CARE

Section 1. Minnesota Statutes 2016, section 256.01, subdivision 29, is amended to read:

Subd. 29. **State medical review team.** (a) To ensure the timely processing of determinations of disability by the commissioner's state medical review team under sections 256B.055, ~~subdivision~~ subdivisions 7, paragraph (b), and 12; 256B.057, subdivision 9, ~~and 256B.055, subdivision 12,~~ the commissioner shall review all medical evidence ~~submitted by county agencies with a referral~~ and seek ~~additional~~ information from providers, applicants, and enrollees to support the determination of disability where necessary. Disability shall

be determined according to the rules of title XVI and title XIX of the Social Security Act and pertinent rules and policies of the Social Security Administration.

(b) Prior to a denial or withdrawal of a requested determination of disability due to insufficient evidence, the commissioner shall (1) ensure that the missing evidence is necessary and appropriate to a determination of disability, and (2) assist applicants and enrollees to obtain the evidence, including, but not limited to, medical examinations and electronic medical records.

(c) The commissioner shall provide the chairs of the legislative committees with jurisdiction over health and human services finance and budget the following information on the activities of the state medical review team by February 1 of each year:

(1) the number of applications to the state medical review team that were denied, approved, or withdrawn;

(2) the average length of time from receipt of the application to a decision;

(3) the number of appeals, appeal results, and the length of time taken from the date the person involved requested an appeal for a written decision to be made on each appeal;

(4) for applicants, their age, health coverage at the time of application, hospitalization history within three months of application, and whether an application for Social Security or Supplemental Security Income benefits is pending; and

(5) specific information on the medical certification, licensure, or other credentials of the person or persons performing the medical review determinations and length of time in that position.

(d) Any appeal made under section 256.045, subdivision 3, of a disability determination made by the state medical review team must be decided according to the timelines under section 256.0451, subdivision 22, paragraph (a). If a written decision is not issued within the timelines under section 256.0451, subdivision 22, paragraph (a), the appeal must be immediately reviewed by the chief human services judge.

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

Sec. 2. Minnesota Statutes 2016, section 256B.0659, subdivision 21, is amended to read:

Subd. 21. **Requirements for provider enrollment of personal care assistance provider agencies.** (a) All personal care assistance provider agencies must provide, at the time of enrollment, reenrollment, and revalidation as a personal care assistance provider agency in

a format determined by the commissioner, information and documentation that includes, but is not limited to, the following:

(1) the personal care assistance provider agency's current contact information including address, telephone number, and e-mail address;

(2) proof of surety bond coverage. Upon new enrollment, or if the provider's Medicaid revenue in the previous calendar year is up to and including $300,000, the provider agency must purchase a surety bond of $50,000. If the Medicaid revenue in the previous year is over $300,000, the provider agency must purchase a surety bond of $100,000. The surety bond must be in a form approved by the commissioner, must be renewed annually, and must allow for recovery of costs and fees in pursuing a claim on the bond;

(3) proof of fidelity bond coverage in the amount of $20,000;

(4) proof of workers' compensation insurance coverage;

(5) proof of liability insurance;

(6) a description of the personal care assistance provider agency's organization identifying the names of all owners, managing employees, staff, board of directors, and the affiliations of the directors, owners, or staff to other service providers;

(7) a copy of the personal care assistance provider agency's written policies and procedures including: hiring of employees; training requirements; service delivery; and employee and consumer safety including process for notification and resolution of consumer grievances, identification and prevention of communicable diseases, and employee misconduct;

(8) copies of all other forms the personal care assistance provider agency uses in the course of daily business including, but not limited to:

(i) a copy of the personal care assistance provider agency's time sheet if the time sheet varies from the standard time sheet for personal care assistance services approved by the commissioner, and a letter requesting approval of the personal care assistance provider agency's nonstandard time sheet;

(ii) the personal care assistance provider agency's template for the personal care assistance care plan; and

(iii) the personal care assistance provider agency's template for the written agreement in subdivision 20 for recipients using the personal care assistance choice option, if applicable;

(9) a list of all training and classes that the personal care assistance provider agency requires of its staff providing personal care assistance services;

(10) documentation that the personal care assistance provider agency and staff have successfully completed all the training required by this section;

(11) documentation of the agency's marketing practices;

(12) disclosure of ownership, leasing, or management of all residential properties that is used or could be used for providing home care services;

(13) documentation that the agency will use the following percentages of revenue generated from the medical assistance rate paid for personal care assistance services for employee personal care assistant wages and benefits: 72.5 percent of revenue in the personal care assistance choice option and 72.5 percent of revenue from other personal care assistance providers. The revenue generated by the qualified professional and the reasonable costs associated with the qualified professional shall not be used in making this calculation; and

(14) effective May 15, 2010, documentation that the agency does not burden recipients' free exercise of their right to choose service providers by requiring personal care assistants to sign an agreement not to work with any particular personal care assistance recipient or for another personal care assistance provider agency after leaving the agency and that the agency is not taking action on any such agreements or requirements regardless of the date signed.

(b) Personal care assistance provider agencies shall provide the information specified in paragraph (a) to the commissioner at the time the personal care assistance provider agency enrolls as a vendor or upon request from the commissioner. The commissioner shall collect the information specified in paragraph (a) from all personal care assistance providers beginning July 1, 2009.

(c) All personal care assistance provider agencies shall require all employees in management and supervisory positions and owners of the agency who are active in the day-to-day management and operations of the agency to complete mandatory training as determined by the commissioner before submitting an application for enrollment of the agency as a provider. All personal care provider agencies shall also require qualified professionals to complete the training required by subdivision 13 before submitting an application for enrollment of the agency as a provider. Employees in management and supervisory positions and owners who are active in the day-to-day operations of an agency who have completed the required training as an employee with a personal care assistance provider agency do not need to repeat the required training if they are hired by another

agency, if they have completed the training within the past three years. By September 1, 2010, the required training must be available with meaningful access according to title VI of the Civil Rights Act and federal regulations adopted under that law or any guidance from the United States Health and Human Services Department. The required training must be available online or by electronic remote connection. The required training must provide for competency testing. Personal care assistance provider agency billing staff shall complete training about personal care assistance program financial management. This training is effective July 1, 2009. Any personal care assistance provider agency enrolled before that date shall, if it has not already, complete the provider training within 18 months of July 1, 2009. Any new owners or employees in management and supervisory positions involved in the day-to-day operations are required to complete mandatory training as a requisite of working for the agency. Personal care assistance provider agencies certified for participation in Medicare as home health agencies are exempt from the training required in this subdivision. When available, Medicare-certified home health agency owners, supervisors, or managers must successfully complete the competency test.

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

Sec. 3. Minnesota Statutes 2016, section 256B.0659, subdivision 23, is amended to read:

Subd. 23. **Enrollment requirements following termination.** (a) A terminated personal care assistance provider agency, including all named individuals on the current enrollment disclosure form and known or discovered affiliates of the personal care assistance provider agency, is not eligible to enroll as a personal care assistance provider agency for two years following the termination.

(b) After the two-year period in paragraph (a), if the provider seeks to reenroll as a personal care assistance provider agency, the personal care assistance provider agency must be placed on a one-year probation period, beginning after completion of the following:

(1) the department's provider trainings under this section; and

(2) initial enrollment requirements under subdivision 21.

(c) During the probationary period the commissioner shall complete site visits and request submission of documentation to review compliance with program policy.

(d) This subdivision does not apply to a personal care assistance provider agency terminated solely for failure to timely and completely comply with the requirements of revalidation required by section 256B.04, subdivision 22.

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

ARTICLE 5

COMMUNITY SUPPORTS

Section 1. Minnesota Statutes 2016, section 144D.04, subdivision 2, is amended to read:

Subd. 2. **Contents of contract.** A housing with services contract, which need not be entitled as such to comply with this section, shall include at least the following elements in itself or through supporting documents or attachments:

(1) the name, street address, and mailing address of the establishment;

(2) the name and mailing address of the owner or owners of the establishment and, if the owner or owners is not a natural person, identification of the type of business entity of the owner or owners;

(3) the name and mailing address of the managing agent, through management agreement or lease agreement, of the establishment, if different from the owner or owners;

(4) the name and address of at least one natural person who is authorized to accept service of process on behalf of the owner or owners and managing agent;

(5) a statement describing the registration and licensure status of the establishment and any provider providing health-related or supportive services under an arrangement with the establishment;

(6) the term of the contract;

(7) a description of the services to be provided to the resident in the base rate to be paid by resident, including a delineation of the portion of the base rate that constitutes rent and a delineation of charges for each service included in the base rate;

(8) a description of any additional services, including home care services, available for an additional fee from the establishment directly or through arrangements with the establishment, and a schedule of fees charged for these services;

(9) a description of the process through which the contract may be modified, amended, or terminated, including whether a move to a different room or sharing a room would be required in the event that the tenant can no longer pay the current rent;

(10) a description of the establishment's complaint resolution process available to residents including the toll-free complaint line for the Office of Ombudsman for Long-Term Care;

(11) the resident's designated representative, if any;

(12) the establishment's referral procedures if the contract is terminated;

(13) requirements of residency used by the establishment to determine who may reside or continue to reside in the housing with services establishment;

(14) billing and payment procedures and requirements;

(15) a statement regarding the ability of ~~residents~~ a resident to receive services from service providers with whom the establishment does not have an arrangement;

(16) a statement regarding the availability of public funds for payment for residence or services in the establishment; and

(17) a statement regarding the availability of and contact information for long-term care consultation services under section 256B.0911 in the county in which the establishment is located.

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

Sec. 2. Minnesota Statutes 2016, section 144D.04, is amended by adding a subdivision to read:

Subd. 2a. **Additional contract requirements.** (a) For a resident receiving one or more health-related services from the establishment's arranged home care provider, as defined in section 144D.01, subdivision 6, the contract must include the requirements in paragraph (b), clauses (1) to (5). A restriction of a resident's rights under this subdivision is allowed for a resident served under sections 256B.0915 and 256B.49 only if determined necessary for the resident's health, safety, and well-being. A restriction of the resident's rights must be documented in the resident's coordinated service and support plan as defined under sections 256B.49, subdivision 15, and 256B.0915, subdivision 6, and in the resident's service plan as defined under section 144A.4791, subdivision 9.

(b) The contract must include a statement:

(1) regarding the ability of a resident to furnish and decorate the resident's unit within the terms of the lease;

(2) regarding the resident's right to access food at any time, based on the resident's preferences and schedule when the provider is responsible for the provision of food;

(3) regarding a resident's right to choose the resident's visitors and times of visits;

(4) regarding the resident's right to choose a roommate if sharing a unit; and

(5) notifying the resident of the resident's right to have and use a lockable door to the resident's unit. The landlord shall provide the locks on the unit. Only a staff member with

a specific need to enter the unit shall have keys, and advance notice must be given to the resident before entrance, when possible.

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

Sec. 3. Minnesota Statutes 2016, section 245A.03, subdivision 7, is amended to read:

Subd. 7. **Licensing moratorium.** (a) The commissioner shall not issue an initial license for child foster care licensed under Minnesota Rules, parts 2960.3000 to 2960.3340, or adult foster care licensed under Minnesota Rules, parts 9555.5105 to 9555.6265, under this chapter for a physical location that will not be the primary residence of the license holder for the entire period of licensure. If a license is issued during this moratorium, and the license holder changes the license holder's primary residence away from the physical location of the foster care license, the commissioner shall revoke the license according to section 245A.07. The commissioner shall not issue an initial license for a community residential setting licensed under chapter 245D. Exceptions to the moratorium include:

(1) foster care settings that are required to be registered under chapter 144D;

(2) foster care licenses replacing foster care licenses in existence on May 15, 2009, or community residential setting licenses replacing adult foster care licenses in existence on December 31, 2013, and determined to be needed by the commissioner under paragraph (b);

(3) new foster care licenses or community residential setting licenses determined to be needed by the commissioner under paragraph (b) for the closure of a nursing facility, ICF/DD, or regional treatment center; restructuring of state-operated services that limits the capacity of state-operated facilities; or allowing movement to the community for people who no longer require the level of care provided in state-operated facilities as provided under section 256B.092, subdivision 13, or 256B.49, subdivision 24;

(4) new foster care licenses or community residential setting licenses determined to be needed by the commissioner under paragraph (b) for persons requiring hospital level care; or

(5) new foster care licenses or community residential setting licenses determined to be needed by the commissioner for the transition of people from personal care assistance to the home and community-based services.

When approving an exception under this paragraph, the commissioner shall consider the resource need determination process in paragraph (d), the availability of foster care licensed beds in the geographic area in which the licensee seeks to operate, and the recommendation

of the local county board. The determination by the commissioner is final and not subject to appeal.

(b) The commissioner shall determine the need for newly licensed foster care homes or community residential settings as defined under this subdivision. As part of the determination, the commissioner shall consider the availability of foster care capacity in the area in which the licensee seeks to operate, and the recommendation of the local county board. The determination by the commissioner must be final. A determination of need is not required for a change in ownership at the same address.

(c) When an adult resident served by the program moves out of a foster home that is not the primary residence of the license holder according to section 256B.49, subdivision 15, paragraph (f), or the adult community residential setting, the county shall immediately inform the Department of Human Services Licensing Division. ~~The department shall decrease the statewide licensed capacity for adult foster care settings where the physical location is not the primary residence of the license holder, or for adult community residential settings, if the voluntary changes described in paragraph (e) are not sufficient to meet the savings required by reductions in licensed bed capacity under Laws 2011, First Special Session chapter 9, article 7, sections 1 and 40, paragraph (f), and maintain statewide long-term care residential services capacity within budgetary limits. Implementation of the statewide licensed capacity reduction shall begin on July 1, 2013. The commissioner shall delicense up to 128 beds by June 30, 2014, using the needs determination process. Prior to any involuntary reduction of licensed capacity, the commissioner shall consult with lead agencies and license holders to determine which adult foster care settings, where the physical location is not the primary residence of the license holder, or community residential settings, are licensed for up to five beds, but have operated at less than full capacity for 12 or more months as of March 1, 2014. The settings that meet these criteria must be the first to be considered for an involuntary decrease in statewide licensed capacity, up to a maximum of 35 beds. If more than 35 beds are identified that meet these criteria, the commissioner shall prioritize the selection of those beds to be closed based on the length of time the beds have been vacant. The longer a bed has been vacant, the higher priority it must be given for closure.~~ Under this paragraph, the commissioner has the authority to reduce unused licensed capacity of a current foster care program, or the community residential settings, to accomplish the consolidation or closure of settings. Under this paragraph, the commissioner has the authority to manage statewide capacity, including adjusting the capacity available to each county and adjusting statewide available capacity, to meet the statewide needs identified

through the resource need determination process in paragraph ~~(c)~~ (d). ~~A decreased licensed capacity according to this paragraph is not subject to appeal under this chapter.~~

~~(d) Residential settings that would otherwise be subject to the decreased license capacity established in paragraph (c) shall be exempt if the license holder's beds are occupied by residents whose primary diagnosis is mental illness and the license holder is certified under the requirements in subdivision 6a or section 245D.33.~~

~~(c)~~ (d) A resource need determination process, managed at the state level, using the available reports required by section 144A.351, and other data and information shall be used to determine where the reduced capacity required under paragraph (c) will be implemented. The commissioner shall consult with the stakeholders described in section 144A.351, and employ a variety of methods to improve the state's capacity to meet long-term care service needs within budgetary limits, including seeking proposals from service providers or lead agencies to change service type, capacity, or location to improve services, increase the independence of residents, and better meet needs identified by the long-term care services reports and statewide data and information. By February 1, 2013, and August 1, 2014, and each following year, the commissioner shall provide information and data on the overall capacity of licensed long-term care services, actions taken under this subdivision to manage statewide long-term care services and supports resources, and any recommendations for change to the legislative committees with jurisdiction over health and human services budget.

(e) The commissioner must notify a license holder when its corporate foster care or community residential setting licensed beds are reduced under this section. The notice of reduction of licensed beds must be in writing and delivered to the license holder by certified mail or personal service. The notice must state why the licensed beds are reduced and must inform the license holder of its right to request reconsideration by the commissioner. The license holder's request for reconsideration must be in writing. If mailed, the request for reconsideration must be postmarked and sent to the commissioner within 20 calendar days after the license holder's receipt of the notice of reduction of licensed beds. If a request for reconsideration is made by personal service, it must be received by the commissioner within 20 calendar days after the license holder's receipt of the notice of reduction of licensed beds.

(f) At the time of application and reapplication for licensure, the applicant and the license holder that are subject to the moratorium or an exclusion established in paragraph (a) are required to inform the commissioner whether the physical location where the foster care will be provided is or will be the primary residence of the license holder for the entire period of licensure. If the primary residence of the applicant or license holder changes, the applicant or license holder must notify the commissioner immediately. The commissioner shall print

on the foster care license certificate whether or not the physical location is the primary residence of the license holder.

(g) License holders of foster care homes identified under paragraph (f) that are not the primary residence of the license holder and that also provide services in the foster care home that are covered by a federally approved home and community-based services waiver, as authorized under section 256B.0915, 256B.092, or 256B.49, must inform the human services licensing division that the license holder provides or intends to provide these waiver-funded services.

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

Sec. 4. Minnesota Statutes 2016, section 245A.04, subdivision 14, is amended to read:

Subd. 14. **Policies and procedures for program administration required and enforceable.** (a) The license holder shall develop program policies and procedures necessary to maintain compliance with licensing requirements under Minnesota Statutes and Minnesota Rules.

(b) The license holder shall:

(1) provide training to program staff related to their duties in implementing the program's policies and procedures developed under paragraph (a);

(2) document the provision of this training; and

(3) monitor implementation of policies and procedures by program staff.

(c) The license holder shall keep program policies and procedures readily accessible to staff and index the policies and procedures with a table of contents or another method approved by the commissioner.

(d) An adult foster care license holder that provides foster care services to a resident under section 256B.0915 must annually provide a copy of the resident termination policy under section 245A.11, subdivision 11, to a resident covered by the policy.

Sec. 5. Minnesota Statutes 2016, section 245A.11, is amended by adding a subdivision to read:

Subd. 9. **Adult foster care bedrooms.** (a) A resident receiving services must have a choice of roommate. Each roommate must consent in writing to sharing a bedroom with one another. The license holder is responsible for notifying a resident of the resident's right to request a change of roommate.

(b) The license holder must provide a lock for each resident's bedroom door, unless otherwise indicated for the resident's health, safety, or well-being. A restriction on the use of the lock must be documented and justified in the resident's individual abuse prevention plan required by sections 626.557, subdivision 14, and 245A.65, subdivision 2, paragraph (b). For a resident served under section 256B.0915, the case manager must be part of the interdisciplinary team under section 245A.65, subdivision 2, paragraph (b).

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

Sec. 6. Minnesota Statutes 2016, section 245A.11, is amended by adding a subdivision to read:

Subd. 10. **Adult foster care resident rights.** (a) The license holder shall ensure that a resident and a resident's legal representative are given, at admission:

(1) an explanation and copy of the resident's rights specified in paragraph (b);

(2) a written summary of the Vulnerable Adults Protection Act prepared by the department; and

(3) the name, address, and telephone number of the local agency to which a resident or a resident's legal representative may submit an oral or written complaint.

(b) Adult foster care resident rights include the right to:

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

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

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

(4) have privacy for visits with the resident's spouse, next of kin, legal counsel, religious adviser, or others, according to section 363A.09 of the Human Rights Act, including privacy in the resident's bedroom;

(5) keep, use, and access the resident's personal clothing and possessions as space permits, unless this right infringes on the health, safety, or rights of another resident or household member, including the right to access the resident's personal possessions at any time;

(6) choose the resident's visitors and time of visits and participate in activities of commercial, religious, political, and community groups without interference if the activities do not infringe on the rights of another resident or household member;

(7) if married, privacy for visits by the resident's spouse, and, if both spouses are residents of the adult foster home, the residents have the right to share a bedroom and bed;

(8) privacy, including use of the lock on the resident's bedroom door or unit door. A resident's privacy must be respected by license holders, caregivers, household members, and volunteers by knocking on the door of a resident's bedroom or bathroom and seeking consent before entering, except in an emergency;

(9) furnish and decorate the resident's bedroom or living unit;

(10) engage in chosen activities and have an individual schedule supported by the license holder that meets the resident's preferences;

(11) freedom and support to access food at any time;

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

(13) access records and recorded information about the resident according to applicable state and federal law, regulation, or rule;

(14) be free from maltreatment;

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

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

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

(18) be informed of and use the license holder's grievance policy and procedures, including how to contact the highest level of authority in the program;

(19) assert the resident's rights personally, or have the rights asserted by the resident's family, authorized representative, or legal representative, without retaliation; and

(20) give or withhold written informed consent to participate in any research or experimental treatment.

(c) A restriction of a resident's rights under paragraph (b), clauses (1) to (4), (6), (8), (10), and (11), is allowed only if determined necessary to ensure the health, safety, and

well-being of the resident. Any restriction of a resident's right must be documented and justified in the resident's individual abuse prevention plan required by sections 626.557, subdivision 14, and 245A.65, subdivision 2, paragraph (b). For a resident served under section 256B.0915, the case manager must be part of the interdisciplinary team under section 245A.65, subdivision 2, paragraph (b). The restriction must be implemented in the least restrictive manner necessary to protect the resident and provide support to reduce or eliminate the need for the restriction.

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

Sec. 7. Minnesota Statutes 2016, section 245A.11, is amended by adding a subdivision to read:

Subd. 11. **Adult foster care service termination for elderly waiver participants.** (a) This subdivision applies to foster care services for a resident served under section 256B.0915.

(b) The foster care license holder must establish policies and procedures for service termination that promote continuity of care and service coordination with the resident and the case manager and with another licensed caregiver, if any, who also provides support to the resident. The policy must include the requirements specified in paragraphs (c) to (h).

(c) The license holder must allow a resident to remain in the program and cannot terminate services unless:

(1) the termination is necessary for the resident's health, safety, and well-being and the resident's needs cannot be met in the facility;

(2) the safety of the resident or another resident in the program is endangered and positive support strategies were attempted and have not achieved and effectively maintained safety for the resident or another resident in the program;

(3) the health, safety, and well-being of the resident or another resident in the program would otherwise be endangered;

(4) the program was not paid for services;

(5) the program ceases to operate; or

(6) the resident was terminated by the lead agency from waiver eligibility.

(d) Before giving notice of service termination, the license holder must document the action taken to minimize or eliminate the need for termination. The action taken by the license holder must include, at a minimum:

(1) consultation with the resident's interdisciplinary team to identify and resolve issues leading to a notice of service termination; and

(2) a request to the case manager or other professional consultation or intervention services to support the resident in the program. This requirement does not apply to a notice of service termination issued under paragraph (c), clause (4) or (5).

(e) If, based on the best interests of the resident, the circumstances at the time of notice were such that the license holder was unable to take the action specified in paragraph (d), the license holder must document the specific circumstances and the reason the license holder was unable to take the action.

(f) The license holder must notify the resident or the resident's legal representative and the case manager in writing of the intended service termination. The notice must include:

(1) the reason for the action;

(2) except for service termination under paragraph (c), clause (4) or (5), a summary of the action taken to minimize or eliminate the need for termination and the reason the action failed to prevent the termination;

(3) the resident's right to appeal the service termination under section 256.045, subdivision 3, paragraph (a); and

(4) the resident's right to seek a temporary order staying the service termination according to the procedures in section 256.045, subdivision 4a, or subdivision 6, paragraph (c).

(g) Notice of the proposed service termination must be given at least 30 days before terminating a resident's service.

(h) After the resident receives the notice of service termination and before the services are terminated, the license holder must:

(1) work with the support team or expanded support team to develop reasonable alternatives to support continuity of care and to protect the resident;

(2) provide information requested by the resident or case manager; and

(3) maintain information about the service termination, including the written notice of service termination, in the resident's record.

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

Sec. 8. Minnesota Statutes 2016, section 245D.03, subdivision 1, is amended to read:

Subdivision 1. **Applicability.** (a) The commissioner shall regulate the provision of home and community-based services to persons with disabilities and persons age 65 and older pursuant to this chapter. The licensing standards in this chapter govern the provision of basic support services and intensive support services.

(b) Basic support services provide the level of assistance, supervision, and care that is necessary to ensure the health and welfare of the person and do not include services that are specifically directed toward the training, treatment, habilitation, or rehabilitation of the person. Basic support services include:

(1) in-home and out-of-home respite care services as defined in section 245A.02, subdivision 15, and under the brain injury, community alternative care, community access for disability inclusion, developmental disability, and elderly waiver plans, excluding out-of-home respite care provided to children in a family child foster care home licensed under Minnesota Rules, parts 2960.3000 to 2960.3100, when the child foster care license holder complies with the requirements under section 245D.06, subdivisions 5, 6, 7, and 8, or successor provisions; and section 245D.061 or successor provisions, which must be stipulated in the statement of intended use required under Minnesota Rules, part 2960.3000, subpart 4;

(2) adult companion services as defined under the brain injury, community access for disability inclusion, and elderly waiver plans, excluding adult companion services provided under the Corporation for National and Community Services Senior Companion Program established under the Domestic Volunteer Service Act of 1973, Public Law 98-288;

(3) personal support as defined under the developmental disability waiver plan;

(4) 24-hour emergency assistance, personal emergency response as defined under the community access for disability inclusion and developmental disability waiver plans;

(5) night supervision services as defined under the brain injury waiver plan; and

(6) homemaker services as defined under the community access for disability inclusion, brain injury, community alternative care, developmental disability, and elderly waiver plans, excluding providers licensed by the Department of Health under chapter 144A and those providers providing cleaning services only.

(c) Intensive support services provide assistance, supervision, and care that is necessary to ensure the health and welfare of the person and services specifically directed toward the training, habilitation, or rehabilitation of the person. Intensive support services include:

(1) intervention services, including:

(i) behavioral support services as defined under the brain injury and community access for disability inclusion waiver plans;

(ii) in-home or out-of-home crisis respite services as defined under the developmental disability waiver plan; and

(iii) specialist services as defined under the current developmental disability waiver plan;

(2) in-home support services, including:

(i) in-home family support and supported living services as defined under the developmental disability waiver plan;

(ii) independent living services training as defined under the brain injury and community access for disability inclusion waiver plans; ~~and~~

(iii) semi-independent living services; and

(iv) individualized home supports services as defined under the brain injury, community alternative care, and community access for disability inclusion waiver plans;

(3) residential supports and services, including:

(i) supported living services as defined under the developmental disability waiver plan provided in a family or corporate child foster care residence, a family adult foster care residence, a community residential setting, or a supervised living facility;

(ii) foster care services as defined in the brain injury, community alternative care, and community access for disability inclusion waiver plans provided in a family or corporate child foster care residence, a family adult foster care residence, or a community residential setting; and

(iii) residential services provided to more than four persons with developmental disabilities in a supervised living facility, including ICFs/DD;

(4) day services, including:

(i) structured day services as defined under the brain injury waiver plan;

(ii) day training and habilitation services under sections 252.41 to 252.46, and as defined under the developmental disability waiver plan; and

(iii) prevocational services as defined under the brain injury and community access for disability inclusion waiver plans; and

(5) supported employment as defined under the brain injury, developmental disability, and community access for disability inclusion waiver plans.

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

Sec. 9. Minnesota Statutes 2016, section 245D.04, subdivision 3, is amended to read:

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

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

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

(3) be free from maltreatment;

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

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

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

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

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

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

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

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

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

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

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

(15) engage in chosen activities; and

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

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

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

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

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

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

(5) the freedom and support to access food at any time;

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

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

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

(9) a setting that meets state and local building and zoning definitions of a dwelling unit in a residential occupancy; and

(10) have access to potable water and three nutritionally balanced meals and nutritious snacks between meals each day.

(c) Restriction of a person's rights under paragraph (a), clauses (13) to ~~(15)~~ (16), or paragraph (b) is allowed only if determined necessary to ensure the health, safety, and well-being of the person. Any restriction of those rights must be documented in the person's coordinated service and support plan or coordinated service and support plan addendum. The restriction must be implemented in the least restrictive alternative manner necessary to protect the person and provide support to reduce or eliminate the need for the restriction in the most integrated setting and inclusive manner. The documentation must include the following information:

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

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

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

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

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

Sec. 10. Minnesota Statutes 2016, section 245D.071, subdivision 1, is amended to read:

Subdivision 1. **Requirements for intensive support services.** Except for services identified in section 245D.03, subdivision 1, paragraph (c), ~~clauses~~ clause (1) ~~and (2)~~, a license holder providing intensive support services identified in section 245D.03, subdivision 1, paragraph (c), must comply with the requirements in this section and section 245D.07, subdivisions 1, 1a, and 3. Services identified in section 245D.03, subdivision 1, paragraph (c), ~~clauses~~ clause (1) ~~and (2)~~, must comply with the requirements in section 245D.07, subdivision 2.

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

Sec. 11. Minnesota Statutes 2016, section 245D.071, subdivision 3, is amended to read:

Subd. 3. **Assessment and initial service planning.** (a) Within 15 days of service initiation the license holder must complete a preliminary coordinated service and support plan addendum based on the coordinated service and support plan.

(b) Within the scope of services, the license holder must, at a minimum, complete assessments in the following areas before the 45-day planning meeting:

(1) the person's ability to self-manage health and medical needs to maintain or improve physical, mental, and emotional well-being, including, when applicable, allergies, seizures, choking, special dietary needs, chronic medical conditions, self-administration of medication or treatment orders, preventative screening, and medical and dental appointments;

(2) the person's ability to self-manage personal safety to avoid injury or accident in the service setting, including, when applicable, risk of falling, mobility, regulating water temperature, community survival skills, water safety skills, and sensory disabilities; and

(3) the person's ability to self-manage symptoms or behavior that may otherwise result in an incident as defined in section 245D.02, subdivision 11, clauses (4) to (7), suspension or termination of services by the license holder, or other symptoms or behaviors that may jeopardize the health and welfare of the person or others.

Assessments must produce information about the person that describes the person's overall strengths, functional skills and abilities, and behaviors or symptoms. Assessments must be based on the person's status within the last 12 months at the time of service initiation. Assessments based on older information must be documented and justified. Assessments must be conducted annually at a minimum or within 30 days of a written request from the person or the person's legal representative or case manager. The results must be reviewed by the support team or expanded support team as part of a service plan review.

(c) Within 45 days of service initiation, the license holder must meet with the person, the person's legal representative, the case manager, and other members of the support team or expanded support team to determine the following based on information obtained from the assessments identified in paragraph (b), the person's identified needs in the coordinated service and support plan, and the requirements in subdivision 4 and section 245D.07, subdivision 1a:

(1) the scope of the services to be provided to support the person's daily needs and activities;

(2) the person's desired outcomes and the supports necessary to accomplish the person's desired outcomes;

(3) the person's preferences for how services and supports are provided, including how the provider will support the person to have control of the person's schedule;

(4) whether the current service setting is the most integrated setting available and appropriate for the person; and

(5) how services must be coordinated across other providers licensed under this chapter serving the person and members of the support team or expanded support team to ensure continuity of care and coordination of services for the person.

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

Sec. 12. Minnesota Statutes 2016, section 245D.09, subdivision 5a, is amended to read:

Subd. 5a. **Alternative sources of training.** The commissioner may approve online training and competency-based assessments in place of a specific number of hours of training in the topics covered in subdivision 4.

Orientation or training received by the staff person from sources other than the license holder in the same subjects as identified in subdivision 4 may count toward the orientation and annual training requirements if received in the 12-month period before the staff person's date of hire. The license holder must maintain documentation of the training received from other sources and of each staff person's competency in the required area according to the requirements in subdivision 3.

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

Sec. 13. Minnesota Statutes 2016, section 245D.11, subdivision 4, is amended to read:

Subd. 4. **Admission criteria.** The license holder must establish policies and procedures that promote continuity of care by ensuring that admission or service initiation criteria:

(1) is consistent with the service-related rights identified in section 245D.04, subdivisions 2, clauses (4) to (7), and 3, clause (8);

(2) identifies the criteria to be applied in determining whether the license holder can develop services to meet the needs specified in the person's coordinated service and support plan;

(3) requires a license holder providing services in a health care facility to comply with the requirements in section 243.166, subdivision 4b, to provide notification to residents

when a registered predatory offender is admitted into the program or to a potential admission when the facility was already serving a registered predatory offender. For purposes of this clause, "health care facility" means a facility licensed by the commissioner as a residential facility under chapter 245A to provide adult foster care or residential services to persons with disabilities; ~~and~~

(4) requires that when a person or the person's legal representative requests services from the license holder, a refusal to admit the person must be based on an evaluation of the person's assessed needs and the license holder's lack of capacity to meet the needs of the person. The license holder must not refuse to admit a person based solely on the type of residential services the person is receiving, or solely on the person's severity of disability, orthopedic or neurological handicaps, sight or hearing impairments, lack of communication skills, physical disabilities, toilet habits, behavioral disorders, or past failure to make progress. Documentation of the basis for refusal must be provided to the person or the person's legal representative and case manager upon request~~.~~; and

(5) requires the person or the person's legal representative and license holder to sign and date the residency agreement when the license holder provides foster care or supported living services under section 245D.03, subdivision 1, paragraph (c), clause (3), item (i) or (ii), to a person living in a community residential setting defined in section 245D.02, subdivision 4a; an adult foster home defined in Minnesota Rules, part 9555.5105, subpart 5; or a foster family home defined in Minnesota Rules, part 9560.0521, subpart 12. The residency agreement must include service termination requirements specified in section 245D.10, subdivision 3a, paragraphs (b) to (f). The residency agreement must be reviewed annually, dated, and signed by the person or the person's legal representative and license holder.

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

Sec. 14. Minnesota Statutes 2016, section 245D.24, subdivision 3, is amended to read:

Subd. 3. **Bedrooms.** (a) ~~People~~ Each person receiving services must have a choice of roommate and must mutually consent, in writing, to sharing a bedroom with one another. No more than two people receiving services may share one bedroom.

(b) A single occupancy bedroom must have at least 80 square feet of floor space with a 7-1/2 foot ceiling. A double occupancy room must have at least 120 square feet of floor space with a 7-1/2 foot ceiling. Bedrooms must be separated from halls, corridors, and other habitable rooms by floor-to-ceiling walls containing no openings except doorways and must not serve as a corridor to another room used in daily living.

(c) A person's personal possessions and items for the person's own use are the only items permitted to be stored in a person's bedroom.

(d) Unless otherwise documented through assessment as a safety concern for the person, each person must be provided with the following furnishings:

(1) a separate bed of proper size and height for the convenience and comfort of the person, with a clean mattress in good repair;

(2) clean bedding appropriate for the season for each person;

(3) an individual cabinet, or dresser, shelves, and a closet, for storage of personal possessions and clothing; and

(4) a mirror for grooming.

(e) When possible, a person must be allowed to have items of furniture that the person personally owns in the bedroom, unless doing so would interfere with safety precautions, violate a building or fire code, or interfere with another person's use of the bedroom. A person may choose not to have a cabinet, dresser, shelves, or a mirror in the bedroom, as otherwise required under paragraph (d), clause (3) or (4). A person may choose to use a mattress other than an innerspring mattress and may choose not to have the mattress on a mattress frame or support. If a person chooses not to have a piece of required furniture, the license holder must document this choice and is not required to provide the item. If a person chooses to use a mattress other than an innerspring mattress or chooses not to have a mattress frame or support, the license holder must document this choice and allow the alternative desired by the person.

(f) A person must be allowed to bring personal possessions into the bedroom and other designated storage space, if such space is available, in the residence. The person must be allowed to accumulate possessions to the extent the residence is able to accommodate them, unless doing so is contraindicated for the person's physical or mental health, would interfere with safety precautions or another person's use of the bedroom, or would violate a building or fire code. The license holder must allow for locked storage of personal items. Any restriction on the possession or locked storage of personal items, including requiring a person to use a lock provided by the license holder, must comply with section 245D.04, subdivision 3, paragraph (c), and allow the person to be present if and when the license holder opens the lock.

(g) A person must be allowed to lock the person's bedroom door. The license holder must document and assess the physical plant and the environment, and the population served,

and identify the risk factors that require using locked doors, and the specific action taken to minimize the safety risk to a person receiving services at the site.

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

Sec. 15. Minnesota Statutes 2016, section 256.045, subdivision 3, is amended to read:

Subd. 3. **State agency hearings.** (a) State agency hearings are available for the following:

(1) any person applying for, receiving or having received public assistance, medical care, or a program of social services granted by the state agency or a county agency or the federal Food Stamp Act whose application for assistance is denied, not acted upon with reasonable promptness, or whose assistance is suspended, reduced, terminated, or claimed to have been incorrectly paid;

(2) any patient or relative aggrieved by an order of the commissioner under section 252.27;

(3) a party aggrieved by a ruling of a prepaid health plan;

(4) except as provided under chapter 245C, any individual or facility determined by a lead investigative agency to have maltreated a vulnerable adult under section 626.557 after they have exercised their right to administrative reconsideration under section 626.557;

(5) any person whose claim for foster care payment according to a placement of the child resulting from a child protection assessment under section 626.556 is denied or not acted upon with reasonable promptness, regardless of funding source;

(6) any person to whom a right of appeal according to this section is given by other provision of law;

(7) an applicant aggrieved by an adverse decision to an application for a hardship waiver under section 256B.15;

(8) an applicant aggrieved by an adverse decision to an application or redetermination for a Medicare Part D prescription drug subsidy under section 256B.04, subdivision 4a;

(9) except as provided under chapter 245A, an individual or facility determined to have maltreated a minor under section 626.556, after the individual or facility has exercised the right to administrative reconsideration under section 626.556;

(10) except as provided under chapter 245C, an individual disqualified under sections 245C.14 and 245C.15, following a reconsideration decision issued under section 245C.23, on the basis of serious or recurring maltreatment; a preponderance of the evidence that the

individual has committed an act or acts that meet the definition of any of the crimes listed in section 245C.15, subdivisions 1 to 4; or for failing to make reports required under section 626.556, subdivision 3, or 626.557, subdivision 3. Hearings regarding a maltreatment determination under clause (4) or (9) and a disqualification under this clause in which the basis for a disqualification is serious or recurring maltreatment, shall be consolidated into a single fair hearing. In such cases, the scope of review by the human services judge shall include both the maltreatment determination and the disqualification. The failure to exercise the right to an administrative reconsideration shall not be a bar to a hearing under this section if federal law provides an individual the right to a hearing to dispute a finding of maltreatment;

(11) any person with an outstanding debt resulting from receipt of public assistance, medical care, or the federal Food Stamp Act who is contesting a setoff claim by the Department of Human Services or a county agency. The scope of the appeal is the validity of the claimant agency's intention to request a setoff of a refund under chapter 270A against the debt;

(12) a person issued a notice of service termination under section 245D.10, subdivision 3a, from residential supports and services as defined in section 245D.03, subdivision 1, paragraph (c), clause (3), that is not otherwise subject to appeal under subdivision 4a; ~~or~~

(13) an individual disability waiver recipient based on a denial of a request for a rate exception under section 256B.4914~~.~~; or

(14) a person issued a notice of service termination under section 245A.11, subdivision 11, that is not otherwise subject to appeal under subdivision 4a.

(b) The hearing for an individual or facility under paragraph (a), clause (4), (9), or (10), is the only administrative appeal to the final agency determination specifically, including a challenge to the accuracy and completeness of data under section 13.04. Hearings requested under paragraph (a), clause (4), apply only to incidents of maltreatment that occur on or after October 1, 1995. Hearings requested by nursing assistants in nursing homes alleged to have maltreated a resident prior to October 1, 1995, shall be held as a contested case proceeding under the provisions of chapter 14. Hearings requested under paragraph (a), clause (9), apply only to incidents of maltreatment that occur on or after July 1, 1997. A hearing for an individual or facility under paragraph (a), clauses (4), (9), and (10), is only available when there is no district court action pending. If such action is filed in district court while an administrative review is pending that arises out of some or all of the events or circumstances on which the appeal is based, the administrative review must be suspended

until the judicial actions are completed. If the district court proceedings are completed, dismissed, or overturned, the matter may be considered in an administrative hearing.

(c) For purposes of this section, bargaining unit grievance procedures are not an administrative appeal.

(d) The scope of hearings involving claims to foster care payments under paragraph (a), clause (5), shall be limited to the issue of whether the county is legally responsible for a child's placement under court order or voluntary placement agreement and, if so, the correct amount of foster care payment to be made on the child's behalf and shall not include review of the propriety of the county's child protection determination or child placement decision.

(e) The scope of hearings under paragraph (a), ~~clause~~ clauses (12) and (14), shall be limited to whether the proposed termination of services is authorized under section 245D.10, subdivision 3a, paragraph (b), or 245A.11, subdivision 11, and whether the requirements of section 245D.10, subdivision 3a, ~~paragraph~~ paragraphs (c) to (e), or 245A.11, subdivision 2a, paragraphs (d) to (f), were met. If the appeal includes a request for a temporary stay of termination of services, the scope of the hearing shall also include whether the case management provider has finalized arrangements for a residential facility, a program, or services that will meet the assessed needs of the recipient by the effective date of the service termination.

(f) A vendor of medical care as defined in section 256B.02, subdivision 7, or a vendor under contract with a county agency to provide social services is not a party and may not request a hearing under this section, except if assisting a recipient as provided in subdivision 4.

(g) An applicant or recipient is not entitled to receive social services beyond the services prescribed under chapter 256M or other social services the person is eligible for under state law.

(h) The commissioner may summarily affirm the county or state agency's proposed action without a hearing when the sole issue is an automatic change due to a change in state or federal law.

(i) Unless federal or Minnesota law specifies a different time frame in which to file an appeal, an individual or organization specified in this section may contest the specified action, decision, or final disposition before the state agency by submitting a written request for a hearing to the state agency within 30 days after receiving written notice of the action, decision, or final disposition, or within 90 days of such written notice if the applicant, recipient, patient, or relative shows good cause, as defined in section 256.0451, subdivision

13, why the request was not submitted within the 30-day time limit. The individual filing the appeal has the burden of proving good cause by a preponderance of the evidence.

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

Sec. 16. Minnesota Statutes 2016, section 256B.0659, subdivision 24, is amended to read:

Subd. 24. **Personal care assistance provider agency; general duties.** A personal care assistance provider agency shall:

(1) enroll as a Medicaid provider meeting all provider standards, including completion of the required provider training;

(2) comply with general medical assistance coverage requirements;

(3) demonstrate compliance with law and policies of the personal care assistance program to be determined by the commissioner;

(4) comply with background study requirements;

(5) verify and keep records of hours worked by the personal care assistant and qualified professional;

(6) not engage in any agency-initiated direct contact or marketing in person, by phone, or other electronic means to potential recipients, guardians, or family members;

(7) pay the personal care assistant and qualified professional based on actual hours of services provided;

(8) withhold and pay all applicable federal and state taxes;

(9) effective January 1, 2010, document that the agency uses a minimum of 72.5 percent of the revenue generated by the medical assistance rate for personal care assistance services for employee personal care assistant wages and benefits. The revenue generated by the qualified professional and the reasonable costs associated with the qualified professional shall not be used in making this calculation;

(10) make the arrangements and pay unemployment insurance, taxes, workers' compensation, liability insurance, and other benefits, if any;

(11) enter into a written agreement under subdivision 20 before services are provided;

(12) report suspected neglect and abuse to the common entry point according to section 256B.0651;

(13) provide the recipient with a copy of the home care bill of rights at start of service; and

(14) request reassessments at least 60 days prior to the end of the current authorization for personal care assistance services, on forms provided by the commissioner.; and

(15) provide written notice to a recipient at least 30 calendar days before the service termination becomes effective except when:

(i) the recipient engages in conduct that significantly alters the terms of the recipient's personal care assistance care plan with the agency;

(ii) the recipient or another person present at the setting where services are provided engage in conduct that creates an imminent risk of harm to the personal care assistant or other agency staff;

(iii) the agency cannot safely meet the recipient's needs because an emergency or a significant change in the recipient's condition occurred within a 24-hour period causing the recipient's service needs to exceed the recipient's identified needs in the personal care assistance care plan; or

(iv) a recipient initiates a request to terminate personal care assistance services, the agency must give the recipient a written acknowledgment of the recipient's service termination request that includes the date the request was received by the agency and the requested date of termination.

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

Sec. 17. Minnesota Statutes 2016, section 256B.0911, subdivision 3a, is amended to read:

Subd. 3a. **Assessment and support planning.** (a) Persons requesting assessment, services planning, or other assistance intended to support community-based living, including persons who need assessment in order to determine waiver or alternative care program eligibility, must be visited by a long-term care consultation team within 20 calendar days after the date on which an assessment was requested or recommended. Upon statewide implementation of subdivisions 2b, 2c, and 5, this requirement also applies to an assessment of a person requesting personal care assistance services and home care nursing. The commissioner shall provide at least a 90-day notice to lead agencies prior to the effective date of this requirement. Face-to-face assessments must be conducted according to paragraphs (b) to (i).

(b) Upon implementation of subdivisions 2b, 2c, and 5, lead agencies shall use certified assessors to conduct the assessment. For a person with complex health care needs, a public health or registered nurse from the team must be consulted.

(c) The MnCHOICES assessment provided by the commissioner to lead agencies must be used to complete a comprehensive, person-centered assessment. The assessment must include the health, psychological, functional, environmental, and social needs of the individual necessary to develop a community support plan that meets the individual's needs and preferences.

(d) The assessment must be conducted in a face-to-face interview with the person being assessed and the person's legal representative. At the request of the person, other individuals may participate in the assessment to provide information on the needs, strengths, and preferences of the person necessary to develop a community support plan that ensures the person's health and safety. Except for legal representatives or family members invited by the person, persons participating in the assessment may not be a provider of service or have any financial interest in the provision of services. For persons who are to be assessed for elderly waiver customized living services under section 256B.0915, with the permission of the person being assessed or the person's designated or legal representative, the client's current or proposed provider of services may submit a copy of the provider's nursing assessment or written report outlining its recommendations regarding the client's care needs. The person conducting the assessment must notify the provider of the date by which this information is to be submitted. This information shall be provided to the person conducting the assessment prior to the assessment. For a person who is to be assessed for waiver services under section 256B.092 or 256B.49, with the permission of the person being assessed or the person's designated legal representative, the person's current provider of services may submit a written report outlining recommendations regarding the person's care needs prepared by a direct service employee with at least 20 hours of service to that client. The person conducting the assessment or reassessment must notify the provider of the date by which this information is to be submitted. This information shall be provided to the person conducting the assessment and the person or the person's legal representative, and must be considered prior to the finalization of the assessment or reassessment.

(e) The person or the person's legal representative must be provided with a written community support plan within 40 calendar days of the assessment visit, regardless of whether the individual is eligible for Minnesota health care programs. The written community support plan must include:

(1) a summary of assessed needs as defined in paragraphs (c) and (d);

(2) the individual's options and choices to meet identified needs, including all available options for case management services and providers, including service provided in a non-disability-specific setting;

(3) identification of health and safety risks and how those risks will be addressed, including personal risk management strategies;

(4) referral information; and

(5) informal caregiver supports, if applicable.

For a person determined eligible for state plan home care under subdivision 1a, paragraph (b), clause (1), the person or person's representative must also receive a copy of the home care service plan developed by the certified assessor.

(f) A person may request assistance in identifying community supports without participating in a complete assessment. Upon a request for assistance identifying community support, the person must be transferred or referred to long-term care options counseling services available under sections 256.975, subdivision 7, and 256.01, subdivision 24, for telephone assistance and follow up.

(g) The person has the right to make the final decision between institutional placement and community placement after the recommendations have been provided, except as provided in section 256.975, subdivision 7a, paragraph (d).

(h) The lead agency must give the person receiving assessment or support planning, or the person's legal representative, materials, and forms supplied by the commissioner containing the following information:

(1) written recommendations for community-based services and consumer-directed options;

(2) documentation that the most cost-effective alternatives available were offered to the individual. For purposes of this clause, "cost-effective" means community services and living arrangements that cost the same as or less than institutional care. For an individual found to meet eligibility criteria for home and community-based service programs under section 256B.0915 or 256B.49, "cost-effectiveness" has the meaning found in the federally approved waiver plan for each program;

(3) the need for and purpose of preadmission screening conducted by long-term care options counselors according to section 256.975, subdivisions 7a to 7c, if the person selects nursing facility placement. If the individual selects nursing facility placement, the lead agency shall forward information needed to complete the level of care determinations and

screening for developmental disability and mental illness collected during the assessment to the long-term care options counselor using forms provided by the commissioner;

(4) the role of long-term care consultation assessment and support planning in eligibility determination for waiver and alternative care programs, and state plan home care, case management, and other services as defined in subdivision 1a, paragraphs (a), clause (6), and (b);

(5) information about Minnesota health care programs;

(6) the person's freedom to accept or reject the recommendations of the team;

(7) the person's right to confidentiality under the Minnesota Government Data Practices Act, chapter 13;

(8) the certified assessor's decision regarding the person's need for institutional level of care as determined under criteria established in subdivision 4e and the certified assessor's decision regarding eligibility for all services and programs as defined in subdivision 1a, paragraphs (a), clause (6), and (b); and

(9) the person's right to appeal the certified assessor's decision regarding eligibility for all services and programs as defined in subdivision 1a, paragraphs (a), clauses (6), (7), and (8), and (b), and incorporating the decision regarding the need for institutional level of care or the lead agency's final decisions regarding public programs eligibility according to section 256.045, subdivision 3.

(i) Face-to-face assessment completed as part of eligibility determination for the alternative care, elderly waiver, community access for disability inclusion, community alternative care, and brain injury waiver programs under sections 256B.0913, 256B.0915, and 256B.49 is valid to establish service eligibility for no more than 60 calendar days after the date of assessment.

(j) The effective eligibility start date for programs in paragraph (i) can never be prior to the date of assessment. If an assessment was completed more than 60 days before the effective waiver or alternative care program eligibility start date, assessment and support plan information must be updated and documented in the department's Medicaid Management Information System (MMIS). Notwithstanding retroactive medical assistance coverage of state plan services, the effective date of eligibility for programs included in paragraph (i) cannot be prior to the date the most recent updated assessment is completed.

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

Sec. 18. Minnesota Statutes 2016, section 256B.092, subdivision 1a, is amended to read:

Subd. 1a. **Case management services.** (a) Each recipient of a home and community-based waiver shall be provided case management services by qualified vendors as described in the federally approved waiver application.

(b) Case management service activities provided to or arranged for a person include:

(1) development of the coordinated service and support plan under subdivision 1b;

(2) informing the individual or the individual's legal guardian or conservator, or parent if the person is a minor, of service options;

(3) consulting with relevant medical experts or service providers;

(4) assisting the person in the identification of potential providers, including services provided in a non-disability-specific setting;

(5) assisting the person to access services and assisting in appeals under section 256.045;

(6) coordination of services, if coordination is not provided by another service provider;

(7) evaluation and monitoring of the services identified in the coordinated service and support plan, which must incorporate at least one annual face-to-face visit by the case manager with each person; and

(8) reviewing coordinated service and support plans and providing the lead agency with recommendations for service authorization based upon the individual's needs identified in the coordinated service and support plan.

(c) Case management service activities that are provided to the person with a developmental disability shall be provided directly by county agencies or under contract. Case management services must be provided by a public or private agency that is enrolled as a medical assistance provider determined by the commissioner to meet all of the requirements in the approved federal waiver plans. Case management services must not be provided to a recipient by a private agency that has a financial interest in the provision of any other services included in the recipient's coordinated service and support plan. For purposes of this section, "private agency" means any agency that is not identified as a lead agency under section 256B.0911, subdivision 1a, paragraph (e).

(d) Case managers are responsible for service provisions listed in paragraphs (a) and (b). Case managers shall collaborate with consumers, families, legal representatives, and relevant medical experts and service providers in the development and annual review of the coordinated service and support plan and habilitation plan.

(e) For persons who need a positive support transition plan as required in chapter 245D, the case manager shall participate in the development and ongoing evaluation of the plan with the expanded support team. At least quarterly, the case manager, in consultation with the expanded support team, shall evaluate the effectiveness of the plan based on progress evaluation data submitted by the licensed provider to the case manager. The evaluation must identify whether the plan has been developed and implemented in a manner to achieve the following within the required timelines:

(1) phasing out the use of prohibited procedures;

(2) acquisition of skills needed to eliminate the prohibited procedures within the plan's timeline; and

(3) accomplishment of identified outcomes.

If adequate progress is not being made, the case manager shall consult with the person's expanded support team to identify needed modifications and whether additional professional support is required to provide consultation.

(f) The Department of Human Services shall offer ongoing education in case management to case managers. Case managers shall receive no less than ten hours of case management education and disability-related training each year.

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

Sec. 19. Minnesota Statutes 2016, section 256B.49, subdivision 13, is amended to read:

Subd. 13. **Case management.** (a) Each recipient of a home and community-based waiver shall be provided case management services by qualified vendors as described in the federally approved waiver application. The case management service activities provided must include:

(1) finalizing the written coordinated service and support plan within ten working days after the case manager receives the plan from the certified assessor;

(2) informing the recipient or the recipient's legal guardian or conservator of service options;

(3) assisting the recipient in the identification of potential service providers and available options for case management service and providers, including services provided in non-disability-specific setting;

(4) assisting the recipient to access services and assisting with appeals under section 256.045; and

(5) coordinating, evaluating, and monitoring of the services identified in the service plan.

(b) The case manager may delegate certain aspects of the case management service activities to another individual provided there is oversight by the case manager. The case manager may not delegate those aspects which require professional judgment including:

(1) finalizing the coordinated service and support plan;

(2) ongoing assessment and monitoring of the person's needs and adequacy of the approved coordinated service and support plan; and

(3) adjustments to the coordinated service and support plan.

(c) Case management services must be provided by a public or private agency that is enrolled as a medical assistance provider determined by the commissioner to meet all of the requirements in the approved federal waiver plans. Case management services must not be provided to a recipient by a private agency that has any financial interest in the provision of any other services included in the recipient's coordinated service and support plan. For purposes of this section, "private agency" means any agency that is not identified as a lead agency under section 256B.0911, subdivision 1a, paragraph (e).

(d) For persons who need a positive support transition plan as required in chapter 245D, the case manager shall participate in the development and ongoing evaluation of the plan with the expanded support team. At least quarterly, the case manager, in consultation with the expanded support team, shall evaluate the effectiveness of the plan based on progress evaluation data submitted by the licensed provider to the case manager. The evaluation must identify whether the plan has been developed and implemented in a manner to achieve the following within the required timelines:

(1) phasing out the use of prohibited procedures;

(2) acquisition of skills needed to eliminate the prohibited procedures within the plan's timeline; and

(3) accomplishment of identified outcomes.

If adequate progress is not being made, the case manager shall consult with the person's expanded support team to identify needed modifications and whether additional professional support is required to provide consultation.

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

Sec. 20. Minnesota Statutes 2016, section 256B.4913, is amended by adding a subdivision to read:

Subd. 7. **New services.** A service added to section 256B.4914 after January 1, 2014, is not subject to rate stabilization adjustment in this section.

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

Sec. 21. Minnesota Statutes 2016, section 256B.4914, subdivision 3, is amended to read:

Subd. 3. **Applicable services.** Applicable services are those authorized under the state's home and community-based services waivers under sections 256B.092 and 256B.49, including the following, as defined in the federally approved home and community-based services plan:

(1) 24-hour customized living;

(2) adult day care;

(3) adult day care bath;

(4) behavioral programming;

(5) companion services;

(6) customized living;

(7) day training and habilitation;

(8) housing access coordination;

(9) independent living skills;

(10) in-home family support;

(11) night supervision;

(12) personal support;

(13) prevocational services;

(14) residential care services;

(15) residential support services;

(16) respite services;

(17) structured day services;

(18) supported employment services;

(19) supported living services;

(20) transportation services; ~~and~~

(21) individualized home supports; and

(22) other services as approved by the federal government in the state home and community-based services plan.

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

Sec. 22. Minnesota Statutes 2016, section 256B.4914, subdivision 5, is amended to read:

Subd. 5. **Base wage index and standard component values.** (a) The base wage index is established to determine staffing costs associated with providing services to individuals receiving home and community-based services. For purposes of developing and calculating the proposed base wage, Minnesota-specific wages taken from job descriptions and standard occupational classification (SOC) codes from the Bureau of Labor Statistics as defined in the most recent edition of the Occupational Handbook must be used. The base wage index must be calculated as follows:

(1) for residential direct care staff, the sum of:

(i) 15 percent of the subtotal of 50 percent of the median wage for personal and home health aide (SOC code 39-9021); 30 percent of the median wage for nursing aide (SOC code 31-1012); and 20 percent of the median wage for social and human services aide (SOC code 21-1093); and

(ii) 85 percent of the subtotal of 20 percent of the median wage for home health aide (SOC code 31-1011); 20 percent of the median wage for personal and home health aide (SOC code 39-9021); 20 percent of the median wage for nursing aide (SOC code 31-1012); 20 percent of the median wage for psychiatric technician (SOC code 29-2053); and 20 percent of the median wage for social and human services aide (SOC code 21-1093);

(2) for day services, 20 percent of the median wage for nursing aide (SOC code 31-1012); 20 percent of the median wage for psychiatric technician (SOC code 29-2053); and 60 percent of the median wage for social and human services aide (SOC code 21-1093);

(3) for residential asleep-overnight staff, the wage will be $7.66 per hour, except in a family foster care setting, the wage is $2.80 per hour;

(4) for behavior program analyst staff, 100 percent of the median wage for mental health counselors (SOC code 21-1014);

(5) for behavior program professional staff, 100 percent of the median wage for clinical counseling and school psychologist (SOC code 19-3031);

(6) for behavior program specialist staff, 100 percent of the median wage for psychiatric technicians (SOC code 29-2053);

(7) for supportive living services staff, 20 percent of the median wage for nursing aide (SOC code 31-1012); 20 percent of the median wage for psychiatric technician (SOC code 29-2053); and 60 percent of the median wage for social and human services aide (SOC code 21-1093);

(8) for housing access coordination staff, 50 percent of the median wage for community and social services specialist (SOC code 21-1099); and 50 percent of the median wage for social and human services aide (SOC code 21-1093);

(9) for in-home family support staff, 20 percent of the median wage for nursing aide (SOC code 31-1012); 30 percent of the median wage for community social service specialist (SOC code 21-1099); 40 percent of the median wage for social and human services aide (SOC code 21-1093); and ten percent of the median wage for psychiatric technician (SOC code 29-2053);

(10) for independent living skills staff, 40 percent of the median wage for community social service specialist (SOC code 21-1099); 50 percent of the median wage for social and human services aide (SOC code 21-1093); and ten percent of the median wage for psychiatric technician (SOC code 29-2053);

(11) for individualized home supports services staff, 40 percent of the median wage for community social service specialist (SOC code 21-1099); 50 percent of the median wage for social and human services aide (SOC code 21-1093); and ten percent of the median wage for psychiatric technician (SOC code 29-2053).

~~(11)~~ (12) for supported employment staff, 20 percent of the median wage for nursing aide (SOC code 31-1012); 20 percent of the median wage for psychiatric technician (SOC code 29-2053); and 60 percent of the median wage for social and human services aide (SOC code 21-1093);

~~(12)~~ (13) for adult companion staff, 50 percent of the median wage for personal and home care aide (SOC code 39-9021); and 50 percent of the median wage for nursing aides, orderlies, and attendants (SOC code 31-1012);

~~(13)~~ (14) for night supervision staff, 20 percent of the median wage for home health aide (SOC code 31-1011); 20 percent of the median wage for personal and home health

aide (SOC code 39-9021); 20 percent of the median wage for nursing aide (SOC code 31-1012); 20 percent of the median wage for psychiatric technician (SOC code 29-2053); and 20 percent of the median wage for social and human services aide (SOC code 21-1093);

~~(14)~~ (15) for respite staff, 50 percent of the median wage for personal and home care aide (SOC code 39-9021); and 50 percent of the median wage for nursing aides, orderlies, and attendants (SOC code 31-1012);

~~(15)~~ (16) for personal support staff, 50 percent of the median wage for personal and home care aide (SOC code 39-9021); and 50 percent of the median wage for nursing aides, orderlies, and attendants (SOC code 31-1012);

~~(16)~~ (17) for supervisory staff, the basic wage is $17.43 per hour with exception of the supervisor of behavior analyst and behavior specialists, which must be $30.75 per hour;

~~(17)~~ (18) for registered nurse, the basic wage is $30.82 per hour; and

~~(18)~~ (19) for licensed practical nurse, the basic wage is $18.64 per hour.

(b) Component values for residential support services are:

(1) supervisory span of control ratio: 11 percent;

(2) employee vacation, sick, and training allowance ratio: 8.71 percent;

(3) employee-related cost ratio: 23.6 percent;

(4) general administrative support ratio: 13.25 percent;

(5) program-related expense ratio: 1.3 percent; and

(6) absence and utilization factor ratio: 3.9 percent.

(c) Component values for family foster care are:

(1) supervisory span of control ratio: 11 percent;

(2) employee vacation, sick, and training allowance ratio: 8.71 percent;

(3) employee-related cost ratio: 23.6 percent;

(4) general administrative support ratio: 3.3 percent;

(5) program-related expense ratio: 1.3 percent; and

(6) absence factor: 1.7 percent.

(d) Component values for day services for all services are:

(1) supervisory span of control ratio: 11 percent;

(2) employee vacation, sick, and training allowance ratio: 8.71 percent;

(3) employee-related cost ratio: 23.6 percent;

(4) program plan support ratio: 5.6 percent;

(5) client programming and support ratio: ten percent;

(6) general administrative support ratio: 13.25 percent;

(7) program-related expense ratio: 1.8 percent; and

(8) absence and utilization factor ratio: 3.9 percent.

(e) Component values for unit-based services with programming are:

(1) supervisory span of control ratio: 11 percent;

(2) employee vacation, sick, and training allowance ratio: 8.71 percent;

(3) employee-related cost ratio: 23.6 percent;

(4) program plan supports ratio: 3.1 percent;

(5) client programming and supports ratio: 8.6 percent;

(6) general administrative support ratio: 13.25 percent;

(7) program-related expense ratio: 6.1 percent; and

(8) absence and utilization factor ratio: 3.9 percent.

(f) Component values for unit-based services without programming except respite are:

(1) supervisory span of control ratio: 11 percent;

(2) employee vacation, sick, and training allowance ratio: 8.71 percent;

(3) employee-related cost ratio: 23.6 percent;

(4) program plan support ratio: 3.1 percent;

(5) client programming and support ratio: 8.6 percent;

(6) general administrative support ratio: 13.25 percent;

(7) program-related expense ratio: 6.1 percent; and

(8) absence and utilization factor ratio: 3.9 percent.

(g) Component values for unit-based services without programming for respite are:

(1) supervisory span of control ratio: 11 percent;

(2) employee vacation, sick, and training allowance ratio: 8.71 percent;

(3) employee-related cost ratio: 23.6 percent;

(4) general administrative support ratio: 13.25 percent;

(5) program-related expense ratio: 6.1 percent; and

(6) absence and utilization factor ratio: 3.9 percent.

(h) On July 1, 2017, the commissioner shall update the base wage index in paragraph (a) based on the wage data by standard occupational code (SOC) from the Bureau of Labor Statistics available on December 31, 2016. The commissioner shall publish these updated values and load them into the rate management system. This adjustment occurs every five years. For adjustments in 2021 and beyond, the commissioner shall use the data available on December 31 of the calendar year five years prior.

(i) On July 1, 2017, the commissioner shall update the framework components in paragraphs (b) to (g); subdivision 6, clauses (8) and (9); and subdivision 7, clauses (16) and (17), for changes in the Consumer Price Index. The commissioner will adjust these values higher or lower by the percentage change in the Consumer Price Index-All Items, United States city average (CPI-U) from January 1, 2014, to January 1, 2017. The commissioner shall publish these updated values and load them into the rate management system. This adjustment occurs every five years. For adjustments in 2021 and beyond, the commissioner shall use the data available on January 1 of the calendar year four years prior and January 1 of the current calendar year.

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

Sec. 23. Minnesota Statutes 2016, section 256B.4914, subdivision 8, is amended to read:

Subd. 8. **Payments for unit-based services with programming.** Payments for unit-based services with programming, including behavior programming, housing access coordination, in-home family support, independent living skills training, individualized home supports, hourly supported living services, and supported employment provided to an individual outside of any day or residential service plan must be calculated as follows, unless the services are authorized separately under subdivision 6 or 7:

(1) determine the number of units of service to meet a recipient's needs;

(2) personnel hourly wage rate must be based on the 2009 Bureau of Labor Statistics Minnesota-specific rates or rates derived by the commissioner as provided in subdivision 5;

(3) for a recipient requiring customization for deaf and hard-of-hearing language accessibility under subdivision 12, add the customization rate provided in subdivision 12 to the result of clause (2). This is defined as the customized direct-care rate;

(4) multiply the number of direct staff hours by the appropriate staff wage in subdivision 5, paragraph (a), or the customized direct-care rate;

(5) multiply the number of direct staff hours by the product of the supervision span of control ratio in subdivision 5, paragraph (e), clause (1), and the appropriate supervision wage in subdivision 5, paragraph (a), clause (16);

(6) combine the results of clauses (4) and (5), and multiply the result by one plus the employee vacation, sick, and training allowance ratio in subdivision 5, paragraph (e), clause (2). This is defined as the direct staffing rate;

(7) for program plan support, multiply the result of clause (6) by one plus the program plan supports ratio in subdivision 5, paragraph (e), clause (4);

(8) for employee-related expenses, multiply the result of clause (7) by one plus the employee-related cost ratio in subdivision 5, paragraph (e), clause (3);

(9) for client programming and supports, multiply the result of clause (8) by one plus the client programming and supports ratio in subdivision 5, paragraph (e), clause (5);

(10) this is the subtotal rate;

(11) sum the standard general and administrative rate, the program-related expense ratio, and the absence and utilization factor ratio;

(12) divide the result of clause (10) by one minus the result of clause (11). This is the total payment amount;

(13) for supported employment provided in a shared manner, divide the total payment amount in clause (12) by the number of service recipients, not to exceed three. For independent living skills training and individualized home supports provided in a shared manner, divide the total payment amount in clause (12) by the number of service recipients, not to exceed two; and

(14) adjust the result of clause (13) by a factor to be determined by the commissioner to adjust for regional differences in the cost of providing services.

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

Sec. 24. Minnesota Statutes 2016, section 256B.4914, subdivision 16, is amended to read:

Subd. 16. **Budget neutrality adjustments.** (a) The commissioner shall use the following adjustments to the rate generated by the framework to assure budget neutrality until the rate information is available to implement paragraph (b). The rate generated by the framework shall be multiplied by the appropriate factor, as designated below:

(1) for residential services: 1.003;

(2) for day services: 1.000;

(3) for unit-based services with programming: 0.941; and

(4) for unit-based services without programming: 0.796.

(b) Within 12 months of January 1, 2014, the commissioner shall compare estimated spending for all home and community-based waiver services under the new payment rates defined in subdivisions 6 to 9 with estimated spending for the same recipients and services under the rates in effect on July 1, 2013. This comparison must distinguish spending under each of subdivisions 6, 7, 8, and 9. The comparison must be based on actual recipients and services for one or more service months after the new rates have gone into effect. The commissioner shall consult with the commissioner of management and budget on this analysis to ensure budget neutrality. If estimated spending under the new rates for services under one or more subdivisions differs in this comparison by 0.3 percent or more, the commissioner shall assure aggregate budget neutrality across all service areas by adjusting the budget neutrality factor in paragraph (a) in each subdivision so that total estimated spending for each subdivision under the new rates matches estimated spending under the rates in effect on July 1, 2013.

(c) A service rate developed using values in subdivision 5, paragraph (a), clause (11), is not subject to budget neutrality adjustments.

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

Sec. 25. Minnesota Statutes 2016, section 256B.85, subdivision 12b, is amended to read:

Subd. 12b. **CFSS agency-provider requirements; notice regarding termination of services.** (a) An agency-provider must provide written notice when it intends to terminate services with a participant at least ~~ten~~ 30 calendar days before the proposed service termination is to become effective, except in cases where:

(1) the participant engages in conduct that significantly alters the terms of the CFSS service delivery plan with the agency-provider;

(2) the participant or other persons at the setting where services are being provided engage in conduct that creates an imminent risk of harm to the support worker or other agency-provider staff; or

(3) an emergency or a significant change in the participant's condition occurs within a 24-hour period that results in the participant's service needs exceeding the participant's identified needs in the current CFSS service delivery plan so that the agency-provider cannot safely meet the participant's needs.

(b) When a participant initiates a request to terminate CFSS services with the agency-provider, the agency-provider must give the participant a written ~~acknowledgement~~ acknowledgment of the participant's service termination request that includes the date the request was received by the agency-provider and the requested date of termination.

(c) The agency-provider must participate in a coordinated transfer of the participant to a new agency-provider to ensure continuity of care.

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

Sec. 26. **REPEALER.**

Minnesota Rules, part 9555.6255, is repealed.

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

ARTICLE 6

TECHNICAL CORRECTIONS

Section 1. Minnesota Statutes 2016, section 245.4871, is amended by adding a subdivision to read:

Subd. 11a. **Diagnostic assessment.** "Diagnostic assessment" has the meaning given in Minnesota Rules, part 9505.0370, subpart 11, and is delivered according to part 9505.0372, subpart 1.

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

Sec. 2. Minnesota Statutes 2016, section 245.735, subdivision 3, is amended to read:

Subd. 3. **Certified community behavioral health clinics.** (a) The commissioner shall establish a state certification process for a certified community behavioral health ~~clinics (CCBHCs)~~ clinic (CCBHC) to be eligible for the prospective payment system in paragraph (f). Entities that choose to be ~~CCBHCs~~ a CCBHC must:

(1) comply with the CCBHC criteria published by the United States Department of Health and Human Services;

(2) employ or contract for clinic staff who have backgrounds in diverse disciplines, including licensed mental health professionals, and staff who are culturally and linguistically trained to serve the needs of the clinic's patient population;

(3) ensure that clinic services are available and accessible to patients of all ages and genders and that crisis management services are available 24 hours per day;

(4) establish fees for clinic services for nonmedical assistance patients using a sliding fee scale that ensures that services to patients are not denied or limited due to a patient's inability to pay for services;

(5) comply with quality assurance reporting requirements and other reporting requirements, including any required reporting of encounter data, clinical outcomes data, and quality data;

(6) provide crisis mental health services, withdrawal management services, emergency crisis intervention services, and stabilization services; screening, assessment, and diagnosis services, including risk assessments and level of care determinations; patient-centered treatment planning; outpatient mental health and substance use services; targeted case management; psychiatric rehabilitation services; peer support and counselor services and family support services; and intensive community-based mental health services, including mental health services for members of the armed forces and veterans;

(7) provide coordination of care across settings and providers to ensure seamless transitions for patients across the full spectrum of health services, including acute, chronic, and behavioral needs. Care coordination may be accomplished through partnerships or formal contracts with:

(i) counties, health plans, pharmacists, pharmacies, rural health clinics, federally qualified health centers, inpatient psychiatric facilities, substance use and detoxification facilities, or community-based mental health providers; and

(ii) other community services, supports, and providers, including schools, child welfare agencies, juvenile and criminal justice agencies, Indian health services clinics, tribally licensed health care and mental health facilities, urban Indian health clinics, Department of Veterans Affairs medical centers, outpatient clinics, drop-in centers, acute care hospitals, and hospital outpatient clinics;

(8) be certified as mental health clinics under section 245.69, subdivision 2;

(9) be certified to provide integrated treatment for co-occurring mental illness and substance use disorders in adults or children under Minnesota Rules, chapter 9533, effective July 1, 2017;

(10) comply with standards relating to mental health services in Minnesota Rules, parts 9505.0370 to 9505.0372;

(11) be licensed to provide chemical dependency treatment under Minnesota Rules, parts 9530.6405 to 9530.6505;

(12) be certified to provide children's therapeutic services and supports under section 256B.0943;

(13) be certified to provide adult rehabilitative mental health services under section 256B.0623;

(14) be enrolled to provide mental health crisis response services under section 256B.0624;

(15) be enrolled to provide mental health targeted case management under section 256B.0625, subdivision 20;

(16) comply with standards relating to mental health case management in Minnesota Rules, parts 9520.0900 to 9520.0926; and

(17) provide services that comply with the evidence-based practices described in paragraph (e).

(b) If an entity is unable to provide one or more of the services listed in paragraph (a), clauses (6) to (17), the commissioner may certify the entity as a CCBHC, if the entity has a current contract with another entity that has the required authority to provide that service and that meets federal CCBHC criteria as a designated collaborating organization, or, to the extent allowed by the federal CCBHC criteria, the commissioner may approve a referral arrangement. The CCBHC must meet federal requirements regarding the type and scope of services to be provided directly by the CCBHC.

(c) Notwithstanding any other law that requires a county contract or other form of county approval for certain services listed in paragraph (a), clause (6), a clinic that otherwise meets CCBHC requirements may receive the prospective payment under paragraph (f) for those services without a county contract or county approval. There is no county share when medical assistance pays the CCBHC prospective payment. As part of the certification process in paragraph (a), the commissioner shall require a letter of support from the CCBHC's host county confirming that the CCBHC and the county or counties it serves have an ongoing

relationship to facilitate access and continuity of care, especially for individuals who are uninsured or who may go on and off medical assistance.

(d) When the standards listed in paragraph (a) or other applicable standards conflict or address similar issues in duplicative or incompatible ways, the commissioner may grant variances to state requirements if the variances do not conflict with federal requirements. If standards overlap, the commissioner may substitute all or a part of a licensure or certification that is substantially the same as another licensure or certification. The commissioner shall consult with stakeholders, as described in subdivision 4, before granting variances under this provision.

(e) The commissioner shall issue a list of required evidence-based practices to be delivered by ~~CCBHCs~~ a CCBHC, and may also provide a list of recommended evidence-based practices. The commissioner may update the list to reflect advances in outcomes research and medical services for persons living with mental illnesses or substance use disorders. The commissioner shall take into consideration the adequacy of evidence to support the efficacy of the practice, the quality of workforce available, and the current availability of the practice in the state. At least 30 days before issuing the initial list and any revisions, the commissioner shall provide stakeholders with an opportunity to comment.

(f) The commissioner shall establish standards and methodologies for a prospective payment system for medical assistance payments for services delivered by ~~certified community behavioral health clinics~~ a CCBHC, in accordance with guidance issued by the Centers for Medicare and Medicaid Services. During the operation of the demonstration project, payments shall comply with federal requirements for an enhanced federal medical assistance percentage. The commissioner may include quality bonus payment in the prospective payment system based on federal criteria and on a clinic's provision of the evidence-based practices in paragraph (e). The prospective payment system does not apply to MinnesotaCare. Implementation of the prospective payment system is effective July 1, 2017, or upon federal approval, whichever is later.

(g) The commissioner shall seek federal approval to continue federal financial participation in payment for CCBHC services after the federal demonstration period ends for clinics that were certified as ~~CCBHCs~~ a CCBHC during the demonstration period and that continue to meet the CCBHC certification standards in paragraph (a). Payment for CCBHC services shall cease effective July 1, 2019, if continued federal financial participation for the payment of CCBHC services cannot be obtained.

(h) The commissioner may certify at least one CCBHC located in an urban area and at least one CCBHC located in a rural area, as defined by federal criteria. To the extent allowed by federal law, the commissioner may limit the number of certified clinics so that the projected claims for certified clinics will not exceed the funds budgeted for this purpose. The commissioner shall give preference to clinics that:

(1) provide a comprehensive range of services and evidence-based practices for all age groups, with services being fully coordinated and integrated; and

(2) enhance the state's ability to meet the federal priorities to be selected as a CCBHC demonstration state.

(i) The commissioner shall recertify ~~CCBHCs~~ a CCBHC at least every three years. The commissioner shall establish a process for decertification and shall require corrective action, medical assistance repayment, or decertification of a CCBHC that no longer meets the requirements in this section or that fails to meet the standards provided by the commissioner in the application and certification process.

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

Sec. 3. Minnesota Statutes 2016, section 254B.15, subdivision 4, is amended to read:

Subd. 4. **Legislative update.** No later than February 1, 2017, the commissioner shall present an update on the progress of the proposal to members of the legislative committees in the house of representatives and senate with jurisdiction over health and human services policy and finance ~~on the progress of the proposal~~ and shall make recommendations on any legislative changes and state appropriations necessary to implement the proposal.

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

Sec. 4. Minnesota Statutes 2016, section 254B.15, subdivision 5, is amended to read:

Subd. 5. **Stakeholder input.** In developing the proposal, the commissioner shall consult with consumers, providers, counties, tribes, ~~health plans~~ managed care organizations, and other stakeholders.

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

Sec. 5. Minnesota Statutes 2016, section 256B.055, subdivision 12, is amended to read:

Subd. 12. **Disabled children.** (a) A person is eligible for medical assistance if the person is under age 19 and qualifies as a disabled individual under United States Code, title 42, section 1382c(a), and would be eligible for medical assistance under the state plan if residing

in a medical institution, and the child requires a level of care provided in a hospital, nursing facility, or intermediate care facility for persons with developmental disabilities, for whom home care is appropriate, provided that the cost to medical assistance under this section is not more than the amount that medical assistance would pay for if the child resides in an institution. After the child is determined to be eligible under this section, the commissioner shall review the child's disability under United States Code, title 42, section 1382c(a) and level of care defined under this section no more often than annually and may elect, based on the recommendation of health care professionals under contract with the state medical review team, to extend the review of disability and level of care up to a maximum of four years. The commissioner's decision on the frequency of continuing review of disability and level of care is not subject to administrative appeal under section 256.045. The county agency shall send a notice of disability review to the enrollee six months prior to the date the recertification of disability is due. Nothing in this subdivision shall be construed as affecting other redeterminations of medical assistance eligibility under this chapter and annual cost-effective reviews under this section.

(b) For purposes of this subdivision, "hospital" means an institution as defined in section 144.696, subdivision 3, 144.55, subdivision 3, or Minnesota Rules, part 4640.3600, and licensed pursuant to sections 144.50 to 144.58. For purposes of this subdivision, a child requires a level of care provided in a hospital if the child is determined by the commissioner to need an extensive array of health services, including mental health services, for an undetermined period of time, whose health condition requires frequent monitoring and treatment by a health care professional or by a person supervised by a health care professional, who would reside in a hospital or require frequent hospitalization if these services were not provided, and the daily care needs are more complex than a nursing facility level of care.

A child with serious emotional disturbance requires a level of care provided in a hospital if the commissioner determines that the individual requires 24-hour supervision because the person exhibits recurrent or frequent suicidal or homicidal ideation or behavior, recurrent or frequent psychosomatic disorders or somatopsychic disorders that may become life threatening, recurrent or frequent severe socially unacceptable behavior associated with psychiatric disorder, ongoing and chronic psychosis or severe, ongoing and chronic developmental problems requiring continuous skilled observation, or severe disabling symptoms for which office-centered outpatient treatment is not adequate, and which overall severely impact the individual's ability to function.

(c) For purposes of this subdivision, "nursing facility" means a facility which provides nursing care as defined in section 144A.01, subdivision 5, licensed pursuant to sections 144A.02 to 144A.10, which is appropriate if a person is in active restorative treatment; is in need of special treatments provided or supervised by a licensed nurse; or has unpredictable episodes of active disease processes requiring immediate judgment by a licensed nurse. For purposes of this subdivision, a child requires the level of care provided in a nursing facility if the child is determined by the commissioner to meet the requirements of the preadmission screening assessment document under section 256B.0911, adjusted to address age-appropriate standards for children age 18 and under.

(d) For purposes of this subdivision, "intermediate care facility for persons with developmental disabilities" or "ICF/DD" means a program licensed to provide services to persons with developmental disabilities under section 252.28, and chapter 245A, and a physical plant licensed as a supervised living facility under chapter 144, which together are certified by the Minnesota Department of Health as meeting the standards in Code of Federal Regulations, title 42, part 483, for an intermediate care facility which provides services for persons with developmental disabilities who require 24-hour supervision and active treatment for medical, behavioral, or habilitation needs. For purposes of this subdivision, a child requires a level of care provided in an ICF/DD if the commissioner finds that the child has a developmental disability in accordance with section 256B.092, is in need of a 24-hour plan of care and active treatment similar to persons with developmental disabilities, and there is a reasonable indication that the child will need ICF/DD services.

(e) For purposes of this subdivision, a person requires the level of care provided in a nursing facility if the person requires 24-hour monitoring or supervision and a plan of mental health treatment because of specific symptoms or functional impairments associated with a serious mental illness or disorder diagnosis, which meet severity criteria for mental health established by the commissioner and published in March 1997 as the Minnesota Mental Health Level of Care for Children and Adolescents with Severe Emotional Disorders.

(f) The determination of the level of care needed by the child shall be made by the commissioner based on information supplied to the commissioner by the parent or guardian, the child's physician or physicians, and other professionals as requested by the commissioner. The commissioner shall establish a screening team to conduct the level of care determinations according to this subdivision.

(g) If a child meets the conditions in paragraph (b), (c), (d), or (e), the commissioner must assess the case to determine whether:

(1) the child qualifies as a disabled individual under United States Code, title 42, section 1382c(a), and would be eligible for medical assistance if residing in a medical institution; and

(2) the cost of medical assistance services for the child, if eligible under this subdivision, would not be more than the cost to medical assistance if the child resides in a medical institution ~~to be determined as follows:~~. The commissioner shall presume that the cost of medical assistance services for a child who meets the conditions in paragraph (b), (c), (d), or (e) is not more than the cost to medical assistance if the child resides in a medical institution.

~~(i) for a child who requires a level of care provided in an ICF/DD, the cost of care for the child in an institution shall be determined using the average payment rate established for the regional treatment centers that are certified as ICF's/DD;~~

~~(ii) for a child who requires a level of care provided in an inpatient hospital setting according to paragraph (b), cost-effectiveness shall be determined according to Minnesota Rules, part 9505.3520, items F and G; and~~

~~(iii) for a child who requires a level of care provided in a nursing facility according to paragraph (c) or (e), cost-effectiveness shall be determined according to Minnesota Rules, part 9505.3040, except that the nursing facility average rate shall be adjusted to reflect rates which would be paid for children under age 16. The commissioner may authorize an amount up to the amount medical assistance would pay for a child referred to the commissioner by the preadmission screening team under section 256B.0911.~~

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

Sec. 6. Minnesota Statutes 2016, section 256B.0622, subdivision 2, is amended to read:

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.

(c) "Assertive community treatment" means intensive nonresidential treatment and rehabilitative mental health services provided according to the 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.

(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~~ the client's 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.

(n) "Intensive residential treatment services" means short-term, time-limited services provided in a residential setting to 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.

(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.

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

(r) "Mental health certified peer specialist 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.

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

Sec. 7. Minnesota Statutes 2016, section 256B.0622, subdivision 2b, is amended to read:

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~~ the client's 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 individual 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.

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

Sec. 8. Minnesota Statutes 2016, section 256B.0622, subdivision 7a, is amended to read:

Subd. 7a. **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 certified by the American Osteopathic Board of Neurology and Psychiatry 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 individual 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~~ the staff member's 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.

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

Sec. 9. Minnesota Statutes 2016, section 256B.0625, subdivision 60a, is amended to read:

Subd. 60a. **Community emergency medical technician services.** (a) Medical assistance covers services provided by a ~~community emergency medical technician~~ community medical response emergency medical technician (CEMT) who is certified under section 144E.275, subdivision 7, when the services are provided in accordance with this subdivision.

(b) A CEMT may provide a posthospital discharge visit when ordered by a treating physician. The posthospital discharge visit includes:

(1) verbal or visual reminders of discharge orders;

(2) recording and reporting of vital signs to the patient's primary care provider;

(3) medication access confirmation;

(4) food access confirmation; and

(5) identification of home hazards.

(c) An individual who has repeat ambulance calls due to falls, has been discharged from a nursing home, or has been identified by the individual's primary care provider as at risk for nursing home placement, may receive a safety evaluation visit from a CEMT when ordered by a primary care provider in accordance with the individual's care plan. A safety evaluation visit includes:

(1) medication access confirmation;

(2) food access confirmation; and

(3) identification of home hazards.

(d) A CEMT shall be paid at $9.75 per 15-minute increment. A safety evaluation visit may not be billed for the same day as a posthospital discharge visit for the same individual.

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

Sec. 10. Minnesota Statutes 2016, section 256P.08, subdivision 4, is amended to read:

Subd. 4. **Recovering general assistance and Minnesota supplemental aid overpayments.** (a) If an amount of assistance is paid to an assistance unit in excess of the payment due, it shall be recoverable by the agency. The agency shall give written notice to the participant of its intention to recover the overpayment.

(b) If the individual is no longer receiving assistance, the agency may request voluntary repayment or pursue civil recovery.

(c) If the individual is receiving assistance, except as provided for interim assistance in section 256D.06, subdivision 5, when an overpayment occurs the agency shall recover the overpayment by withholding an amount equal to:

(1) three percent of the assistance unit's standard of need for all Minnesota supplemental aid assistance units, and nonfraud cases for general assistance; ~~and~~ or

(2) ten percent where fraud has occurred in general assistance cases; or

(3) the amount of the monthly general assistance or Minnesota supplemental aid payment, whichever is less.

(d) In cases when there is both an overpayment and underpayment, the county agency shall offset one against the other in correcting the payment.

(e) Overpayments may also be voluntarily repaid, in part or in full, by the individual, in addition to the assistance reductions provided in this subdivision, to include further voluntary reductions in the grant level agreed to in writing by the individual, until the total amount of the overpayment is repaid.

(f) The county agency shall make reasonable efforts to recover overpayments to individuals no longer on assistance. The agency need not attempt to recover overpayments of less than $35 paid to an individual no longer on assistance if the individual does not receive assistance again within three years, unless the individual has been convicted of violating section 256.98.

(g) Establishment of an overpayment is limited to 12 months prior to the month of discovery due to agency error and six years prior to the month of discovery due to client error or an intentional program violation determined under section 256.046.

(h) Residents of licensed residential facilities shall not have overpayments recovered from their personal needs allowance.

(i) Overpayments by another maintenance benefit program shall not be recovered from the general assistance or Minnesota supplemental aid grant.

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

Sec. 11. Minnesota Statutes 2016, section 626.5572, subdivision 21, is amended to read:

Subd. 21. **Vulnerable adult.** (a) "Vulnerable adult" means any person 18 years of age or older who:

(1) is a resident or inpatient of a facility;

(2) receives services required to be licensed under chapter 245A, except that a person receiving outpatient services for treatment of chemical dependency or mental illness, or one who is served in the Minnesota sex offender program on a court-hold order for commitment, or is committed as a sexual psychopathic personality or as a sexually dangerous person under chapter 253B, is not considered a vulnerable adult unless the person meets the requirements of clause (4);

(3) receives services from a home care provider required to be licensed under ~~sections 144A.43 to 144A.482~~ section 144A.471; or from a person or organization that offers, provides, or arranges for personal care assistance services under the medical assistance

program as authorized under section 256B.0625, subdivision 19a, 256B.0651, 256B.0653, 256B.0654, 256B.0659, or 256B.85; or

(4) regardless of residence or whether any type of service is received, possesses a physical or mental infirmity or other physical, mental, or emotional dysfunction:

(i) that impairs the individual's ability to provide adequately for the individual's own care without assistance, including the provision of food, shelter, clothing, health care, or supervision; and

(ii) because of the dysfunction or infirmity and the need for care or services, the individual has an impaired ability to protect the individual's self from maltreatment.

(b) For purposes of this subdivision, "care or services" means care or services for the health, safety, welfare, or maintenance of an individual.

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

Sec. 12. **REVISOR'S INSTRUCTION.**

In each section of Minnesota Statutes referred to in column A, the revisor of statutes shall delete the reference in column B and insert the reference in column C. The revisor shall make changes necessary to correct the punctuation, grammar, or structure of the remaining text and preserve its meaning.

Column A	Column B	Column C
144.651, subd. 20, 29	Older Americans Act, section 307(a)(12)	Older Americans Act of 1965, as amended, United States Code, title 42, section 3027(a)(12) (2016)
256.01, subd. 2, 24	United States Code, title 42, section 3001, the Older Americans Act Amendments of 2006	Older Americans Act of 1965, as amended, United States Code, title 42, sections 3001 - 3058ff (2016)
256.974	Older Americans Act, as amended, United States Code, title 42, section 3027(a)(9) and 3058g(a)	Older Americans Act of 1965, as amended, United States Code, title 42, sections 3027(a)(9) and 3058g(a) (2016)
256.974	Code of Federal Regulations, title 45, parts 1321 and 1327	Code of Federal Regulations, title 45, parts 1321 (2015) and 1324 (Federal Register, volume 81, page 35644 (2016))
256.9744, subd. 1	Older Americans Act, as amended, United States Code, title 42, section 3058g(d)	Older Americans Act of 1965, as amended, United States Code, title 42, section 3058g(d) (2016)

256.975, subd. 2	Older Americans Act of 1965, as amended	Older Americans Act of 1965, as amended, United States Code, title 42, sections 3001 - 3058ff (2016)
256.975, subd. 7	United States Code, title 42, section 3001, the Older Americans Act Amendments of 2006	Older Americans Act of 1965, as amended, United States Code, title 42, sections 3001 - 3058ff (2016)
256.977, subd. 3	Older Americans Act	Older Americans Act of 1965, as amended, United States Code, title 42, sections 3001 - 3058ff (2016)
256B.0917, subd. 1c	title III of the Older Americans Act	Older Americans Act of 1965, as amended, United States Code, title 42, sections 3021 - 3030s-2 (2016)

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

Sec. 13. **REPEALER.**

(a) Minnesota Statutes 2016, section 119B.125, subdivision 8, is repealed.

(b) Minnesota Rules, parts 9555.7100; 9555.7200; 9555.7300; and 9555.7600, are repealed.

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

APPENDIX
Article locations in 17-0004

119B.125 PROVIDER REQUIREMENTS.

Subd. 8. **Overpayment claim for failure to comply with access to records requirement.** (a) In establishing an overpayment claim under subdivision 6 for failure to provide access to attendance records, the county or commissioner is limited to the six years prior to the date the county or the commissioner requested the attendance records.

(b) When the commissioner or county establishes an overpayment claim against a current or former provider, the commissioner or county must provide notice of the claim to the provider. A notice of overpayment claim must specify the reason for the overpayment, the authority for making the overpayment claim, the time period in which the overpayment occurred, the amount of the overpayment, and the provider's right to appeal.

(c) The commissioner or county may seek to recover overpayments paid to a current or former provider. When a provider has been convicted of fraud under section 256.98, theft under section 609.52, or a federal crime relating to theft of state funds or fraudulent billing for a program administered by the commissioner or a county, recovery may be sought regardless of the amount of overpayment.

245.469 EMERGENCY SERVICES.

Subdivision 1. **Availability of emergency services.** By July 1, 1988, county boards must provide or contract for enough emergency services within the county to meet the needs of adults in the county who are experiencing an emotional crisis or mental illness. Clients may be required to pay a fee according to section 245.481. Emergency services must include assessment, crisis intervention, and appropriate case disposition. Emergency services must:

(1) promote the safety and emotional stability of adults with mental illness or emotional crises;

(2) minimize further deterioration of adults with mental illness or emotional crises;

(3) help adults with mental illness or emotional crises to obtain ongoing care and treatment; and

(4) prevent placement in settings that are more intensive, costly, or restrictive than necessary and appropriate to meet client needs.

Subd. 2. **Specific requirements.** (a) The county board shall require that all service providers of emergency services to adults with mental illness provide immediate direct access to a mental health professional during regular business hours. For evenings, weekends, and holidays, the service may be by direct toll-free telephone access to a mental health professional, a mental health practitioner, or until January 1, 1991, a designated person with training in human services who receives clinical supervision from a mental health professional.

(b) The commissioner may waive the requirement in paragraph (a) that the evening, weekend, and holiday service be provided by a mental health professional or mental health practitioner after January 1, 1991, if the county documents that:

(1) mental health professionals or mental health practitioners are unavailable to provide this service;

(2) services are provided by a designated person with training in human services who receives clinical supervision from a mental health professional; and

(3) the service provider is not also the provider of fire and public safety emergency services.

(c) The commissioner may waive the requirement in paragraph (b), clause (3), that the evening, weekend, and holiday service not be provided by the provider of fire and public safety emergency services if:

(1) every person who will be providing the first telephone contact has received at least eight hours of training on emergency mental health services reviewed by the state advisory council on mental health and then approved by the commissioner;

(2) every person who will be providing the first telephone contact will annually receive at least four hours of continued training on emergency mental health services reviewed by the state advisory council on mental health and then approved by the commissioner;

(3) the local social service agency has provided public education about available emergency mental health services and can assure potential users of emergency services that their calls will be handled appropriately;

(4) the local social service agency agrees to provide the commissioner with accurate data on the number of emergency mental health service calls received;

(5) the local social service agency agrees to monitor the frequency and quality of emergency services; and

(6) the local social service agency describes how it will comply with paragraph (d).

(d) Whenever emergency service during nonbusiness hours is provided by anyone other than a mental health professional, a mental health professional must be available on call for an emergency assessment and crisis intervention services, and must be available for at least telephone consultation within 30 minutes.

Subd. 3. **Mental health crisis services.** The commissioner of human services shall increase access to mental health crisis services for children and adults. In order to increase access, the commissioner must:

(1) develop a central phone number where calls can be routed to the appropriate crisis services;

(2) provide telephone consultation 24 hours a day to mobile crisis teams who are serving people with traumatic brain injury or intellectual disabilities who are experiencing a mental health crisis;

(3) expand crisis services across the state, including rural areas of the state and examining access per population;

(4) establish and implement state standards for crisis services; and

(5) provide grants to adult mental health initiatives, counties, tribes, or community mental health providers to establish new mental health crisis residential service capacity.

Priority will be given to regions that do not have a mental health crisis residential services program, do not have an inpatient psychiatric unit within the region, do not have an inpatient psychiatric unit within 90 miles, or have a demonstrated need based on the number of crisis residential or intensive residential treatment beds available to meet the needs of the residents in the region. At least 50 percent of the funds must be distributed to programs in rural Minnesota. Grant funds may be used for start-up costs, including but not limited to renovations, furnishings, and staff training. Grant applications shall provide details on how the intended service will address identified needs and shall demonstrate collaboration with crisis teams, other mental health providers, hospitals, and police.

245.4879 EMERGENCY SERVICES.

Subdivision 1. **Availability of emergency services.** County boards must provide or contract for enough mental health emergency services within the county to meet the needs of children, and children's families when clinically appropriate, in the county who are experiencing an emotional crisis or emotional disturbance. The county board shall ensure that parents, providers, and county residents are informed about when and how to access emergency mental health services for children. A child or the child's parent may be required to pay a fee according to section 245.481. Emergency service providers shall not delay the timely provision of emergency service because of delays in determining this fee or because of the unwillingness or inability of the parent to pay the fee. Emergency services must include assessment, crisis intervention, and appropriate case disposition. Emergency services must:

(1) promote the safety and emotional stability of children with emotional disturbances or emotional crises;

(2) minimize further deterioration of the child with emotional disturbance or emotional crisis;

(3) help each child with an emotional disturbance or emotional crisis to obtain ongoing care and treatment; and

(4) prevent placement in settings that are more intensive, costly, or restrictive than necessary and appropriate to meet the child's needs.

Subd. 2. **Specific requirements.** (a) The county board shall require that all service providers of emergency services to the child with an emotional disturbance provide immediate direct access to a mental health professional during regular business hours. For evenings, weekends, and holidays, the service may be by direct toll-free telephone access to a mental health professional, a mental health practitioner, or until January 1, 1991, a designated person with training in human services who receives clinical supervision from a mental health professional.

(b) The commissioner may waive the requirement in paragraph (a) that the evening, weekend, and holiday service be provided by a mental health professional or mental health practitioner after January 1, 1991, if the county documents that:

(1) mental health professionals or mental health practitioners are unavailable to provide this service;

(2) services are provided by a designated person with training in human services who receives clinical supervision from a mental health professional; and

(3) the service provider is not also the provider of fire and public safety emergency services.

(c) The commissioner may waive the requirement in paragraph (b), clause (3), that the evening, weekend, and holiday service not be provided by the provider of fire and public safety emergency services if:

(1) every person who will be providing the first telephone contact has received at least eight hours of training on emergency mental health services reviewed by the state advisory council on mental health and then approved by the commissioner;

(2) every person who will be providing the first telephone contact will annually receive at least four hours of continued training on emergency mental health services reviewed by the state advisory council on mental health and then approved by the commissioner;

(3) the local social service agency has provided public education about available emergency mental health services and can assure potential users of emergency services that their calls will be handled appropriately;

(4) the local social service agency agrees to provide the commissioner with accurate data on the number of emergency mental health service calls received;

(5) the local social service agency agrees to monitor the frequency and quality of emergency services; and

(6) the local social service agency describes how it will comply with paragraph (d).

(d) When emergency service during nonbusiness hours is provided by anyone other than a mental health professional, a mental health professional must be available on call for an emergency assessment and crisis intervention services, and must be available for at least telephone consultation within 30 minutes.

256B.0624 ADULT CRISIS RESPONSE SERVICES COVERED.

Subd. 4a. **Alternative provider standards.** If a county demonstrates that, due to geographic or other barriers, it is not feasible to provide mobile crisis intervention services according to the standards in subdivision 4, paragraph (b), clause (9), the commissioner may approve a crisis response provider based on an alternative plan proposed by a county or group of counties. The alternative plan must:

(1) result in increased access and a reduction in disparities in the availability of crisis services;

(2) provide mobile services outside of the usual nine-to-five office hours and on weekends and holidays; and

(3) comply with standards for emergency mental health services in section 245.469.

Subd. 5. **Mobile crisis intervention staff qualifications.** For provision of adult mental health mobile crisis intervention services, a mobile crisis intervention team is comprised of at least two mental health professionals as defined in section 245.462, subdivision 18, clauses (1) to (6), or a combination of at least one mental health professional and one mental health practitioner as defined in section 245.462, subdivision 17, with the required mental health crisis training and under the clinical supervision of a mental health professional on the team. The team must have at least two people with at least one member providing on-site crisis intervention services when needed. Team members must be experienced in mental health assessment, crisis intervention techniques, treatment engagement strategies, working with families, and clinical decision-making under emergency conditions and have knowledge of local services and resources. The team must recommend and coordinate the team's services with appropriate local resources such as the county social services agency, mental health services, and local law enforcement when necessary.

Subd. 6. **Crisis assessment and mobile intervention treatment planning.** (a) Prior to initiating mobile crisis intervention services, a screening of the potential crisis situation must be conducted. The screening may use the resources of crisis assistance and emergency services as defined in sections 245.462, subdivision 6, and 245.469, subdivisions 1 and 2. The screening must gather information, determine whether a crisis situation exists, identify parties involved, and determine an appropriate response.

(b) If a crisis exists, a crisis assessment must be completed. A crisis assessment evaluates any immediate needs for which emergency services are needed and, as time permits, the recipient's current life situation, sources of stress, mental health problems and symptoms, strengths, cultural considerations, support network, vulnerabilities, current functioning, and the recipient's preferences as communicated directly by the recipient, or as communicated in a

health care directive as described in chapters 145C and 253B, the treatment plan described under paragraph (d), a crisis prevention plan, or a wellness recovery action plan.

(c) If the crisis assessment determines mobile crisis intervention services are needed, the intervention services must be provided promptly. As opportunity presents during the intervention, at least two members of the mobile crisis intervention team must confer directly or by telephone about the assessment, treatment plan, and actions taken and needed. At least one of the team members must be on site providing crisis intervention services. If providing on-site crisis intervention services, a mental health practitioner must seek clinical supervision as required in subdivision 9.

(d) The mobile crisis intervention team must develop an initial, brief crisis treatment plan as soon as appropriate but no later than 24 hours after the initial face-to-face intervention. The plan must address the needs and problems noted in the crisis assessment and include measurable short-term goals, cultural considerations, and frequency and type of services to be provided to achieve the goals and reduce or eliminate the crisis. The treatment plan must be updated as needed to reflect current goals and services.

(e) The team must document which short-term goals have been met and when no further crisis intervention services are required.

(f) If the recipient's crisis is stabilized, but the recipient needs a referral to other services, the team must provide referrals to these services. If the recipient has a case manager, planning for other services must be coordinated with the case manager. If the recipient is unable to follow up on the referral, the team must link the recipient to the service and follow up to ensure the recipient is receiving the service.

(g) If the recipient's crisis is stabilized and the recipient does not have an advance directive, the case manager or crisis team shall offer to work with the recipient to develop one.

Subd. 7. **Crisis stabilization services.** (a) Crisis stabilization services must be provided by qualified staff of a crisis stabilization services provider entity and must meet the following standards:

(1) a crisis stabilization treatment plan must be developed which meets the criteria in subdivision 11;

(2) staff must be qualified as defined in subdivision 8; and

(3) services must be delivered according to the treatment plan and include face-to-face contact with the recipient by qualified staff for further assessment, help with referrals, updating of the crisis stabilization treatment plan, supportive counseling, skills training, and collaboration with other service providers in the community.

(b) If crisis stabilization services are provided in a supervised, licensed residential setting, the recipient must be contacted face-to-face daily by a qualified mental health practitioner or mental health professional. The program must have 24-hour-a-day residential staffing which may include staff who do not meet the qualifications in subdivision 8. The residential staff must have 24-hour-a-day immediate direct or telephone access to a qualified mental health professional or practitioner.

(c) If crisis stabilization services are provided in a supervised, licensed residential setting that serves no more than four adult residents, and one or more individuals are present at the setting to receive residential crisis stabilization services, the residential staff must include, for at least eight hours per day, at least one individual who meets the qualifications in subdivision 8, paragraph (a), clause (1) or (2).

(d) If crisis stabilization services are provided in a supervised, licensed residential setting that serves more than four adult residents, and one or more are recipients of crisis stabilization services, the residential staff must include, for 24 hours a day, at least one individual who meets the qualifications in subdivision 8. During the first 48 hours that a recipient is in the residential program, the residential program must have at least two staff working 24 hours a day. Staffing levels may be adjusted thereafter according to the needs of the recipient as specified in the crisis stabilization treatment plan.

Subd. 8. **Adult crisis stabilization staff qualifications.** (a) Adult mental health crisis stabilization services must be provided by qualified individual staff of a qualified provider entity. Individual provider staff must have the following qualifications:

(1) be a mental health professional as defined in section 245.462, subdivision 18, clauses (1) to (6);

(2) be a mental health practitioner as defined in section 245.462, subdivision 17. The mental health practitioner must work under the clinical supervision of a mental health professional;

(3) be a certified peer specialist under section 256B.0615. The certified peer specialist must work under the clinical supervision of a mental health professional; or

(4) be a mental health rehabilitation worker who meets the criteria in section 256B.0623, subdivision 5, clause (4); works under the direction of a mental health practitioner as defined in section 245.462, subdivision 17, or under direction of a mental health professional; and works under the clinical supervision of a mental health professional.

(b) Mental health practitioners and mental health rehabilitation workers must have completed at least 30 hours of training in crisis intervention and stabilization during the past two years.

Subd. 9. **Supervision.** Mental health practitioners may provide crisis assessment and mobile crisis intervention services if the following clinical supervision requirements are met:

(1) the mental health provider entity must accept full responsibility for the services provided;

(2) the mental health professional of the provider entity, who is an employee or under contract with the provider entity, must be immediately available by phone or in person for clinical supervision;

(3) the mental health professional is consulted, in person or by phone, during the first three hours when a mental health practitioner provides on-site service;

(4) the mental health professional must:

(i) review and approve of the tentative crisis assessment and crisis treatment plan;

(ii) document the consultation; and

(iii) sign the crisis assessment and treatment plan within the next business day;

(5) if the mobile crisis intervention services continue into a second calendar day, a mental health professional must contact the recipient face-to-face on the second day to provide services and update the crisis treatment plan; and

(6) the on-site observation must be documented in the recipient's record and signed by the mental health professional.

Subd. 10. **Recipient file.** Providers of mobile crisis intervention or crisis stabilization services must maintain a file for each recipient containing the following information:

(1) individual crisis treatment plans signed by the recipient, mental health professional, and mental health practitioner who developed the crisis treatment plan, or if the recipient refused to sign the plan, the date and reason stated by the recipient as to why the recipient would not sign the plan;

(2) signed release forms;

(3) recipient health information and current medications;

(4) emergency contacts for the recipient;

(5) case records which document the date of service, place of service delivery, signature of the person providing the service, and the nature, extent, and units of service. Direct or telephone contact with the recipient's family or others should be documented;

(6) required clinical supervision by mental health professionals;

(7) summary of the recipient's case reviews by staff;

(8) any written information by the recipient that the recipient wants in the file; and

(9) an advance directive, if there is one available.

Documentation in the file must comply with all requirements of the commissioner.

Subd. 11. **Treatment plan.** The individual crisis stabilization treatment plan must include, at a minimum:

(1) a list of problems identified in the assessment;

(2) a list of the recipient's strengths and resources;

(3) concrete, measurable short-term goals and tasks to be achieved, including time frames for achievement;

(4) specific objectives directed toward the achievement of each one of the goals;

(5) documentation of the participants involved in the service planning. The recipient, if possible, must be a participant. The recipient or the recipient's legal guardian must sign the service plan or documentation must be provided why this was not possible. A copy of the plan must be given to the recipient and the recipient's legal guardian. The plan should include services arranged, including specific providers where applicable;

(6) planned frequency and type of services initiated;

(7) a crisis response action plan if a crisis should occur;

(8) clear progress notes on outcome of goals;

(9) a written plan must be completed within 24 hours of beginning services with the recipient; and

(10) a treatment plan must be developed by a mental health professional or mental health practitioner under the clinical supervision of a mental health professional. The mental health professional must approve and sign all treatment plans.

256B.0944 CHILDREN'S MENTAL HEALTH CRISIS RESPONSE SERVICES.

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

(a) "Mental health crisis" means a child's behavioral, emotional, or psychiatric situation that, but for the provision of crisis response services to the child, would likely result in significantly reduced levels of functioning in primary activities of daily living, an emergency situation, or the child's placement in a more restrictive setting, including, but not limited to, inpatient hospitalization.

(b) "Mental health emergency" means a child's behavioral, emotional, or psychiatric situation that causes an immediate need for mental health services and is consistent with section 62Q.55. A physician, mental health professional, or crisis mental health practitioner determines a mental health crisis or emergency for medical assistance reimbursement with input from the client and the client's family, if possible.

(c) "Mental health crisis assessment" means an immediate face-to-face assessment by a physician, mental health professional, or mental health practitioner under the clinical supervision of a mental health professional, following a screening that suggests the child may be experiencing a mental health crisis or mental health emergency situation.

(d) "Mental health mobile crisis intervention services" means face-to-face, short-term intensive mental health services initiated during a mental health crisis or mental health emergency. Mental health mobile crisis services must help the recipient cope with immediate stressors, identify and utilize available resources and strengths, and begin to return to the recipient's baseline level of functioning. Mental health mobile services must be provided on site by a mobile crisis intervention team outside of an emergency room, urgent care, or an inpatient hospital setting.

(e) "Mental health crisis stabilization services" means individualized mental health services provided to a recipient following crisis intervention services that are designed to restore the recipient to the recipient's prior functional level. The individual treatment plan recommending mental health crisis stabilization must be completed by the intervention team or by staff after an inpatient or urgent care visit. Mental health crisis stabilization services may be provided in the recipient's home, the home of a family member or friend of the recipient, schools, another community setting, or a short-term supervised, licensed residential program if the service is not included in the facility's cost pool or per diem. Mental health crisis stabilization is not reimbursable when provided as part of a partial hospitalization or day treatment program.

Subd. 2. **Medical assistance coverage.** Medical assistance covers medically necessary children's mental health crisis response services, subject to federal approval, if provided to an eligible recipient under subdivision 3, by a qualified provider entity under subdivision 4 or a qualified individual provider working within the provider's scope of practice, and identified in the recipient's individual crisis treatment plan under subdivision 8.

Subd. 3. **Eligibility.** An eligible recipient is an individual who:

(1) is eligible for medical assistance;

(2) is under age 18 or between the ages of 18 and 21;

(3) is screened as possibly experiencing a mental health crisis or mental health emergency where a mental health crisis assessment is needed;

(4) is assessed as experiencing a mental health crisis or mental health emergency, and mental health mobile crisis intervention or mental health crisis stabilization services are determined to be medically necessary; and

(5) meets the criteria for emotional disturbance or mental illness.

Subd. 4. **Provider entity standards.** (a) A crisis intervention and crisis stabilization provider entity must meet the administrative and clinical standards specified in section 256B.0943, subdivisions 5 and 6, meet the standards listed in paragraph (b), and be:

(1) an Indian health service facility or facility owned and operated by a tribe or a tribal organization operating under Public Law 93-638 as a 638 facility;

(2) a county board-operated entity; or

(3) a provider entity that is under contract with the county board in the county where the potential crisis or emergency is occurring.

(b) The children's mental health crisis response services provider entity must:

(1) ensure that mental health crisis assessment and mobile crisis intervention services are available 24 hours a day, seven days a week;

(2) directly provide the services or, if services are subcontracted, the provider entity must maintain clinical responsibility for services and billing;

(3) ensure that crisis intervention services are provided in a manner consistent with sections 245.487 to 245.4889; and

(4) develop and maintain written policies and procedures regarding service provision that include safety of staff and recipients in high-risk situations.

Subd. 4a. **Alternative provider standards.** If a provider entity demonstrates that, due to geographic or other barriers, it is not feasible to provide mobile crisis intervention services 24 hours a day, seven days a week, according to the standards in subdivision 4, paragraph (b), clause (1), the commissioner may approve a crisis response provider based on an alternative plan proposed by a provider entity. The alternative plan must:

(1) result in increased access and a reduction in disparities in the availability of crisis services; and

(2) provide mobile services outside of the usual nine-to-five office hours and on weekends and holidays.

Subd. 5. **Mobile crisis intervention staff qualifications.** (a) To provide children's mental health mobile crisis intervention services, a mobile crisis intervention team must include:

(1) at least two mental health professionals as defined in section 256B.0943, subdivision 1, paragraph (o); or

(2) a combination of at least one mental health professional and one mental health practitioner as defined in section 245.4871, subdivision 26, with the required mental health crisis training and under the clinical supervision of a mental health professional on the team.

(b) The team must have at least two people with at least one member providing on-site crisis intervention services when needed. Team members must be experienced in mental health assessment, crisis intervention techniques, and clinical decision making under emergency conditions and have knowledge of local services and resources. The team must recommend and coordinate the team's services with appropriate local resources, including the county social services agency, mental health service providers, and local law enforcement, if necessary.

Subd. 6. **Initial screening and crisis assessment planning.** (a) Before initiating mobile crisis intervention services, a screening of the potential crisis situation must be conducted. The screening may use the resources of crisis assistance and emergency services as defined in sections 245.4871, subdivision 14, and 245.4879, subdivisions 1 and 2. The screening must gather information, determine whether a crisis situation exists, identify the parties involved, and determine an appropriate response.

(b) If a crisis exists, a crisis assessment must be completed. A crisis assessment must evaluate any immediate needs for which emergency services are needed and, as time permits, the recipient's current life situation, sources of stress, mental health problems and symptoms, strengths, cultural considerations, support network, vulnerabilities, and current functioning.

(c) If the crisis assessment determines mobile crisis intervention services are needed, the intervention services must be provided promptly. As the opportunity presents itself during the intervention, at least two members of the mobile crisis intervention team must confer directly or by telephone about the assessment, treatment plan, and actions taken and needed. At least one of the team members must be on site providing crisis intervention services. If providing on-site crisis intervention services, a mental health practitioner must seek clinical supervision as required under subdivision 9.

(d) The mobile crisis intervention team must develop an initial, brief crisis treatment plan as soon as appropriate but no later than 24 hours after the initial face-to-face intervention. The plan must address the needs and problems noted in the crisis assessment and include measurable short-term goals, cultural considerations, and frequency and type of services to be provided to achieve the goals and reduce or eliminate the crisis. The crisis treatment plan must be updated as needed to reflect current goals and services. The team must involve the client and the client's family in developing and implementing the plan.

(e) The team must document in progress notes which short-term goals have been met and when no further crisis intervention services are required.

(f) If the client's crisis is stabilized, but the client needs a referral for mental health crisis stabilization services or to other services, the team must provide a referral to these services. If the recipient has a case manager, planning for other services must be coordinated with the case manager.

Subd. 7. **Crisis stabilization services.** Crisis stabilization services must be provided by a mental health professional or a mental health practitioner who works under the clinical supervision of a mental health professional and for a crisis stabilization services provider entity and must meet the following standards:

(1) a crisis stabilization treatment plan must be developed which meets the criteria in subdivision 8;

(2) services must be delivered according to the treatment plan and include face-to-face contact with the recipient by qualified staff for further assessment, help with referrals, updating the crisis stabilization treatment plan, supportive counseling, skills training, and collaboration with other service providers in the community; and

(3) mental health practitioners must have completed at least 30 hours of training in crisis intervention and stabilization during the past two years.

Subd. 8. **Treatment plan.** (a) The individual crisis stabilization treatment plan must include, at a minimum:

(1) a list of problems identified in the assessment;

(2) a list of the recipient's strengths and resources;

(3) concrete, measurable short-term goals and tasks to be achieved, including time frames for achievement of the goals;

(4) specific objectives directed toward the achievement of each goal;

(5) documentation of the participants involved in the service planning;

(6) planned frequency and type of services initiated;

(7) a crisis response action plan if a crisis should occur; and

(8) clear progress notes on the outcome of goals.

(b) The client, if clinically appropriate, must be a participant in the development of the crisis stabilization treatment plan. The client or the client's legal guardian must sign the service plan or documentation must be provided why this was not possible. A copy of the plan must be given to the client and the client's legal guardian. The plan should include services arranged, including specific providers where applicable.

(c) A treatment plan must be developed by a mental health professional or mental health practitioner under the clinical supervision of a mental health professional. A written plan must be completed within 24 hours of beginning services with the client.

Subd. 9. **Supervision.** (a) A mental health practitioner may provide crisis assessment and mobile crisis intervention services if the following clinical supervision requirements are met:

(1) the mental health provider entity must accept full responsibility for the services provided;

(2) the mental health professional of the provider entity, who is an employee or under contract with the provider entity, must be immediately available by telephone or in person for clinical supervision;

(3) the mental health professional is consulted, in person or by telephone, during the first three hours when a mental health practitioner provides on-site service; and

(4) the mental health professional must review and approve the tentative crisis assessment and crisis treatment plan, document the consultation, and sign the crisis assessment and treatment plan within the next business day.

(b) If the mobile crisis intervention services continue into a second calendar day, a mental health professional must contact the client face-to-face on the second day to provide services and update the crisis treatment plan. The on-site observation must be documented in the client's record and signed by the mental health professional.

Subd. 10. **Client record.** The provider must maintain a file for each client that complies with the requirements under section 256B.0943, subdivision 11, and contains the following information:

(1) individual crisis treatment plans signed by the recipient, mental health professional, and mental health practitioner who developed the crisis treatment plan, or if the recipient refused to sign the plan, the date and reason stated by the recipient for not signing the plan;

(2) signed release of information forms;

(3) recipient health information and current medications;

(4) emergency contacts for the recipient;

(5) case records that document the date of service, place of service delivery, signature of the person providing the service, and the nature, extent, and units of service. Direct or telephone contact with the recipient's family or others should be documented;

(6) required clinical supervision by mental health professionals;

(7) summary of the recipient's case reviews by staff; and

(8) any written information by the recipient that the recipient wants in the file.

Subd. 11. **Excluded services.** The following services are excluded from reimbursement under this section:

(1) room and board services;

(2) services delivered to a recipient while admitted to an inpatient hospital;

(3) transportation services under children's mental health crisis response service;

(4) services provided and billed by a provider who is not enrolled under medical assistance to provide children's mental health crisis response services;

(5) crisis response services provided by a residential treatment center to clients in their facility;

(6) services performed by volunteers;

(7) direct billing of time spent "on call" when not delivering services to a recipient;

(8) provider service time included in case management reimbursement;

(9) outreach services to potential recipients; and

(10) a mental health service that is not medically necessary.

9555.6255 RESIDENT'S RIGHTS.

Subpart 1. **Information about rights.** The operator shall ensure that a resident and a resident's legal representative are given, at admission:

A. an explanation and copy of the resident's rights specified in subparts 2 to 7;

B. a written summary of the Vulnerable Adults Act prepared by the department; and

C. the name, address, and telephone number of the local agency to which a resident or a resident's legal representative may submit an oral or written complaint.

Subp. 2. **Right to use telephone.** A resident has the right to daily, private access to and use of a non-coin operated telephone for local calls and long distance calls made collect or paid for by the resident.

Subp. 3. **Right to receive and send mail.** A resident has the right to receive and send uncensored, unopened mail.

Subp. 4. **Right to privacy.** A resident has the right to personal privacy and privacy for visits from others, and the respect of individuality and cultural identity. Privacy must be respected by operators, caregivers, household members, and volunteers by knocking on the door of a resident's bedroom and seeking consent before entering, except in an emergency, and during toileting, bathing, and other activities of personal hygiene, except as needed for resident safety or assistance as noted in the resident's individual record.

Subp. 5. **Right to use personal property.** A resident has the right to keep and use personal clothing and possessions as space permits, unless to do so would infringe on the health, safety, or rights of other residents or household members.

Subp. 6. **Right to associate.** A resident has the right to meet with or refuse to meet with visitors and participate in activities of commercial, religious, political, and community groups without interference if the activities do not infringe on the rights of other residents or household members.

Subp. 7. **Married residents.** Married residents have the right to privacy for visits by their spouses, and, if both spouses are residents of the adult foster home, they have the right to share a bedroom and bed.

9555.7100 SCOPE.

Parts 9555.7100 to 9555.7600 govern the investigation and reporting of maltreatment of vulnerable adults and some aspects of the emergency and continuing protective social services required to be furnished by local social services agencies under Minnesota Statutes, section 626.557.

9555.7200 DEFINITIONS.

Subpart 1. **Scope.** As used in parts 9555.7100 to 9555.7600, the following terms have the meanings given them.

Subp. 2. **Abuse.** "Abuse" means:

A. any act which constitutes a violation of Minnesota Statutes, section 609.322related to prostitution;

B. any act which constitutes a violation of Minnesota Statutes, sections 609.342to 609.345 related to criminal sexual conduct; or

C. the intentional and nontherapeutic infliction of physical pain or injury, or any persistent course of conduct intended to produce mental or emotional distress.

Subp. 3. **Caretaker.** "Caretaker" means an individual or facility which has responsibility for the care of a vulnerable adult as a result of family relationship, or which has assumed responsibility for all or a portion of the care of the vulnerable adult voluntarily, by contract, or by agreement. A person who has assumed only financial responsibility for an adult is not a caretaker.

Subp. 4. **County of financial responsibility.** "County of financial responsibility" means the county designated as the county of financial responsibility.

Subp. 5. **Facility.** "Facility" means a hospital or other entity required to be licensed pursuant to Minnesota Statutes, sections 144.50 to 144.58; a nursing home required to be licensed pursuant to Minnesota Statutes, section 144A.02; an agency, residential or nonresidential program required to be licensed pursuant to Minnesota Statutes, chapter 245A; a mental health program receiving funds pursuant to Minnesota Statutes, section 245.61; and any entity required to be certified for

participation in titles XVIII or XIX of the Social Security Act, United States Code, title 42, section 1395 et seq.

Subp. 6. **False.** "False" means disproved to the satisfaction of the investigating agency.

Subp. 7. **Host county.** "Host county" means the county in which a facility is located.

Subp. 8. **Impairment of mental or physical function or emotional status.** "Impairment of mental or physical function or emotional status" means a condition which includes being substantially unable to carry out one or more of the essential major activities of daily living, such as caring for oneself, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning, or working; being unable to protect oneself from hazardous or abusive situations without assistance; a substantial disorder of thought or mood which significantly impairs judgment, behavior, capacity to recognize reality or ability to cope with the ordinary demands of life; substantial difficulty in engaging in the rational decision-making process, and inability to weigh the possible benefits and risks of seeking assistance; a condition in which an individual is so fearful, so ashamed, so confused, or so anxious about the consequences of reporting that that individual would be unable or unlikely to make a responsible decision regarding whether or not to report abuse or neglect.

Subp. 9. **Licensing agency.** "Licensing agency" means:

A. the commissioner of health, for a facility which is required to be licensed or certified by the Department of Health;

B. the commissioner of human services for programs required by Minnesota Statutes, chapter 245A, to be licensed;

C. any licensing board which regulates persons pursuant to Minnesota Statutes, section 214.01; and

D. the Minnesota Department of Health if the human services occupation of the alleged perpetrator is credentialed pursuant to Minnesota Statutes, section 149A.20or 214.13.

Subp. 10. **Local social services agency.** "Local social services agency" means the local agency under the authority of the human services board or board of county commissioners which is responsible for social services.

Subp. 11. **Neglect.** "Neglect" means failure by a caretaker to supply or to ensure the supply of necessary food, clothing, shelter, health care, or supervision for a vulnerable adult.

Subp. 12. **Report.** "Report" means any verbal or written report of abuse or neglect of a vulnerable adult received by the local social services agency, police department, county sheriff, or licensing agency.

Subp. 13. **State agency.** "State agency" means the Minnesota Department of Human Services.

Subp. 14. **Substantiated.** "Substantiated" means proved to the satisfaction of the investigating agency.

Subp. 15. **Vulnerable adult.** "Vulnerable adult" means any person 18 years of age or older:

A. who is a resident or patient of a facility;

B. who receives services at or from a program required to be licensed pursuant to Minnesota Statutes, chapter 245A; or

C. who, regardless of residence, is unable or unlikely to report abuse or neglect without assistance because of impairment of mental or physical function or emotional status.

Subp. 16. **Inconclusive.** "Inconclusive" means a report which cannot be substantiated or disproved to the satisfaction of the investigating agency.

9555.7300 COMPLAINT INVESTIGATION BY LOCAL SOCIAL SERVICES AGENCIES.

Subpart 1. **Duty to accept and investigate complaints.** The local social services agency shall accept and investigate all complaints alleging that a vulnerable adult has been abused or neglected in that agency's county. The local social services agency shall notify each relevant licensing agency and the local police departments or county sheriffs and shall cooperate in coordinating its investigation with the investigations of the licensing agencies, police departments, and sheriffs. The local social services agency shall immediately send a report of its findings to all other agencies notified concerning the complaint in question.

Subp. 2. **Time limits to initiate investigations.** The local social services agency shall begin to investigate all complaints within the following time limits:

A. The local social services agency shall conduct an immediate on-site investigation for complaints alleging or from which it can be inferred that a vulnerable adult is in need of immediate care or protection because the adult is life-threatened or likely to experience physical injury due to abuse or abandonment.

B. The local social services agency shall begin its investigation within 24 hours for complaints alleging, or when there is substantial evidence, that a vulnerable adult is not in need of immediate care or protection but is allegedly abused.

C. The local social services agency shall begin its investigation within 72 hours for complaints alleging, or when there is substantial evidence, that a vulnerable adult is not in need of immediate care or protection but is allegedly neglected.

Subp. 3. **Investigations related to a facility.** When an investigation involves an alleged incident or situation related to a facility, the local social services agency shall make an on-site visit to the facility to assess the validity of the complaint. This investigation shall include the following activities when necessary to make an accurate assessment, but activities specified in items A, C, and E need not occur on the site of the facility:

A. discussion with the reporter;

B. discussion with the facility administrator or responsible designee;

C. discussion with the physician or other professionals, or any corroborating contacts as necessary;

D. contact with the alleged victim;

E. discussion with the alleged perpetrator;

F. examination of the physical conditions or the psychological climate of the facility; and

G. inspection of the alleged victim's record.

The local social services agency shall also determine whether the reported abuse or neglect places other vulnerable adults in jeopardy of being abused or neglected.

The local social services agency shall immediately send a report of its findings to all other agencies notified concerning the complaint in question.

Subp. 4. **Investigations not related to a facility.** When an investigation involves an alleged incident or situation which is not related to a facility, the local social services agency shall assess the validity of the complaint. This investigation shall include the following activities where necessary to make an accurate assessment:

A. discussion with the alleged victim;

B. discussion with the reporter or any corroborating contacts, as necessary;

C. discussion with the alleged perpetrator;

D. discussion with the physician or other professionals; and

E. examination of the physical conditions or the psychological climate of the residence.

The local social services agency shall also determine whether the reported abuse or neglect places other vulnerable adults in jeopardy of being abused or neglected.

Subp. 5. **Investigations by agencies which are not in the county of financial responsibility.** When a complaint involves a vulnerable adult who is receiving services from a facility located in a county other than the adult's county of financial responsibility, the local social services agency of the host county shall:

A. investigate the complaint in accordance with subpart 3 and determine whether the complaint is substantiated, inconclusive, or false;

B. notify each relevant licensing agency, the police or sheriff, and the county of financial responsibility;

C. consult with the county of financial responsibility, unless the host county must take immediate emergency measures and representatives of the county of financial responsibility are not available;

D. take whatever measures are necessary to correct the situation or to remove the adult from the facility and notify the county of financial responsibility of the actions taken to correct the situation or of the removal of the adult from the facility; and

E. complete and transmit all required written forms and findings to appropriate agencies.

The local social services agency of the county of financial responsibility shall then resume responsibility for ensuring ongoing planning and services for the vulnerable adult.

Subp. 6. **Use of outside experts.** When it is investigating alleged abuse or neglect of a vulnerable adult, the local social services agency shall consult persons with appropriate expertise if the local agency believes that it lacks the expertise necessary for making judgments pertaining to the allegations. This consultation may include matters of physical health, mental health, specialized treatment such as behavior modification, geriatrics, or other matters.

Subp. 7. **Investigations after initial complaint assessment.** If upon the initial assessment required by subparts 1 to 6 there appears to be substance to a complaint, the local social services agency shall attempt to determine the following:

A. the risk posed if the vulnerable adult remains in the present circumstances;

B. the current physical and emotional condition of the vulnerable adult, including the history or pattern of abuse or neglect or related prior injuries;

C. the name, address, age, sex, and relationship of the alleged perpetrator to the vulnerable adult; and

D. in a complaint of neglect, the relationship of the caretaker to the vulnerable adult, including the agreed-upon roles and responsibilities of the caretaker and the vulnerable adult.

9555.7600 ACTIONS ON BEHALF OF A VULNERABLE ADULT WHO REFUSES SERVICES.

If a vulnerable adult who is the victim of abuse or neglect by a caretaker refuses an offer of services from a local social services agency and in the judgment of that agency the vulnerable adult's safety or welfare is in jeopardy, the agency shall seek the authority to intervene on behalf of that adult. If the agency believes it to be in the adult's best interest, it shall seek or help the family or victim seek any of the following:

A. a restraining order or a court order for removal of the perpetrator from the residence of the vulnerable adult pursuant to Minnesota Statutes, section 518B.01;

B. guardianship or conservatorship pursuant to Minnesota Statutes, sections 525.539 to 525.6198, or guardianship or conservatorship pursuant to Minnesota Statutes, chapter 252A;

C. a hold order or commitment pursuant to the Minnesota Hospitalization and Commitment Act, Minnesota Statutes, chapter 253A; or

D. a referral to the prosecuting attorney for possible criminal prosecution of the perpetrator under Minnesota Statutes, chapter 609.