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State of Minnesota
HOUSE OF REPRESENTATIVES
Unofficial Engrossment

House Engrossment of a Senate File

EIGHTY-NINTH SESSION

S. F. No. 2414

Senate Author(s): Wiklund and Sheran

House Action

04/28/2016 Companion to House File No. 3199. (Authors:Albright)

Read First Time and Sent for Comparison

05/02/2016 Adoption of Report: Placed on the General Register

Read Second Time

05/20/2016 Calendar for the Day, Amended

Read Third Time as Amended

Passed by the House as Amended and transmitted to the Senate to include Floor Amendments

1.1 A bill for an act
1.2 relating to human services; modifying the office of ombudsman for long-term
1.3 care, chemical and mental health treatment services, and miscellaneous policy
1.4 provisions; establishing the Minnesota Eligibility System Executive Steering
1.5 Committee; amending Minnesota Statutes 2014, sections 62V.11, by adding
1.6 a subdivision; 148.975, subdivision 1; 148B.1751; 148F.13, subdivision 2;
1.7 245.462, subdivision 18; 245.4871, subdivision 27; 245A.11, subdivision
1.8 2a; 256.974; 256.9741, subdivision 5, by adding subdivisions; 256.9742;
1.9 256B.0615, subdivisions 1, 2; 256B.0622, as amended; 256B.0751, subdivision
1.10 3; 256B.0947, subdivision 2; Minnesota Statutes 2015 Supplement, sections
1.11 62V.03, subdivision 2; 125A.08; 256.01, subdivision 12a; 256B.0911,
1.12 subdivision 3a; 256B.766; 256I.04, subdivision 2a; 402A.18, subdivision 3;
1.13 proposing coding for new law in Minnesota Statutes, chapter 62V.

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

1.15 ARTICLE 1

1.16 OMBUDSMAN FOR LONG-TERM CARE

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

1.18 **256.974 OFFICE OF OMBUDSMAN FOR LONG-TERM CARE; LOCAL**
1.19 **PROGRAMS.**

1.20 The ombudsman for long-term care serves in the classified service under section
1.21 256.01, subdivision 7, in an office within the Minnesota Board on Aging that incorporates
1.22 the long-term care ombudsman program required by the Older Americans Act, as
1.23 amended, United States Code, title 42, ~~section~~ sections 3027(a)(9) and 3058g(a), and
1.24 ~~established within the Minnesota Board on Aging. The Minnesota Board on Aging may~~
1.25 ~~make grants to and designate local programs for the provision of ombudsman services to~~
1.26 ~~clients in county or multicounty areas. The local program~~ Code of Federal Regulations,
1.27 title 45, parts 1321 and 1327. The office shall be a distinct entity, separately identifiable

2.1 from other state agencies and may not be an agency engaged in the provision of nursing
 2.2 home care, hospital care, or home care services either directly or by contract, or have the
 2.3 responsibility for planning, coordinating, funding, or administering nursing home care,
 2.4 hospital care, or home care services.

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

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

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

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

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

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

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

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

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

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

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

2.26 **256.9742 DUTIES AND POWERS OF THE OFFICE.**

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

2.28 (1) gather information and evaluate any act, practice, policy, procedure, or
 2.29 administrative action of a long-term care facility, acute care facility, home care service

3.1 provider, or government agency that may adversely affect the health, safety, welfare, or
 3.2 rights of any client;

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

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

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

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

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

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

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

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

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

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

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

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

4.1 (e) The ombudsman shall develop and implement a continuing education program
4.2 for certified ombudsman volunteers which will provide, who shall complete a minimum of
4.3 12 hours of continuing education per year.

4.4 (f) The ombudsman may withdraw ~~an individual's~~ a representative's designation if
4.5 the ~~individual~~ representative fails to perform duties of this section or meet continuing
4.6 education requirements. The ~~individual~~ representative may request a reconsideration of
4.7 such action by the Board on Aging ~~whose decision,~~ but any further decision of the state
4.8 ombudsman about designation shall be final.

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

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

4.22 Subd. 4. **Access to long-term care and acute care facilities and clients.** The
4.23 ombudsman or designee may:

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

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

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

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

4.33 (5) inspect records of a long-term care facility, home care service provider, or
4.34 acute care facility that pertain to the care of the client according to sections 144.291 to
4.35 144.298; and

5.1 (6) with the consent of a client or client's legal guardian, the ombudsman or
5.2 designated staff shall have access to review records pertaining to the care of the client
5.3 according to sections 144.291 to 144.298. If a client cannot consent and has no legal
5.4 guardian, access to the records is authorized by this section.

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

5.8 Subd. 5. **Access to state records.** The ombudsman or designee, excluding
5.9 volunteers, has access to data of a state agency necessary for the discharge of the
5.10 ombudsman's duties, including records classified confidential or private under chapter 13,
5.11 or any other law. The data requested must be related to a specific case and is subject
5.12 to section 13.03, subdivision 4. If the data concerns an individual, the ombudsman or
5.13 designee shall first obtain the individual's consent. If the individual cannot consent and
5.14 has no legal guardian, then access to the data is authorized by this section.

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

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

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

- 5.32 (1) discharge or transfer from a facility;
- 5.33 (2) termination of service;
- 5.34 (3) restriction or prohibition of access to the facility or its residents;
- 5.35 (4) discharge from or termination of employment;
- 5.36 (5) demotion or reduction in remuneration for services; and

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

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

6.3 ARTICLE 2

6.4 CHEMICAL AND MENTAL HEALTH SERVICES

6.5 Section 1. Minnesota Statutes 2014, section 245.462, subdivision 18, is amended to read:

6.6 Subd. 18. **Mental health professional.** "Mental health professional" means a
6.7 person providing clinical services in the treatment of mental illness who is qualified in at
6.8 least one of the following ways:

6.9 (1) in psychiatric nursing: a registered nurse who is licensed under sections 148.171
6.10 to 148.285; and:

6.11 (i) who is certified as a clinical specialist or as a nurse practitioner in adult or family
6.12 psychiatric and mental health nursing by a national nurse certification organization; or

6.13 (ii) who has a master's degree in nursing or one of the behavioral sciences or related
6.14 fields from an accredited college or university or its equivalent, with at least 4,000 hours
6.15 of post-master's supervised experience in the delivery of clinical services in the treatment
6.16 of mental illness;

6.17 (2) in clinical social work: a person licensed as an independent clinical social worker
6.18 under chapter 148D, or a person with a master's degree in social work from an accredited
6.19 college or university, with at least 4,000 hours of post-master's supervised experience in
6.20 the delivery of clinical services in the treatment of mental illness;

6.21 (3) in psychology: an individual licensed by the Board of Psychology under sections
6.22 148.88 to 148.98 who has stated to the Board of Psychology competencies in the diagnosis
6.23 and treatment of mental illness;

6.24 (4) in psychiatry: a physician licensed under chapter 147 and certified by the
6.25 American Board of Psychiatry and Neurology or eligible for board certification in
6.26 psychiatry, or an osteopathic physician licensed under chapter 147 and certified by
6.27 the American Osteopathic Board of Neurology and Psychiatry or eligible for board
6.28 certification in psychiatry;

6.29 (5) in marriage and family therapy: the mental health professional must be a
6.30 marriage and family therapist licensed under sections 148B.29 to 148B.39 with at least
6.31 two years of post-master's supervised experience in the delivery of clinical services in
6.32 the treatment of mental illness;

6.33 (6) in licensed professional clinical counseling, the mental health professional
6.34 shall be a licensed professional clinical counselor under section 148B.5301 with at least

7.1 4,000 hours of post-master's supervised experience in the delivery of clinical services in
7.2 the treatment of mental illness; or

7.3 (7) in allied fields: a person with a master's degree from an accredited college or
7.4 university in one of the behavioral sciences or related fields, with at least 4,000 hours of
7.5 post-master's supervised experience in the delivery of clinical services in the treatment of
7.6 mental illness.

7.7 Sec. 2. Minnesota Statutes 2014, section 245.4871, subdivision 27, is amended to read:

7.8 Subd. 27. **Mental health professional.** "Mental health professional" means a
7.9 person providing clinical services in the diagnosis and treatment of children's emotional
7.10 disorders. A mental health professional must have training and experience in working with
7.11 children consistent with the age group to which the mental health professional is assigned.
7.12 A mental health professional must be qualified in at least one of the following ways:

7.13 (1) in psychiatric nursing, the mental health professional must be a registered nurse
7.14 who is licensed under sections 148.171 to 148.285 and who is certified as a clinical
7.15 specialist in child and adolescent psychiatric or mental health nursing by a national nurse
7.16 certification organization or who has a master's degree in nursing or one of the behavioral
7.17 sciences or related fields from an accredited college or university or its equivalent, with
7.18 at least 4,000 hours of post-master's supervised experience in the delivery of clinical
7.19 services in the treatment of mental illness;

7.20 (2) in clinical social work, the mental health professional must be a person licensed
7.21 as an independent clinical social worker under chapter 148D, or a person with a master's
7.22 degree in social work from an accredited college or university, with at least 4,000 hours of
7.23 post-master's supervised experience in the delivery of clinical services in the treatment
7.24 of mental disorders;

7.25 (3) in psychology, the mental health professional must be an individual licensed by
7.26 the board of psychology under sections 148.88 to 148.98 who has stated to the board of
7.27 psychology competencies in the diagnosis and treatment of mental disorders;

7.28 (4) in psychiatry, the mental health professional must be a physician licensed under
7.29 chapter 147 and certified by the American Board of Psychiatry and Neurology or eligible
7.30 for board certification in psychiatry or an osteopathic physician licensed under chapter
7.31 147 and certified by the American Osteopathic Board of Neurology and Psychiatry or
7.32 eligible for board certification in psychiatry;

7.33 (5) in marriage and family therapy, the mental health professional must be a
7.34 marriage and family therapist licensed under sections 148B.29 to 148B.39 with at least

8.1 two years of post-master's supervised experience in the delivery of clinical services in the
8.2 treatment of mental disorders or emotional disturbances;

8.3 (6) in licensed professional clinical counseling, the mental health professional shall
8.4 be a licensed professional clinical counselor under section 148B.5301 with at least 4,000
8.5 hours of post-master's supervised experience in the delivery of clinical services in the
8.6 treatment of mental disorders or emotional disturbances; or

8.7 (7) in allied fields, the mental health professional must be a person with a master's
8.8 degree from an accredited college or university in one of the behavioral sciences or related
8.9 fields, with at least 4,000 hours of post-master's supervised experience in the delivery of
8.10 clinical services in the treatment of emotional disturbances.

8.11 Sec. 3. Minnesota Statutes 2014, section 256B.0615, subdivision 1, is amended to read:

8.12 Subdivision 1. **Scope.** Medical assistance covers mental health certified ~~peers~~
8.13 ~~specialists~~ peer specialist services, as established in subdivision 2, subject to federal
8.14 approval, if provided to recipients who are eligible for services under sections 256B.0622,
8.15 256B.0623, and 256B.0624 and are provided by a certified peer specialist who has
8.16 completed the training under subdivision 5.

8.17 Sec. 4. Minnesota Statutes 2014, section 256B.0615, subdivision 2, is amended to read:

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

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

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

8.23 (3) is individualized to the consumer; and

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

8.26 Sec. 5. Minnesota Statutes 2014, section 256B.0622, as amended by Laws 2015,
8.27 chapter 71, article 2, sections 23 to 32, is amended to read:

8.28 **256B.0622 INTENSIVE REHABILITATIVE MENTAL HEALTH SERVICES**
8.29 **ASSERTIVE COMMUNITY TREATMENT AND INTENSIVE RESIDENTIAL**
8.30 **TREATMENT SERVICES.**

8.31 Subdivision 1. **Scope.** Subject to federal approval, medical assistance covers
8.32 medically necessary, assertive community treatment for clients as defined in subdivision
8.33 2a and intensive residential treatment services ~~as defined in subdivision 2~~, for recipients

9.1 clients as defined in subdivision 3, when the services are provided by an entity meeting the
9.2 standards in this section.

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

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

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

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

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

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

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

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

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

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

9.24 (f) "Benefits and finance support" means assisting clients in capably managing
9.25 financial affairs. Services include, but are not limited to, assisting clients in applying for
9.26 benefits; assisting with redetermination of benefits; providing financial crisis management;
9.27 teaching and supporting budgeting skills and asset development; and coordinating with a
9.28 client's representative payee, if applicable.

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

10.1 relapse prevention to work with clients in later stages of change; and facilitating access
10.2 to community supports.

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

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

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

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

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

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

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

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

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

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

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

11.26 ~~(e) "Treatment team" means all staff who provide services under this section to~~
11.27 ~~recipients. At a minimum, this includes the clinical supervisor, mental health professionals~~
11.28 ~~as defined in section 245.462, subdivision 18, clauses (1) to (6); mental health practitioners~~
11.29 ~~as defined in section 245.462, subdivision 17; mental health rehabilitation workers under~~
11.30 ~~section 256B.0623, subdivision 5, clause (3); and certified peer specialists under section~~
11.31 ~~256B.0615.~~

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

11.34 (s) "Physical health services" means any service or treatment to meet the physical
11.35 health needs of the client to support the client's mental health recovery. Services include,
11.36 but are not limited to, education on primary health issues, including wellness education;

12.1 medication administration and monitoring; providing and coordinating medical screening
12.2 and follow-up; scheduling routine and acute medical and dental care visits; tobacco
12.3 cessation strategies; assisting clients in attending appointments; communicating with other
12.4 providers; and integrating all physical and mental health treatment.

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

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

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

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

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

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

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

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

- 13.1 disabilities, borderline personality disorder, antisocial personality disorder, traumatic brain
13.2 injury, or an autism spectrum disorder are not eligible for assertive community treatment;
13.3 (3) has significant functional impairment as demonstrated by at least one of the
13.4 following conditions:
13.5 (i) significant difficulty consistently performing the range of routine tasks required
13.6 for basic adult functioning in the community or persistent difficulty performing daily
13.7 living tasks without significant support or assistance;
13.8 (ii) significant difficulty maintaining employment at a self-sustaining level or
13.9 significant difficulty consistently carrying out the head-of-household responsibilities; or
13.10 (iii) significant difficulty maintaining a safe living situation;
13.11 (4) has a need for continuous high-intensity services as evidenced by at least two of
13.12 the following:
13.13 (i) two or more psychiatric hospitalizations or residential crisis stabilization services
13.14 in the previous 12 months;
13.15 (ii) frequent utilization of mental health crisis services in the previous six months;
13.16 (iii) 30 or more consecutive days of psychiatric hospitalization in the previous
13.17 24 months;
13.18 (iv) intractable, persistent, or prolonged severe psychiatric symptoms;
13.19 (v) coexisting mental health and substance use disorders lasting at least six months;
13.20 (vi) recent history of involvement with the criminal justice system or demonstrated
13.21 risk of future involvement;
13.22 (vii) significant difficulty meeting basic survival needs;
13.23 (viii) residing in substandard housing, experiencing homelessness, or facing
13.24 imminent risk of homelessness;
13.25 (ix) significant impairment with social and interpersonal functioning such that basic
13.26 needs are in jeopardy;
13.27 (x) coexisting mental health and physical health disorders lasting at least six months;
13.28 (xi) residing in an inpatient or supervised community residence but clinically assessed
13.29 to be able to live in a more independent living situation if intensive services are provided;
13.30 (xii) requiring a residential placement if more intensive services are not available; or
13.31 (xiii) difficulty effectively using traditional office-based outpatient services;
13.32 (5) there are no indications that other available community-based services would
13.33 be equally or more effective as evidenced by consistent and extensive efforts to treat
13.34 the individual; and
13.35 (6) in the written opinion of a licensed mental health professional, has the need for
13.36 mental health services that cannot be met with other available community-based services,

14.1 or is likely to experience a mental health crisis or require a more restrictive setting if
14.2 assertive community treatment is not provided.

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

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

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

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

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

14.14 (5) one of the following must also apply:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

15.20 (1) is age 18 or older;

15.21 (2) is eligible for medical assistance;

15.22 (3) is diagnosed with a mental illness;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

16.20 (10) comply with all applicable laws;

16.21 (11) be an enrolled Medicaid provider;

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

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

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

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

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

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

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

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

17.5 (2) not exceed 16 beds per site;

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

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

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

17.11 ~~Subd. 5. **Standards applicable to both assertive community treatment and**~~
17.12 ~~**residential providers.** (a) Services must be provided by qualified staff as defined in section~~
17.13 ~~256B.0623, subdivision 5, who are trained and supervised according to section 256B.0623,~~
17.14 ~~subdivision 6, except that mental health rehabilitation workers acting as overnight staff are~~
17.15 ~~not required to comply with section 256B.0623, subdivision 5, clause (4), item (iv).~~

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

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

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

17.30 ~~(e) The initial individual treatment plan must be completed within ten days of~~
17.31 ~~intake for assertive community treatment and within 24 hours of admission for intensive~~
17.32 ~~residential treatment services. Within ten days of admission, the initial treatment plan~~
17.33 ~~must be refined and further developed for intensive residential treatment services, except~~
17.34 ~~for providers certified according to Minnesota Rules, parts 9533.0010 to 9533.0180.~~

17.35 ~~The individual treatment plan must be reviewed with the recipient and updated at least~~

18.1 ~~monthly for intensive residential treatment services and at least every six months for~~
18.2 ~~assertive community treatment.~~

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

18.4 ~~(a) The provider of intensive residential services must have sufficient staff to provide~~
18.5 ~~24-hour-per-day coverage to deliver the rehabilitative services described in the treatment~~
18.6 ~~plan and to safely supervise and direct the activities of recipients given the recipient's level~~
18.7 ~~of behavioral and psychiatric stability, cultural needs, and vulnerability. The provider~~
18.8 ~~must have the capacity within the facility to provide integrated services for chemical~~
18.9 ~~dependency, illness management services, and family education when appropriate.~~

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

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

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

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

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

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

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

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

18.34 ~~(c) At a minimum:~~

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

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

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

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

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

19.13 (d) Services must be provided by qualified staff as defined in section 256B.0623,
19.14 subdivision 5, who are trained and supervised according to section 256B.0623, subdivision
19.15 6, except that mental health rehabilitation workers acting as overnight staff are not
19.16 required to comply with section 256B.0623, subdivision 5, clause (4), item (iv).

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

19.23 (f) Treatment staff must have prompt access in person or by telephone to a mental
19.24 health practitioner or mental health professional. The provider must have the capacity to
19.25 promptly and appropriately respond to emergent needs and make any necessary staffing
19.26 adjustments to ensure the health and safety of clients.

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

19.29 (h) The initial individual treatment plan must be completed within 24 hours of
19.30 admission. Within ten days of admission, the initial treatment plan must be refined and
19.31 further developed, except for providers certified according to Minnesota Rules, parts
19.32 9533.0010 to 9533.0180. The individual treatment plan must be reviewed with the client
19.33 and updated at least monthly.

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

- 20.1 ~~(1) The treatment team must use team treatment, not an individual treatment model.~~
- 20.2 ~~(2) The clinical supervisor must function as a practicing clinician at least on a~~
- 20.3 ~~part-time basis.~~
- 20.4 ~~(3) The staffing ratio must not exceed ten recipients to one full-time equivalent~~
- 20.5 ~~treatment team position.~~
- 20.6 ~~(4) Services must be available at times that meet client needs.~~
- 20.7 ~~(5) The treatment team must actively and assertively engage and reach out to the~~
- 20.8 ~~recipient's family members and significant others, after obtaining the recipient's permission.~~
- 20.9 ~~(6) The treatment team must establish ongoing communication and collaboration~~
- 20.10 ~~between the team, family, and significant others and educate the family and significant~~
- 20.11 ~~others about mental illness, symptom management, and the family's role in treatment.~~
- 20.12 ~~(7) The treatment team must provide interventions to promote positive interpersonal~~
- 20.13 ~~relationships.~~
- 20.14 (a) ACT teams must offer and have the capacity to directly provide the following
- 20.15 services:
- 20.16 (1) assertive engagement;
- 20.17 (2) benefits and finance support;
- 20.18 (3) co-occurring disorder treatment;
- 20.19 (4) crisis assessment and intervention;
- 20.20 (5) employment services;
- 20.21 (6) family psychoeducation and support;
- 20.22 (7) housing access support;
- 20.23 (8) medication assistance and support;
- 20.24 (9) medication education;
- 20.25 (10) mental health certified peer specialists services;
- 20.26 (11) physical health services;
- 20.27 (12) rehabilitative mental health services;
- 20.28 (13) symptom management;
- 20.29 (14) therapeutic interventions;
- 20.30 (15) wellness self-management and prevention; and
- 20.31 (16) other services based on client needs as identified in a client's assertive
- 20.32 community treatment individual treatment plan.
- 20.33 (b) ACT teams must ensure the provision of all services necessary to meet a client's
- 20.34 needs as identified in the client's individual treatment plan.
- 20.35 **Subd. 7b. Assertive community treatment team staff requirements and roles.**
- 20.36 (a) The required treatment staff qualifications and roles for an ACT team are:

21.1 (1) the team leader:

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

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

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

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

21.15 (2) the psychiatric care provider:

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

21.22 (ii) shall collaborate with the team leader in sharing overall clinical responsibility for
21.23 screening and admitting clients; monitoring clients' treatment and team member service
21.24 delivery; educating staff on psychiatric and nonpsychiatric medications, their side effects,
21.25 and health-related conditions; actively collaborating with nurses; and helping provide
21.26 clinical supervision to the team;

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

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

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

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

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

22.11 (3) the nursing staff:

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

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

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

22.25 (4) the co-occurring disorder specialist:

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

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

23.4 (5) the vocational specialist:

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

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

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

23.15 (6) the mental health certified peer specialist:

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

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

23.25 (iii) must model recovery values, attitudes, beliefs, and personal action to encourage
23.26 wellness and resilience, provide consultation to team members, promote a culture where
23.27 the clients' points of view and preferences are recognized, understood, respected, and
23.28 integrated into treatment, and serve in a manner equivalent to other team members;

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

23.32 (8) additional staff:

23.33 (i) shall be based on team size. Additional treatment team staff may include licensed
23.34 mental health professionals as defined in Minnesota Rules, part 9505.0371, subpart 5, item
23.35 A; mental health practitioners as defined in Minnesota Rules, part 9505.0370, subpart 17;
23.36 or mental health rehabilitation workers as defined in section 256B.0623, subdivision 5,

24.1 clause (4). These individuals shall have the knowledge, skills, and abilities required by the
24.2 population served to carry out rehabilitation and support functions; and

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

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

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

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

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

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

24.22 (1) a small ACT team must:

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

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

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

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

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

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

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

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

25.14 (2) a midsize ACT team shall:

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

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

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

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

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

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

25.33 (vii) have the authority to arrange for coverage for crisis assessment and intervention
25.34 services through a reliable crisis-intervention provider as long as there is a mechanism by
25.35 which the ACT team communicates routinely with the crisis-intervention provider and

26.1 the on-call ACT team staff are available to see clients face-to-face when necessary or if
26.2 requested by the crisis-intervention services provider; and

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

26.7 (3) a large ACT team must:

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

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

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

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

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

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

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

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

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

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

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

27.5 (d) The ACT team shall have the capacity to rapidly increase service intensity to a
27.6 client when the client's status requires it, regardless of geography, provide flexible service
27.7 in an individualized manner, and see clients on average three times per week for at least
27.8 120 minutes per week. Services must be available at times that meet client needs.

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

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

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

27.24 (h) ACT teams shall maintain a clinical log that succinctly documents important
27.25 clinical information and develop a daily team schedule for the day's contacts based
27.26 on a central file of the clients' weekly or monthly schedules, which are derived from
27.27 interventions specified within the individual treatment plan. The team leader must have a
27.28 record to ensure that all assigned contacts are completed.

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

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

28.4 (c) Within 30 days of the client's assertive community treatment admission, the
28.5 ACT team shall complete an in-depth assessment of the domains listed under section
28.6 245.462, subdivision 11a.

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

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

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

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

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

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

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

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

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

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

29.23 (6) The individual treatment plan and review must be signed or acknowledged by
29.24 the client, the primary team member, individual treatment team members, the team leader,
29.25 the psychiatric care provider, and all individual treatment team members. A copy of the
29.26 signed individual treatment plan is made available to the client.

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

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

29.36 (a) Payment for intensive residential treatment services and assertive community treatment

30.1 in this section shall be based on one daily rate per provider inclusive of the following
30.2 services received by an eligible recipient client in a given calendar day: all rehabilitative
30.3 services under this section, staff travel time to provide rehabilitative services under this
30.4 section, and nonresidential crisis stabilization services under section 256B.0624.

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

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

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

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

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

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

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

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

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

31.1 (3) the number of service units;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

32.17 Sec. 6. Minnesota Statutes 2014, section 256B.0947, subdivision 2, is amended to read:

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

32.20 (a) "Intensive nonresidential rehabilitative mental health services" means child
32.21 rehabilitative mental health services as defined in section 256B.0943, except that these
32.22 services are provided by a multidisciplinary staff using a total team approach consistent
32.23 with assertive community treatment, as adapted for youth, and are directed to recipients
32.24 ages ~~16 to 21~~, 17, 18, 19, or 20 with a serious mental illness or co-occurring mental illness
32.25 and substance abuse addiction who require intensive services to prevent admission to an
32.26 inpatient psychiatric hospital or placement in a residential treatment facility or who require
32.27 intensive services to step down from inpatient or residential care to community-based care.

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

32.32 (c) "Diagnostic assessment" has the meaning given to it in Minnesota Rules, part
32.33 9505.0370, subpart 11. A diagnostic assessment must be provided according to Minnesota
32.34 Rules, part 9505.0372, subpart 1, and for this section must incorporate a determination of

33.1 the youth's necessary level of care using a standardized functional assessment instrument
33.2 approved and periodically updated by the commissioner.

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

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

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

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

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

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

33.19 (3) the side effects of medications.

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

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

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

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

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

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

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

33.35 (6) meets the following criteria:

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

34.1 (ii) has had a diagnosis of mental illness, as defined in Minnesota Rules, part
34.2 9505.0370, subpart 20, or co-occurring mental illness and substance abuse addiction;

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

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

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

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

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

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

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

34.15 (k) "Transition services" means:

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

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

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

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

34.23 (5) establishing and enforcing procedures and schedules.

34.24 A youth's transition from the children's mental health system and services to
34.25 the adult mental health system and services and return to the client's home and entry
34.26 or re-entry into community-based mental health services following discharge from an
34.27 out-of-home placement or inpatient hospital stay.

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

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

34.31 **Sec. 7. SUBSTANCE USE DISORDER SYSTEM REFORM.**

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

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

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

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

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

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

35.8 (4) build aftercare and recovery support services;

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

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

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

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

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

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

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

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

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

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

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

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

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

36.1 (b) The commissioner shall seek all federal authority necessary to implement the
 36.2 proposal. The commissioner shall seek any federal waivers, state plan amendments,
 36.3 requests for new funding, realignment of existing funding, and other authority necessary
 36.4 to implement elements of the reform proposal outlined in this section.

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

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

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

36.15 **ARTICLE 3**

36.16 **MISCELLANEOUS**

36.17 Section 1. Minnesota Statutes 2015 Supplement, section 125A.08, is amended to read:

36.18 **125A.08 INDIVIDUALIZED EDUCATION PROGRAMS.**

36.19 (a) At the beginning of each school year, each school district shall have in effect, for
 36.20 each child with a disability, an individualized education program.

36.21 (b) As defined in this section, every district must ensure the following:

36.22 (1) all students with disabilities are provided the special instruction and services
 36.23 which are appropriate to their needs. Where the individualized education program team
 36.24 has determined appropriate goals and objectives based on the student's needs, including
 36.25 the extent to which the student can be included in the least restrictive environment,
 36.26 and where there are essentially equivalent and effective instruction, related services, or
 36.27 assistive technology devices available to meet the student's needs, cost to the district may
 36.28 be among the factors considered by the team in choosing how to provide the appropriate
 36.29 services, instruction, or devices that are to be made part of the student's individualized
 36.30 education program. The individualized education program team shall consider and
 36.31 may authorize services covered by medical assistance according to section 256B.0625,
 36.32 subdivision 26. Before a school district evaluation team makes a determination of other
 36.33 health disability under Minnesota Rules, part 3525.1335, subparts 1 and 2, item A, subitem
 36.34 (1), the evaluation team must seek written documentation of the student's medically

37.1 diagnosed chronic or acute health condition signed by a licensed physician or a licensed
37.2 health care provider acting within the scope of the provider's practice. The student's
37.3 needs and the special education instruction and services to be provided must be agreed
37.4 upon through the development of an individualized education program. The program
37.5 must address the student's need to develop skills to live and work as independently
37.6 as possible within the community. The individualized education program team must
37.7 consider positive behavioral interventions, strategies, and supports that address behavior
37.8 needs for children. During grade 9, the program must address the student's needs for
37.9 transition from secondary services to postsecondary education and training, employment,
37.10 community participation, recreation, and leisure and home living. In developing the
37.11 program, districts must inform parents of the full range of transitional goals and related
37.12 services that should be considered. The program must include a statement of the needed
37.13 transition services, including a statement of the interagency responsibilities or linkages or
37.14 both before secondary services are concluded;

37.15 (2) children with a disability under age five and their families are provided special
37.16 instruction and services appropriate to the child's level of functioning and needs;

37.17 (3) children with a disability and their parents or guardians are guaranteed procedural
37.18 safeguards and the right to participate in decisions involving identification, assessment
37.19 including assistive technology assessment, and educational placement of children with a
37.20 disability;

37.21 (4) eligibility and needs of children with a disability are determined by an initial
37.22 evaluation or reevaluation, which may be completed using existing data under United
37.23 States Code, title 20, section 33, et seq.;

37.24 (5) to the maximum extent appropriate, children with a disability, including those
37.25 in public or private institutions or other care facilities, are educated with children who
37.26 are not disabled, and that special classes, separate schooling, or other removal of children
37.27 with a disability from the regular educational environment occurs only when and to the
37.28 extent that the nature or severity of the disability is such that education in regular classes
37.29 with the use of supplementary services cannot be achieved satisfactorily;

37.30 (6) in accordance with recognized professional standards, testing and evaluation
37.31 materials, and procedures used for the purposes of classification and placement of children
37.32 with a disability are selected and administered so as not to be racially or culturally
37.33 discriminatory; and

37.34 (7) the rights of the child are protected when the parents or guardians are not known
37.35 or not available, or the child is a ward of the state.

38.1 (c) For all paraprofessionals employed to work in programs whose role in part is
38.2 to provide direct support to students with disabilities, the school board in each district
38.3 shall ensure that:

38.4 (1) before or beginning at the time of employment, each paraprofessional must
38.5 develop sufficient knowledge and skills in emergency procedures, building orientation,
38.6 roles and responsibilities, confidentiality, vulnerability, and reportability, among other
38.7 things, to begin meeting the needs, especially disability-specific and behavioral needs, of
38.8 the students with whom the paraprofessional works;

38.9 (2) annual training opportunities are required to enable the paraprofessional to
38.10 continue to further develop the knowledge and skills that are specific to the students with
38.11 whom the paraprofessional works, including understanding disabilities, the unique and
38.12 individual needs of each student according to the student's disability and how the disability
38.13 affects the student's education and behavior, following lesson plans, and implementing
38.14 follow-up instructional procedures and activities; and

38.15 (3) a districtwide process obligates each paraprofessional to work under the ongoing
38.16 direction of a licensed teacher and, where appropriate and possible, the supervision of a
38.17 school nurse.

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

38.19 Sec. 2. Minnesota Statutes 2014, section 148.975, subdivision 1, is amended to read:

38.20 Subdivision 1. **Definitions.** (a) The definitions in this subdivision apply to this
38.21 section.

38.22 (b) "Other person" means an immediate family member or someone who personally
38.23 knows the client and has reason to believe the client is capable of and will carry out the
38.24 serious, specific threat of harm to a specific, clearly identified or identifiable victim.

38.25 (c) "Reasonable efforts" means communicating the serious, specific threat to the
38.26 potential victim and if unable to make contact with the potential victim, communicating
38.27 the serious, specific threat to the law enforcement agency closest to the potential victim or
38.28 the client.

38.29 (d) For purposes of this section, "licensee" includes practicum psychology students,
38.30 predoctoral psychology interns, and individuals who have earned a doctoral degree
38.31 in psychology and are in the process of completing their postdoctoral supervised
38.32 psychological employment in order to qualify for licensure.

39.1 Sec. 3. Minnesota Statutes 2014, section 148B.1751, is amended to read:

39.2 **148B.1751 DUTY TO WARN.**

39.3 (a) A licensee must comply with the duty to warn established in section 148.975.

39.4 (b) For purposes of this section, "licensee" includes students or interns practicing
39.5 marriage and family therapy under qualified supervision as part of an accredited
39.6 educational program or under a supervised postgraduate experience in marriage and
39.7 family therapy required for licensure.

39.8 Sec. 4. Minnesota Statutes 2014, section 148F.13, subdivision 2, is amended to read:

39.9 Subd. 2. **Duty to warn; limitation on liability.** (a) Private information may be
39.10 disclosed without the consent of the client when a duty to warn arises, or as otherwise
39.11 provided by law or court order. The duty to warn of, or take reasonable precautions to
39.12 provide protection from, violent behavior arises only when a client or other person has
39.13 communicated to the provider a specific, serious threat of physical violence to self or a
39.14 specific, clearly identified or identifiable potential victim. If a duty to warn arises, the duty
39.15 is discharged by the provider if reasonable efforts are made to communicate the threat to
39.16 law enforcement agencies, the potential victim, the family of the client, or appropriate
39.17 third parties who are in a position to prevent or avert the harm. No monetary liability
39.18 and no cause of action or disciplinary action by the board may arise against a provider
39.19 for disclosure of confidences to third parties, for failure to disclose confidences to third
39.20 parties, or for erroneous disclosure of confidences to third parties in a good faith effort to
39.21 warn against or take precautions against a client's violent behavior or threat of suicide.

39.22 (b) For purposes of this subdivision, "provider" includes alcohol and drug counseling
39.23 practicum students and individuals who are participating in a postdegree professional
39.24 practice in alcohol and drug counseling.

39.25 Sec. 5. Minnesota Statutes 2014, section 245A.11, subdivision 2a, is amended to read:

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

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

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

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

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

40.10 (e) The commissioner may grant a variance to paragraph (b) to allow for the use of
40.11 ~~a fifth~~ an additional bed, up to five, for respite services, as defined in section 245A.02,
40.12 for persons with disabilities, regardless of age, if the variance complies with sections
40.13 245A.03, subdivision 7, and 245A.04, subdivision 9, and approval of the variance is
40.14 recommended by the county in which the licensed facility is located. Respite care may be
40.15 provided under the following conditions:

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

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

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

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

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

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

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

41.4 (i) individualized plan of care;

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

41.6 (iii) individual resident placement agreement under Minnesota Rules, part
41.7 9555.5105, subpart 19, if required;

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

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

41.13 (g) The commissioner shall not issue a new adult foster care license under paragraph
41.14 (f) after June 30, ~~2016~~ 2019. The commissioner shall allow a facility with an adult foster
41.15 care license issued under paragraph (f) before June 30, ~~2016~~ 2019, to continue with a
41.16 capacity of five adults if the license holder continues to comply with the requirements in
41.17 paragraph (f).

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

41.19 Sec. 6. Minnesota Statutes 2015 Supplement, section 256.01, subdivision 12a, is
41.20 amended to read:

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

42.1 (b) A member of the child fatality and near fatality review team shall not disclose
42.2 what transpired during the review, except to carry out the duties of the child fatality and
42.3 near fatality review team. The proceedings and records of the child fatality and near
42.4 fatality review team are protected nonpublic data as defined in section 13.02, subdivision
42.5 13, and are not subject to discovery or introduction into evidence in a civil or criminal
42.6 action against a professional, the state, or a county agency arising out of the matters the
42.7 team is reviewing. Information, documents, and records otherwise available from other
42.8 sources are not immune from discovery or use in a civil or criminal action solely because
42.9 they were assessed or presented during proceedings of the review team. A person who
42.10 presented information before the review team or who is a member of the team shall not
42.11 be prevented from testifying about matters within the person's knowledge. In a civil or
42.12 criminal proceeding a person shall not be questioned about the person's presentation of
42.13 information to the review team or opinions formed by the person as a result of the review.

42.14 Sec. 7. Minnesota Statutes 2014, section 256B.0751, subdivision 3, is amended to read:

42.15 Subd. 3. **Requirements for clinicians certified as health care homes.** (a) A
42.16 personal clinician or a primary care clinic may be certified as a health care home. If a
42.17 primary care clinic is certified, all of the primary care clinic's clinicians must meet the
42.18 criteria of a health care home. In order to be certified as a health care home, a clinician or
42.19 clinic must meet the standards set by the commissioners in accordance with this section.
42.20 Certification as a health care home is voluntary. In order to maintain their status as health
42.21 care homes, clinicians or clinics must renew their certification annually every three years.

42.22 (b) Clinicians or clinics certified as health care homes must offer their health care
42.23 home services to all their patients with complex or chronic health conditions who are
42.24 interested in participation.

42.25 (c) Health care homes must participate in the health care home collaborative
42.26 established under subdivision 5.

42.27 Sec. 8. Minnesota Statutes 2015 Supplement, section 256B.0911, subdivision 3a,
42.28 is amended to read:

42.29 Subd. 3a. **Assessment and support planning.** (a) Persons requesting assessment,
42.30 services planning, or other assistance intended to support community-based living,
42.31 including persons who need assessment in order to determine waiver or alternative care
42.32 program eligibility, must be visited by a long-term care consultation team within 20
42.33 calendar days after the date on which an assessment was requested or recommended.
42.34 Upon statewide implementation of subdivisions 2b, 2c, and 5, this requirement also

43.1 applies to an assessment of a person requesting personal care assistance services and home
43.2 care nursing. The commissioner shall provide at least a 90-day notice to lead agencies
43.3 prior to the effective date of this requirement. Face-to-face assessments must be conducted
43.4 according to paragraphs (b) to (i).

43.5 (b) Upon implementation of subdivisions 2b, 2c, and 5, lead agencies shall use
43.6 certified assessors to conduct the assessment. For a person with complex health care
43.7 needs, a public health or registered nurse from the team must be consulted.

43.8 (c) The MnCHOICES assessment provided by the commissioner to lead agencies
43.9 must be used to complete a comprehensive, person-centered assessment. The assessment
43.10 must include the health, psychological, functional, environmental, and social needs of the
43.11 individual necessary to develop a community support plan that meets the individual's
43.12 needs and preferences.

43.13 (d) The assessment must be conducted in a face-to-face interview with the person
43.14 being assessed and the person's legal representative, ~~and other individuals as requested by~~
43.15 ~~the person, who can provide information on the needs, strengths, and preferences of the~~
43.16 ~~person necessary to develop a community support plan that ensures the person's health and~~
43.17 ~~safety, but who is not a provider of service or has any financial interest in the provision of~~
43.18 ~~services. At the request of the person, other individuals may participate in the assessment~~
43.19 to provide information on the needs, strengths, and preferences of the person necessary
43.20 to develop a community support plan that ensures the person's health and safety. Except
43.21 for legal representatives or family members invited by the person, persons participating
43.22 in the assessment may not be a provider of service or have any financial interest in the
43.23 provision of services. For persons who are to be assessed for elderly waiver customized
43.24 living services under section 256B.0915, with the permission of the person being assessed
43.25 or the person's designated or legal representative, the client's current or proposed provider
43.26 of services may submit a copy of the provider's nursing assessment or written report
43.27 outlining its recommendations regarding the client's care needs. The person conducting
43.28 the assessment must notify the provider of the date by which this information is to be
43.29 submitted. This information shall be provided to the person conducting the assessment
43.30 prior to the assessment. For a person who is to be assessed for waiver services under
43.31 section 256B.092 or 256B.49, with the permission of the person being assessed or the
43.32 person's designated legal representative, the person's current provider of services may
43.33 submit a written report outlining recommendations regarding the person's care needs
43.34 prepared by a direct service employee with at least 20 hours of service to that client. The
43.35 person conducting the assessment or reassessment must notify the provider of the date
43.36 by which this information is to be submitted. This information shall be provided to the

44.1 person conducting the assessment and the person or the person's legal representative, and
44.2 must be considered prior to the finalization of the assessment or reassessment.

44.3 (e) The person or the person's legal representative must be provided with a written
44.4 community support plan within 40 calendar days of the assessment visit, regardless
44.5 of whether the individual is eligible for Minnesota health care programs. The written
44.6 community support plan must include:

44.7 (1) a summary of assessed needs as defined in paragraphs (c) and (d);

44.8 (2) the individual's options and choices to meet identified needs, including all
44.9 available options for case management services and providers;

44.10 (3) identification of health and safety risks and how those risks will be addressed,
44.11 including personal risk management strategies;

44.12 (4) referral information; and

44.13 (5) informal caregiver supports, if applicable.

44.14 For a person determined eligible for state plan home care under subdivision 1a,
44.15 paragraph (b), clause (1), the person or person's representative must also receive a copy of
44.16 the home care service plan developed by the certified assessor.

44.17 (f) A person may request assistance in identifying community supports without
44.18 participating in a complete assessment. Upon a request for assistance identifying
44.19 community support, the person must be transferred or referred to long-term care options
44.20 counseling services available under sections 256.975, subdivision 7, and 256.01,
44.21 subdivision 24, for telephone assistance and follow up.

44.22 (g) The person has the right to make the final decision between institutional
44.23 placement and community placement after the recommendations have been provided,
44.24 except as provided in section 256.975, subdivision 7a, paragraph (d).

44.25 (h) The lead agency must give the person receiving assessment or support planning,
44.26 or the person's legal representative, materials, and forms supplied by the commissioner
44.27 containing the following information:

44.28 (1) written recommendations for community-based services and consumer-directed
44.29 options;

44.30 (2) documentation that the most cost-effective alternatives available were offered to
44.31 the individual. For purposes of this clause, "cost-effective" means community services and
44.32 living arrangements that cost the same as or less than institutional care. For an individual
44.33 found to meet eligibility criteria for home and community-based service programs under
44.34 section 256B.0915 or 256B.49, "cost-effectiveness" has the meaning found in the federally
44.35 approved waiver plan for each program;

45.1 (3) the need for and purpose of preadmission screening conducted by long-term care
45.2 options counselors according to section 256.975, subdivisions 7a to 7c, if the person selects
45.3 nursing facility placement. If the individual selects nursing facility placement, the lead
45.4 agency shall forward information needed to complete the level of care determinations and
45.5 screening for developmental disability and mental illness collected during the assessment
45.6 to the long-term care options counselor using forms provided by the commissioner;

45.7 (4) the role of long-term care consultation assessment and support planning in
45.8 eligibility determination for waiver and alternative care programs, and state plan home
45.9 care, case management, and other services as defined in subdivision 1a, paragraphs (a),
45.10 clause (6), and (b);

45.11 (5) information about Minnesota health care programs;

45.12 (6) the person's freedom to accept or reject the recommendations of the team;

45.13 (7) the person's right to confidentiality under the Minnesota Government Data
45.14 Practices Act, chapter 13;

45.15 (8) the certified assessor's decision regarding the person's need for institutional
45.16 level of care as determined under criteria established in subdivision 4e and the certified
45.17 assessor's decision regarding eligibility for all services and programs as defined in
45.18 subdivision 1a, paragraphs (a), clause (6), and (b); and

45.19 (9) the person's right to appeal the certified assessor's decision regarding eligibility
45.20 for all services and programs as defined in subdivision 1a, paragraphs (a), clauses (6), (7),
45.21 and (8), and (b), and incorporating the decision regarding the need for institutional level of
45.22 care or the lead agency's final decisions regarding public programs eligibility according to
45.23 section 256.045, subdivision 3.

45.24 (i) Face-to-face assessment completed as part of eligibility determination for the
45.25 alternative care, elderly waiver, community access for disability inclusion, community
45.26 alternative care, and brain injury waiver programs under sections 256B.0913, 256B.0915,
45.27 and 256B.49 is valid to establish service eligibility for no more than 60 calendar days
45.28 after the date of assessment.

45.29 (j) The effective eligibility start date for programs in paragraph (i) can never be prior
45.30 to the date of assessment. If an assessment was completed more than 60 days before
45.31 the effective waiver or alternative care program eligibility start date, assessment and
45.32 support plan information must be updated and documented in the department's Medicaid
45.33 Management Information System (MMIS). Notwithstanding retroactive medical assistance
45.34 coverage of state plan services, the effective date of eligibility for programs included in
45.35 paragraph (i) cannot be prior to the date the most recent updated assessment is completed.

46.1 Sec. 9. Minnesota Statutes 2015 Supplement, section 256B.766, is amended to read:

46.2 **256B.766 REIMBURSEMENT FOR BASIC CARE SERVICES.**

46.3 (a) Effective for services provided on or after July 1, 2009, total payments for basic
46.4 care services, shall be reduced by three percent, except that for the period July 1, 2009,
46.5 through June 30, 2011, total payments shall be reduced by 4.5 percent for the medical
46.6 assistance and general assistance medical care programs, prior to third-party liability and
46.7 spenddown calculation. Effective July 1, 2010, the commissioner shall classify physical
46.8 therapy services, occupational therapy services, and speech-language pathology and
46.9 related services as basic care services. The reduction in this paragraph shall apply to
46.10 physical therapy services, occupational therapy services, and speech-language pathology
46.11 and related services provided on or after July 1, 2010.

46.12 (b) Payments made to managed care plans and county-based purchasing plans shall
46.13 be reduced for services provided on or after October 1, 2009, to reflect the reduction
46.14 effective July 1, 2009, and payments made to the plans shall be reduced effective October
46.15 1, 2010, to reflect the reduction effective July 1, 2010.

46.16 (c) Effective for services provided on or after September 1, 2011, through June 30,
46.17 2013, total payments for outpatient hospital facility fees shall be reduced by five percent
46.18 from the rates in effect on August 31, 2011.

46.19 (d) Effective for services provided on or after September 1, 2011, through June
46.20 30, 2013, total payments for ambulatory surgery centers facility fees, medical supplies
46.21 and durable medical equipment not subject to a volume purchase contract, prosthetics
46.22 and orthotics, renal dialysis services, laboratory services, public health nursing services,
46.23 physical therapy services, occupational therapy services, speech therapy services,
46.24 eyeglasses not subject to a volume purchase contract, hearing aids not subject to a volume
46.25 purchase contract, and anesthesia services shall be reduced by three percent from the
46.26 rates in effect on August 31, 2011.

46.27 (e) Effective for services provided on or after September 1, 2014, payments
46.28 for ambulatory surgery centers facility fees, hospice services, renal dialysis services,
46.29 laboratory services, public health nursing services, eyeglasses not subject to a volume
46.30 purchase contract, and hearing aids not subject to a volume purchase contract shall be
46.31 increased by three percent and payments for outpatient hospital facility fees shall be
46.32 increased by three percent. Payments made to managed care plans and county-based
46.33 purchasing plans shall not be adjusted to reflect payments under this paragraph.

46.34 (f) Payments for medical supplies and durable medical equipment not subject to a
46.35 volume purchase contract, and prosthetics and orthotics, provided on or after July 1, 2014,
46.36 through June 30, 2015, shall be decreased by .33 percent. Payments for medical supplies

47.1 and durable medical equipment not subject to a volume purchase contract, and prosthetics
47.2 and orthotics, provided on or after July 1, 2015, shall be increased by three percent from
47.3 the rates as determined under ~~paragraph (i)~~ paragraphs (i) and (j).

47.4 (g) Effective for services provided on or after July 1, 2015, payments for outpatient
47.5 hospital facility fees, medical supplies and durable medical equipment not subject to a
47.6 volume purchase contract, prosthetics and orthotics, and laboratory services to a hospital
47.7 meeting the criteria specified in section 62Q.19, subdivision 1, paragraph (a), clause (4),
47.8 shall be increased by 90 percent from the rates in effect on June 30, 2015. Payments made
47.9 to managed care plans and county-based purchasing plans shall not be adjusted to reflect
47.10 payments under this paragraph.

47.11 (h) This section does not apply to physician and professional services, inpatient
47.12 hospital services, family planning services, mental health services, dental services,
47.13 prescription drugs, medical transportation, federally qualified health centers, rural health
47.14 centers, Indian health services, and Medicare cost-sharing.

47.15 (i) Effective for services provided on or after July 1, 2015, the medical assistance
47.16 payment rate for durable medical equipment, prosthetics, orthotics, or supplies shall
47.17 be restored to the January 1, 2008, medical assistance fee schedule, updated to include
47.18 subsequent rate increases in the Medicare and medical assistance fee schedules, and
47.19 including following categories of durable medical equipment shall be individually priced
47.20 items for the following categories: enteral nutrition and supplies, customized and other
47.21 specialized tracheostomy tubes and supplies, electric patient lifts, and durable medical
47.22 equipment repair and service. This paragraph does not apply to medical supplies and
47.23 durable medical equipment subject to a volume purchase contract, products subject to the
47.24 preferred diabetic testing supply program, and items provided to dually eligible recipients
47.25 when Medicare is the primary payer for the item. The commissioner shall not apply any
47.26 medical assistance rate reductions to durable medical equipment as a result of Medicare
47.27 competitive bidding.

47.28 (j) Effective for services provided on or after July 1, 2015, medical assistance
47.29 payment rates for durable medical equipment, prosthetics, orthotics, or supplies shall
47.30 be increased as follows:

47.31 (1) payment rates for durable medical equipment, prosthetics, orthotics, or supplies
47.32 that were subject to the Medicare competitive bid that took effect in January of 2009 shall
47.33 be increased by 9.5 percent; and

47.34 (2) payment rates for durable medical equipment, prosthetics, orthotics, or supplies
47.35 on the medical assistance fee schedule, whether or not subject to the Medicare competitive

48.1 bid that took effect in January of 2009, shall be increased by 2.94 percent, with this
48.2 increase being applied after calculation of any increased payment rate under clause (1).

48.3 This paragraph does not apply to medical supplies and durable medical equipment subject
48.4 to a volume purchase contract, products subject to the preferred diabetic testing supply
48.5 program, items provided to dually eligible recipients when Medicare is the primary payer
48.6 for the item, and individually priced items identified in paragraph (i). Payments made to
48.7 managed care plans and county-based purchasing plans shall not be adjusted to reflect the
48.8 rate increases in this paragraph.

48.9 **EFFECTIVE DATE.** This section is effective retroactively from July 1, 2015.

48.10 Sec. 10. Minnesota Statutes 2015 Supplement, section 256I.04, subdivision 2a, is
48.11 amended to read:

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

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

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

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

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

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

48.33 (2) a supportive housing establishment (2) that has an approved habitability inspection
48.34 and an individual lease agreement and that serves people who have experienced long-term

49.1 homelessness and were referred through a coordinated assessment in section 256I.03,
49.2 subdivision 15.

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

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

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

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

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

49.12 (iii) experience as a mental health certified peer specialist according to section
49.13 256B.0615; or

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

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

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

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

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

49.23 Sec. 11. Minnesota Statutes 2015 Supplement, section 402A.18, subdivision 3, is
49.24 amended to read:

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

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

49.30 (2) the county or service delivery authority ~~does not meet the minimum performance~~
49.31 ~~threshold for one or more racial or ethnic subgroup for which there is a statistically valid~~
49.32 ~~population size for three or more measures,~~ has a performance disparity for a racial or
49.33 ethnic subgroup, even if the county or service delivery authority met the threshold for the
49.34 overall population. The council shall make recommendations on performance disparities,
49.35 and the commissioner shall make the final determination.

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

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

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

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

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

50.33 (1) fiscal penalties for the county or service delivery authority that do not exceed
50.34 one percent of the county's human services expenditures and that are negotiated in the
50.35 performance improvement plan, based on what is needed to improve outcomes. Counties
50.36 or service delivery authorities must reinvest the amount of the fiscal penalty into the

51.1 essential human services program that was underperforming. A county or service delivery
51.2 authority shall not be required to pay more than three fiscal penalties in a year; and

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

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

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

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

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

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

51.22 Sec. 12. **ACTION PLAN TO INCREASE COMMUNITY INTEGRATION OF**
51.23 **PEOPLE WITH DISABILITIES.**

51.24 The commissioners of human services, education, the Minnesota Housing Finance
51.25 Agency, employment and economic development, and information technology, in
51.26 consultation with stakeholders, including lead agencies, shall develop a collaborative
51.27 action plan in alignment with the state's Olmstead Plan to increase the community
51.28 integration of people with disabilities, including housing, community living, and
51.29 competitive employment. Priority must be given to actions that align policies and funding,
51.30 streamline access to services, and increase efficiencies in interagency collaboration.
51.31 Recommendations must include a proposed method to allow people with disabilities who
51.32 access services from the state agencies identified in this section to access a unified record
51.33 of the services they receive, using existing methods for unified records, where appropriate.
51.34 This method must also allow people with disabilities to efficiently provide information to

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

52.5 **Sec. 13. HOUSING SUPPORT SERVICES.**

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

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

52.11 (1) improve housing stability;

52.12 (2) increase opportunities for integrated community living;

52.13 (3) prevent and reduce homelessness

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

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

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

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

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

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

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

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

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

53.11 **ARTICLE 4**

53.12 **MINNESOTA ELIGIBILITY SYSTEM EXECUTIVE STEERING COMMITTEE**

53.13 Section 1. Minnesota Statutes 2015 Supplement, section 62V.03, subdivision 2, is
53.14 amended to read:

53.15 Subd. 2. **Application of other law.** (a) MNSure must be reviewed by the legislative
53.16 auditor under section 3.971. The legislative auditor shall audit the books, accounts, and
53.17 affairs of MNSure once each year or less frequently as the legislative auditor's funds and
53.18 personnel permit. Upon the audit of the financial accounts and affairs of MNSure, MNSure
53.19 is liable to the state for the total cost and expenses of the audit, including the salaries paid
53.20 to the examiners while actually engaged in making the examination. The legislative
53.21 auditor may bill MNSure either monthly or at the completion of the audit. All collections
53.22 received for the audits must be deposited in the general fund and are appropriated to
53.23 the legislative auditor. Pursuant to section 3.97, subdivision 3a, the Legislative Audit
53.24 Commission is requested to direct the legislative auditor to report by March 1, 2014, to
53.25 the legislature on any duplication of services that occurs within state government as a
53.26 result of the creation of MNSure. The legislative auditor may make recommendations on
53.27 consolidating or eliminating any services deemed duplicative. The board shall reimburse
53.28 the legislative auditor for any costs incurred in the creation of this report.

53.29 (b) Board members of MNSure are subject to sections 10A.07 and 10A.09. Board
53.30 members and the personnel of MNSure are subject to section 10A.071.

53.31 (c) All meetings of the board and of the Minnesota Eligibility System Executive
53.32 Steering Committee established under section 62V.055 shall comply with the open
53.33 meeting law in chapter 13D.

54.1 (d) The board and the Web site are exempt from chapter 60K. Any employee of
54.2 MNsure who sells, solicits, or negotiates insurance to individuals or small employers must
54.3 be licensed as an insurance producer under chapter 60K.

54.4 (e) Section 3.3005 applies to any federal funds received by MNsure.

54.5 (f) A MNsure decision that requires a vote of the board, other than a decision that
54.6 applies only to hiring of employees or other internal management of MNsure, is an
54.7 "administrative action" under section 10A.01, subdivision 2.

54.8 Sec. 2. **[62V.055] MINNESOTA ELIGIBILITY SYSTEM EXECUTIVE**
54.9 **STEERING COMMITTEE.**

54.10 Subdivision 1. **Definition; Minnesota eligibility system.** For purposes of this
54.11 section, "Minnesota eligibility system" means the system that supports eligibility
54.12 determinations using a modified adjusted gross income methodology for medical
54.13 assistance under section 256B.056, subdivision 1a, paragraph (b), clause (1);
54.14 MinnesotaCare under chapter 256L; and qualified health plan enrollment under section
54.15 62V.05, subdivision 5, paragraph (c).

54.16 Subd. 2. **Establishment; committee membership; costs.** (a) The Minnesota
54.17 Eligibility System Executive Steering Committee is established to provide
54.18 recommendations to the MNsure board, the commissioner of human services, and the
54.19 commissioner of MN.IT services on the governance, administration, and business
54.20 operations of the Minnesota eligibility system. The steering committee shall be composed
54.21 of:

54.22 (1) two members appointed by the commissioner of human services;

54.23 (2) two members appointed by the board;

54.24 (3) two members appointed jointly by the Association of Minnesota Counties, the
54.25 Minnesota Inter-County Association, and the Minnesota Association of County Social
54.26 Service Administrators. One member appointed under this clause shall represent counties
54.27 within the seven-county metropolitan area, and one member shall represent counties
54.28 outside the seven-county metropolitan area; and

54.29 (4) two nonvoting members appointed by the commissioner of MN.IT services.

54.30 (b) One member appointed by the commissioner of human services and one member
54.31 appointed by the commissioner of MN.IT services shall serve as co-chairpersons for
54.32 the steering committee.

54.33 (c) Steering committee costs must be paid from the budgets of the Department of
54.34 Human Services, the Office of MN.IT Services, and MNsure.

55.1 Subd. 3. **Duties.** The Minnesota Eligibility System Executive Steering Committee
55.2 shall provide recommendations on an overall governance structure for the Minnesota
55.3 eligibility system and the ongoing administration and business operations of the Minnesota
55.4 eligibility system. The steering committee shall make recommendations on setting system
55.5 goals and priorities, allocating the system's resources, making major system decisions,
55.6 and tracking total funding and expenditures for the system from all sources. The steering
55.7 committee shall also report to the Legislative Oversight Committee on a quarterly basis
55.8 on Minnesota eligibility system funding and expenditures, including amounts received
55.9 in the most recent quarter by funding source and expenditures made in the most recent
55.10 quarter by funding source.

55.11 Subd. 4. **Meetings.** (a) All meetings of the steering committee must:

55.12 (1) be held in the State Office Building, the Minnesota Senate Building, or when
55.13 approved by the Legislative Oversight Committee, another public location with the
55.14 capacity to live stream steering committee meetings; and

55.15 (2) whenever possible, be made available on a Web site for live audio or video
55.16 streaming and be archived on a Web site for playback at a later time.

55.17 (b) The steering committee must:

55.18 (1) as part of every steering committee meeting, provide the opportunity for oral
55.19 and written public testimony and comments on steering committee recommendations
55.20 for the governance, administration, and business operations of the Minnesota eligibility
55.21 system; and

55.22 (2) provide documents under discussion or review by the steering committee to be
55.23 electronically posted on MNsure's Web site. Documents must be provided and posted
55.24 prior to the meeting at which the documents are scheduled for review or discussion.

55.25 (c) All votes of the steering committee must be recorded, with each member's vote
55.26 identified.

55.27 Subd. 5. **Administrative structure.** The Office of MN.IT Services shall be
55.28 responsible for the design, build, maintenance, operation, and upgrade of the information
55.29 technology for the Minnesota eligibility system. In carrying out its duties, the office shall
55.30 consider recommendations made by the steering committee.

55.31 Sec. 3. Minnesota Statutes 2014, section 62V.11, is amended by adding a subdivision
55.32 to read:

55.33 Subd. 5. **Review of Minnesota eligibility system funding and expenditures.** The
55.34 committee shall review quarterly reports submitted by the Minnesota Eligibility System

- 56.1 Executive Steering Committee under section 62V.055, subdivision 3, regarding Minnesota
- 56.2 eligibility system funding and expenditures.

APPENDIX
Article locations in UES2414-1

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