

**SENATE
STATE OF MINNESOTA
NINETIETH SESSION**

S.F. No. 1291

(SENATE AUTHORS: UTKE and Benson)

DATE	D-PG	OFFICIAL STATUS
02/22/2017	703	Introduction and first reading
		Referred to Human Services Reform Finance and Policy
03/02/2017	965a	Comm report: To pass as amended and re-refer to Health and Human Services Finance and Policy
03/09/2017	1254	Author added Benson
03/13/2017	1290a	Comm report: To pass as amended
	1359	Second reading
	6107	Rule 47, returned to Health and Human Services Finance and Policy
		See First Special Session, SF2, Art. 1, Sec. 21, 23-24, 27; Art. 2, Sec. 1-2, 4-7; Art. 8, Sec. 4; Art. 13, Sec. 2

1.1 A bill for an act

1.2 relating to human services; modifying provisions governing children and families

1.3 services, chemical and mental health services, operations, health care, and

1.4 community supports; making various technical corrections; amending Minnesota

1.5 Statutes 2016, sections 144D.04, subdivision 2, by adding a subdivision; 245.095;

1.6 245.462, subdivisions 6, 11; 245.464, subdivision 2; 245.466, subdivision 2;

1.7 245.470, subdivision 2; 245.4871, subdivisions 9a, 14, by adding a subdivision;

1.8 245.4875, subdivision 2; 245.488, subdivision 2; 245.735, subdivision 3; 245.8261,

1.9 subdivision 1; 245A.02, subdivisions 5a, 8, 9, 12, by adding subdivisions; 245A.03,

1.10 subdivisions 1, 7; 245A.04, subdivisions 2, 4, 6, 7, 10, 14, by adding a subdivision;

1.11 245A.05; 245A.11, by adding subdivisions; 245D.02, subdivision 20; 245D.03,

1.12 subdivision 1; 245D.04, subdivision 3; 245D.071, subdivisions 1, 3; 245D.09,

1.13 subdivision 5a; 245D.11, subdivision 4; 245D.24, subdivision 3; 253B.02,

1.14 subdivision 9; 254B.15, subdivisions 4, 5; 256.01, subdivision 29; 256.045,

1.15 subdivision 3; 256B.02, subdivision 7; 256B.04, subdivision 21; 256B.055,

1.16 subdivision 12; 256B.0615; 256B.0616; 256B.0622, subdivisions 2, 2b, 3a, 4, 7a,

1.17 7b; 256B.0623, subdivision 2; 256B.0624, subdivisions 1, 2, 3, 4; 256B.0625,

1.18 subdivisions 35a, 43, 60a; 256B.064, subdivision 1b; 256B.0651, subdivision 17;

1.19 256B.0659, subdivisions 3, 12, 14, 21, 23, 24; 256B.0911, subdivision 3a;

1.20 256B.092, subdivisions 1a, 14; 256B.0943, subdivisions 1, 2, 4, 7, 8, 9; 256B.0946,

1.21 subdivisions 1, 1a, 4, 6; 256B.0947, subdivisions 3a, 7; 256B.49, subdivisions 13,

1.22 25; 256B.4912, by adding a subdivision; 256B.4913, by adding a subdivision;

1.23 256B.4914, subdivisions 3, 5, 8, 16; 256B.84; 256B.85, subdivision 12b; 256D.051,

1.24 subdivisions 1, 1a, 2, 3, 3a, 3b, 6b, 8, 18; 256G.01, subdivision 4; 256G.02,

1.25 subdivision 4; 256G.09, subdivision 2; 256G.10; 256J.751, subdivisions 2, 5, by

1.26 adding subdivisions; 256N.02, subdivisions 10, 16, 17, 18; 256N.22, subdivision

1.27 1; 256N.23, subdivision 6; 256N.24, subdivisions 1, 8, 11, 12, 14; 256P.02,

1.28 subdivisions 1, 1a; 256P.08, subdivision 4; 626.5572, subdivision 21; proposing

1.29 coding for new law in Minnesota Statutes, chapters 245; 245A; repealing Minnesota

1.30 Statutes 2016, sections 119B.125, subdivision 8; 245.469; 245.4879; 256B.0624,

1.31 subdivisions 4a, 5, 6, 7, 8, 9, 10, 11; 256B.0944; Minnesota Rules, parts 9555.6255;

1.32 9555.7100; 9555.7200; 9555.7300; 9555.7600.

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

ARTICLE 1

CHILDREN AND FAMILIES SERVICES

Section 1. Minnesota Statutes 2016, section 256D.051, subdivision 1, is amended to read:

Subdivision 1. **Food stamp employment and training program.** The commissioner shall implement a food stamp employment and training program in order to meet the food stamp employment and training participation requirements of the United States Department of Agriculture. ~~Unless exempt under subdivision 3a, each adult recipient in the unit must participate in the food stamp employment and training program each month that the person is eligible for food stamps. The person's participation in food stamp employment and training services must begin no later than the first day of the calendar month following the determination of eligibility for food stamps. With the county agency's consent, and~~ To the extent of available resources, the person a recipient may voluntarily continue volunteer to participate in food stamp employment and training services for up to three additional consecutive months immediately following termination of food stamp benefits in order to complete the provisions of the person's employability development plan. A recipient who volunteers for employment and training services is subject to the work requirements in Code of Federal Regulations, title 7, section 273.7.

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

Sec. 2. Minnesota Statutes 2016, section 256D.051, subdivision 1a, is amended to read:

Subd. 1a. **Notices and sanctions.** (a) ~~At the time the county agency notifies the household that it is eligible for food stamps, the county agency must inform all mandatory employment and training services participants as identified in subdivision 1 in the household that they must comply with all food stamp employment and training program requirements each month, including the requirement to attend an initial orientation to the food stamp employment and training program and that food stamp eligibility will end unless the participants comply with the requirements specified in the notice~~ an adult of the opportunity to volunteer for and participate in SNAP employment and training activities, provide plain language material that explains the benefits of voluntary participation, and provide the name and address of the county's designated employment and training service provider.

(b) ~~A participant who fails without good cause to comply with food stamp employment and training program requirements of this section, including attendance at orientation, will lose food stamp eligibility for the following periods: The county must inform each recipient who is an able-bodied adult without dependents that the recipient's SNAP benefits are limited~~

to three months in a 36-month period from the first full month of application unless the recipient meets the work requirements in Code of Federal Regulations, title 7, section 273.7.

~~(1) for the first occurrence, for one month or until the person complies with the requirements not previously complied with, whichever is longer;~~

~~(2) for the second occurrence, for three months or until the person complies with the requirements not previously complied with, whichever is longer; or~~

~~(3) for the third and any subsequent occurrence, for six months or until the person complies with the requirements not previously complied with, whichever is longer.~~

~~If the participant is not the food stamp head of household, the person shall be considered an ineligible household member for food stamp purposes. If the participant is the food stamp head of household, the entire household is ineligible for food stamps as provided in Code of Federal Regulations, title 7, section 273.7(g). "Good cause" means circumstances beyond the control of the participant, such as illness or injury, illness or injury of another household member requiring the participant's presence, a household emergency, or the inability to obtain child care for children between the ages of six and 12 or to obtain transportation needed in order for the participant to meet the food stamp employment and training program participation requirements.~~

~~(e) The county agency shall mail or hand deliver a notice to the participant not later than five days after determining that the participant has failed without good cause to comply with food stamp employment and training program requirements which specifies the requirements that were not complied with, the factual basis for the determination of noncompliance, and the right to reinstate eligibility upon a showing of good cause for failure to meet the requirements. The notice must ask the reason for the noncompliance and identify the participant's appeal rights. The notice must request that the participant inform the county agency if the participant believes that good cause existed for the failure to comply and must state that the county agency intends to terminate eligibility for food stamp benefits due to failure to comply with food stamp employment and training program requirements.~~

~~(d) If the county agency determines that the participant did not comply during the month with all food stamp employment and training program requirements that were in effect, and if the county agency determines that good cause was not present, the county must provide a ten-day notice of termination of food stamp benefits. The amount of food stamps that are withheld from the household and determination of the impact of the sanction on other household members is governed by Code of Federal Regulations, title 7, section 273.7.~~

~~(e) The participant may appeal the termination of food stamp benefits under the provisions of section 256.045.~~

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

Sec. 3. Minnesota Statutes 2016, section 256D.051, subdivision 2, is amended to read:

Subd. 2. **County agency duties.** (a) The county agency shall provide to food stamp recipients a food stamp employment and training program. The program must include:

(1) orientation to the food stamp employment and training program;

(2) an individualized employability assessment and an individualized employability development plan that includes assessment of literacy, ability to communicate in the English language, educational and employment history, and that estimates the length of time it will take the participant to obtain employment. The employability assessment and development plan must be completed in consultation with the participant, must assess the participant's assets, barriers, and strengths, and must identify steps necessary to overcome barriers to employment. A copy of the employability development plan must be provided to the registrant;

(3) referral to available accredited remedial or skills training or career pathways programs designed to address participant's barriers to employment;

(4) referral to available programs that provide subsidized or unsubsidized employment as necessary;

(5) a job search program, including job seeking skills training; and

(6) other activities, to the extent of available resources designed by the county agency to prepare the participant for permanent employment.

~~In order to allow time for job search, the county agency may not require an individual to participate in the food stamp employment and training program for more than 32 hours a week. The county agency shall require an individual to spend at least eight hours a week in job search or other food stamp employment and training program activities.~~

(b) The county agency shall prepare an annual plan for the operation of its food stamp employment and training program. The plan must be submitted to and approved by the commissioner of employment and economic development. The plan must include:

(1) a description of the services to be offered by the county agency;

(2) a plan to coordinate the activities of all public entities and private nonprofit entities providing employment-related services in order to avoid duplication of effort and to provide a wide range of allowable activities and services more efficiently;

(3) a description of the factors that will be taken into account when determining a client's employability development plan; and

(4) provisions to ensure that ~~the~~ a county agency's employment and training service provider provides each recipient with an orientation, employability assessment, and employability development plan as specified in paragraph (a), clauses (1) and (2), within 30 days of the recipient's ~~eligibility for assistance~~ request to participate in employment and training.

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

Sec. 4. Minnesota Statutes 2016, section 256D.051, subdivision 3, is amended to read:

Subd. 3. **Participant duties.** In order to receive food stamp ~~assistance~~ employment and training services, a ~~registrant~~ participant who volunteers shall: (1) cooperate with the county agency in all aspects of the food stamp employment and training program; and (2) ~~accept any suitable employment, including employment offered through the Job Training Partnership Act, and other employment and training options;~~ and (3) participate in food stamp employment and training activities assigned by the county agency. The county agency may terminate employment and training assistance to a ~~registrant~~ voluntary participant who fails to cooperate in the food stamp employment and training program, ~~as provided in subdivision 4a~~ unless good cause is provided.

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

Sec. 5. Minnesota Statutes 2016, section 256D.051, subdivision 3a, is amended to read:

Subd. 3a. **Requirement to register work.** (a) To the extent required under Code of Federal Regulations, title 7, section 273.7(a), each applicant for and recipient of food stamps is required to register for work as a condition of eligibility for food stamp benefits. Applicants and recipients are registered by signing an application or annual reapplication for food stamps, and must be informed that they are registering for work by signing the form.

~~(b) The commissioner shall determine, within federal requirements, persons required to participate in the food stamp employment and training (FSET) program.~~

~~(c) The following food stamp recipients are exempt from mandatory participation in food stamp employment and training services:~~

~~(1) recipients of benefits under the Minnesota family investment program, Minnesota supplemental aid program, or the general assistance program;~~

~~(2) a child;~~

~~(3) a recipient over age 55;~~

~~(4) a recipient who has a mental or physical illness, injury, or incapacity which is expected to continue for at least 30 days and which impairs the recipient's ability to obtain or retain employment as evidenced by professional certification or the receipt of temporary or permanent disability benefits issued by a private or government source;~~

~~(5) a parent or other household member responsible for the care of either a dependent child in the household who is under age six or a person in the household who is professionally certified as having a physical or mental illness, injury, or incapacity. Only one parent or other household member may claim exemption under this provision;~~

~~(6) a recipient receiving unemployment insurance or who has applied for unemployment insurance and has been required to register for work with the Department of Employment and Economic Development as part of the unemployment insurance application process;~~

~~(7) a recipient participating each week in a drug addiction or alcohol abuse treatment and rehabilitation program, provided the operators of the treatment and rehabilitation program, in consultation with the county agency, recommend that the recipient not participate in the food stamp employment and training program;~~

~~(8) a recipient employed or self-employed for 30 or more hours per week at employment paying at least minimum wage, or who earns wages from employment equal to or exceeding 30 hours multiplied by the federal minimum wage; or~~

~~(9) a student enrolled at least half time in any school, training program, or institution of higher education. When determining if a student meets this criteria, the school's, program's or institution's criteria for being enrolled half time shall be used.~~

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

Sec. 6. Minnesota Statutes 2016, section 256D.051, subdivision 3b, is amended to read:

Subd. 3b. **Orientation.** The county agency or its employment and training service ~~provider~~ providers must provide an orientation to food stamp employment and training services to each ~~nonexempt food stamp~~ recipient within 30 days of the date ~~that food stamp eligibility is determined~~ the recipient agreed to volunteer. The orientation must inform the participant of the ~~requirement to participate~~ benefits of participating in services, the date,

time, and address to report to for services, the name and telephone number of the food stamp employment and training service provider, the consequences for failure without good cause to comply, the services and support services available through food stamp employment and training services and other providers of similar services, and must encourage the participant to view the food stamp program as a temporary means of supplementing the family's food needs until the family achieves self-sufficiency through employment. The orientation may be provided through audio-visual methods, but the participant must have the opportunity for face-to-face interaction with county agency staff.

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

Sec. 7. Minnesota Statutes 2016, section 256D.051, subdivision 6b, is amended to read:

Subd. 6b. **Federal reimbursement.** (a) Federal financial participation from the United States Department of Agriculture for food stamp employment and training expenditures that are eligible for reimbursement through the food stamp employment and training program are dedicated funds and are annually appropriated to the commissioner of human services for the operation of the food stamp employment and training program.

(b) The appropriation must be used for skill attainment through employment, training, and support services for food stamp participants. By February 15, 2017, the commissioner shall report to the chairs and ranking minority members of the legislative committees having jurisdiction over the food stamp employment and training program on the progress of securing additional federal reimbursement dollars under this program.

(c) Federal financial participation for the nonstate portion of food stamp employment and training costs must be paid to the county agency or service provider that incurred the costs at a rate to be determined by the Departments of Human Services and Employment and Economic Development.

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

Sec. 8. Minnesota Statutes 2016, section 256D.051, subdivision 8, is amended to read:

Subd. 8. **Voluntary quit.** A person who is required to participate in food stamp employment and training services is not eligible for food stamps if, without good cause, the person refuses a legitimate offer of, or quits, suitable employment within ~~60~~ 30 days before the date of application. A person who is required to participate in food stamp employment and training services and, without good cause, voluntarily quits suitable employment or

refuses a legitimate offer of suitable employment while receiving food stamps shall be terminated from the food stamp program as specified in subdivision 1a.

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

Sec. 9. Minnesota Statutes 2016, section 256D.051, subdivision 18, is amended to read:

Subd. 18. **Work experience placements.** (a) To the extent of available resources, each county agency ~~must~~ may establish and operate a work experience component in the food stamp employment and training program for recipients who are subject to a federal limit of three months of food stamp eligibility in any 36-month period. The purpose of the work experience component is to enhance the participant's employability, self-sufficiency, and to provide meaningful, productive work activities.

(b) The commissioner shall assist counties in the design and implementation of these components. The commissioner must ensure that job placements under a work experience component comply with section 256J.72. Written or oral concurrence with job duties of persons placed under the community work experience program shall be obtained from the appropriate exclusive bargaining representative.

(c) Worksites developed under this section are limited to projects that serve a useful public service such as health, social service, environmental protection, education, urban and rural development and redevelopment, welfare, recreation, public facilities, public safety, community service, services to aged or disabled citizens, and child care. To the extent possible, the prior training, skills, and experience of a recipient must be used in making appropriate work experience assignments.

(d) Structured, supervised ~~volunteer~~ uncompensated work with an agency or organization that is monitored by the county service provider may, with the approval of the county agency, be used as a work experience placement.

(e) As a condition of placing a person receiving food stamps in a program under this subdivision, the county agency shall first provide the recipient the opportunity:

(1) for placement in suitable subsidized or unsubsidized employment through participation in job search under section 256D.051; ~~or~~

(2) for placement in suitable employment through participation in ~~on-the-job training~~ a paid work experience, if such employment is available; or

(3) for placement in an educational program designed to increase job skills and employability.

(f) The county agency shall limit the maximum monthly number of hours that any participant may work in a work experience placement to a number equal to the amount of the family's monthly food stamp allotment divided by the greater of the federal minimum wage or the applicable state minimum wage.

After a participant has been assigned to a position for nine months, the participant may not continue in that assignment unless the maximum number of hours a participant works is no greater than the amount of the food stamp benefit divided by the rate of pay for individuals employed in the same or similar occupations by the same employer at the same site.

(g) The participant's employability development plan must include the length of time needed in the work experience program, the need to continue job seeking activities while participating in work experience, and the participant's employment goals.

(h) After each six months of a recipient's participation in a work experience job placement, and at the conclusion of each work experience assignment under this section, the county agency shall reassess and revise, as appropriate, the participant's employability development plan.

(i) A participant has good cause for failure to cooperate with a work experience job placement if, in the judgment of the employment and training service provider, the reason for failure is reasonable and justified. ~~Good cause for purposes of this section is defined in subdivision 1a, paragraph (b).~~

(j) A recipient who has failed without good cause to participate in or comply with the work experience job placement shall be terminated from participation in work experience job activities. ~~If the recipient is not exempt from mandatory food stamp employment and training program participation under subdivision 3a, the recipient will be assigned to other mandatory program activities. If the recipient is exempt from mandatory participation but is participating as a volunteer, the person shall be terminated from the food stamp employment and training program.~~

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

Sec. 10. Minnesota Statutes 2016, section 256J.751, subdivision 2, is amended to read:

Subd. 2. **Quarterly comparison report TANF work participation rates.** ~~(a) The commissioner shall report quarterly to all counties on each county's performance on the following measures:~~

~~(1) percent of MFIP caseload working in paid employment;~~

- 10.1 ~~(2) percent of MFIP caseload receiving only the food portion of assistance;~~
- 10.2 ~~(3) number of MFIP cases that have left assistance;~~
- 10.3 ~~(4) median placement wage rate;~~
- 10.4 ~~(5) caseload by months of TANF assistance;~~
- 10.5 ~~(6) percent of MFIP and diversionary work program (DWP) cases off cash assistance~~
 10.6 ~~or working 30 or more hours per week at one-year, two-year, and three-year follow-up~~
 10.7 ~~points from a baseline quarter. This measure is called the self-support index. The~~
 10.8 ~~commissioner shall report quarterly an expected range of performance for each county,~~
 10.9 ~~county grouping, and tribe on the self-support index. The expected range shall be derived~~
 10.10 ~~by a statistical methodology developed by the commissioner in consultation with the counties~~
 10.11 ~~and tribes. The statistical methodology shall control differences across counties in economic~~
 10.12 ~~conditions and demographics of the MFIP and DWP case load; and~~
- 10.13 ~~(7) the TANF work participation rate, defined as the participation requirements specified~~
 10.14 ~~under Public Law 109-171, the Deficit Reduction Act of 2005.~~

- 10.15 ~~(b)~~ The commissioner shall not apply the limits on vocational educational training and
 10.16 education activities under Code of Federal Regulations, title 45, section 261.33(c), when
 10.17 determining TANF work participation rates for individual counties under this subdivision.

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

- 10.19 Sec. 11. Minnesota Statutes 2016, section 256J.751, is amended by adding a subdivision
 10.20 to read:

10.21 Subd. 2a. Comparison reports. The commissioner, in cooperation with counties, tribes,
 10.22 and employment services agencies, shall develop and provide monthly and quarterly reports
 10.23 to all counties, tribes, and employment service agencies on each county's and tribe's
 10.24 performance, including work participation rate and racial and geographic data that measures
 10.25 disparities within MFIP.

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

- 10.27 Sec. 12. Minnesota Statutes 2016, section 256J.751, is amended by adding a subdivision
 10.28 to read:

10.29 Subd. 4a. Self-support index. The self-support index is the percentage of MFIP and
 10.30 diversionary work program (DWP) cases off cash assistance or working 30 hours or more
 10.31 per week at one-, two-, and three-year follow-up points from a baseline quarter. The

11.1 commissioner shall report quarterly an expected range of performance for each county,
 11.2 county grouping, and tribe on the self-support index. The expected range shall be based on
 11.3 a statistical methodology developed by the commissioner in consultation with the counties
 11.4 and tribes. The statistical methodology shall control differences across counties in economic
 11.5 conditions and demographics of the MFIP and DWP caseload.

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

11.7 Sec. 13. Minnesota Statutes 2016, section 256J.751, subdivision 5, is amended to read:

11.8 Subd. 5. **Failure to meet federal performance standards.** (a) If sanctions occur for
 11.9 failure to meet the performance standards specified in title 1 of Public Law 104-193 of the
 11.10 Personal Responsibility and Work Opportunity Act of 1996, and under Public Law 109-171,
 11.11 the Deficit Reduction Act of 2005, the state shall pay 88 percent of the sanction. The
 11.12 remaining 12 percent of the sanction will be paid by the counties. The county portion of the
 11.13 sanction will be distributed across all counties in proportion to each county's percentage of
 11.14 the MFIP average monthly caseload during the period for which the sanction was applied.

11.15 (b) If a county fails to meet the performance standards specified in title 1 of Public Law
 11.16 104-193 of the Personal Responsibility and Work Opportunity Act of 1996, and Public Law
 11.17 109-171, the Deficit Reduction Act of 2005, for any year, the commissioner shall work with
 11.18 counties to organize a joint state-county technical assistance team to work with the county.
 11.19 The commissioner shall coordinate any technical assistance with other departments and
 11.20 agencies including the Departments of Employment and Economic Development and
 11.21 Education as necessary to achieve the purpose of this paragraph.

11.22 (c) For state performance measures, a low-performing county is one that:

11.23 (1) performs below the bottom of their expected range for the measure in subdivision
 11.24 ~~2, clause (6), 5~~ in an annualized measurement reported in October of each year; or

11.25 (2) performs below 40 percent for the ~~measure in subdivision 2, clause (7)~~ TANF work
 11.26 participation rate, as averaged across the four quarterly measurements for the year, or the
 11.27 ten counties with the lowest rates if more than ten are below 40 percent.

11.28 (d) Low-performing counties under paragraph (c) must engage in corrective action
 11.29 planning as defined by the commissioner. The commissioner may coordinate technical
 11.30 assistance as specified in paragraph (b) for low-performing counties under paragraph (c).

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

12.1 Sec. 14. Minnesota Statutes 2016, section 256N.02, subdivision 10, is amended to read:

12.2 Subd. 10. **Financially responsible agency.** "Financially responsible agency" means the
12.3 agency that is financially responsible for a child. These agencies include both local social
12.4 service agencies under section 393.07 and tribal social service agencies authorized in section
12.5 256.01, subdivision 14b, as part of the American Indian Child Welfare Initiative, and
12.6 Minnesota tribes who assume financial responsibility of children from other states. Under
12.7 Northstar Care for Children, the agency that is financially responsible at the time of placement
12.8 for foster care continues to be responsible under section 256N.27 for the local share of any
12.9 maintenance payments, even after finalization of the adoption ~~of~~ or transfer of permanent
12.10 legal and physical custody of a child.

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

12.12 Sec. 15. Minnesota Statutes 2016, section 256N.02, subdivision 16, is amended to read:

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

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

12.26 Sec. 16. Minnesota Statutes 2016, section 256N.02, subdivision 17, is amended to read:

12.27 Subd. 17. **Reassessment.** "Reassessment" means an update of a previous assessment
12.28 through the process under section 256N.24 for a child who has been continuously eligible
12.29 for Northstar Care for Children, or when a child identified as an at-risk child (Level A)
12.30 under ~~guardianship or~~ adoption assistance has manifested the disability upon which eligibility
12.31 for the agreement was based according to section 256N.25, subdivision 3, paragraph (b).
12.32 A reassessment may be used to update an initial assessment, a special assessment, or a
12.33 previous reassessment.

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

13.2 Sec. 17. Minnesota Statutes 2016, section 256N.02, subdivision 18, is amended to read:

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

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

13.11 Sec. 18. Minnesota Statutes 2016, section 256N.22, subdivision 1, is amended to read:

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

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

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

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

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

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

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

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

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

14.8 (3) meet the agency determinations regarding permanency requirements in subdivision
14.9 2;

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

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

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

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

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

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

14.30 Sec. 19. Minnesota Statutes 2016, section 256N.23, subdivision 6, is amended to read:

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

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

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

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

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

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

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

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

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

15.20 Sec. 20. Minnesota Statutes 2016, section 256N.24, subdivision 1, is amended to read:

15.21 Subdivision 1. **Assessment.** (a) Each child eligible under sections 256N.21, 256N.22,
15.22 and 256N.23, must be assessed to determine the benefits the child may receive under section
15.23 256N.26, in accordance with the assessment tool, process, and requirements specified in
15.24 subdivision 2.

15.25 (b) If an agency applies the emergency foster care rate for initial placement under section
15.26 256N.26, the agency may wait up to 30 days to complete the initial assessment.

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

15.29 (d) An assessment must not be completed for:

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

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

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

Sec. 21. Minnesota Statutes 2016, section 256N.24, subdivision 8, is amended to read:

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

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

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

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

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

Sec. 22. Minnesota Statutes 2016, section 256N.24, subdivision 11, is amended to read:

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

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

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

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

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

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

Sec. 23. Minnesota Statutes 2016, section 256N.24, subdivision 12, is amended to read:

Subd. 12. Approval of initial assessments, special assessments, and reassessments.

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

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

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

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

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

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

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

Sec. 25. Minnesota Statutes 2016, section 256P.02, subdivision 1, is amended to read:

Subdivision 1. **Property ownership.** (a) The agency must apply paragraphs (b) to (e) to determine the value of personal property. The agency must use the equity value of legally available personal property to determine whether an applicant or participant is eligible for assistance.

(b) When personal property is jointly owned by two or more persons, the agency shall assume that each person owns an equal share, except that either person owns the entire sum of a joint personal checking or savings account. When an applicant or participant documents greater or lesser ownership, the agency must use that greater or lesser share to determine the equity value held by the applicant or participant. Other types of ownership must be evaluated according to law.

(c) Personal property owned by the applicant or participant must be presumed legally available to the applicant or participant unless the applicant or participant documents that the property is not legally available to the applicant or participant. When personal property is not legally available, its equity value must not be applied against the limits of subdivision 2.

(d) An applicant must disclose whether the applicant has transferred personal property valued in excess of the property limits in subdivision 2 for which reasonable compensation was not received within one year prior to application. A participant must disclose all transfers of property valued in excess of these limits, according to the reporting requirements in section 256J.30, subdivision 9. When a transfer of personal property without reasonable compensation has occurred:

(1) the person who transferred the property must provide the property's description, information needed to determine the property's equity value, the names of the persons who received the property, and the circumstances of and reasons for the transfer; and

(2) when the transferred property can be reasonably reacquired, or when reasonable compensation can be secured, the property is presumed legally available to the applicant or participant.

(e) A participant may build the equity value of personal property to the limits in subdivision 2.

(f) Any lump sum payment that remains in the third month after the month of receipt is counted in the asset limit.

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

Sec. 26. Minnesota Statutes 2016, section 256P.02, subdivision 1a, is amended to read:

Subd. 1a. **Exemption.** Participants who qualify for child care assistance programs under chapter 119B and funds under chapter 256Q are exempt from this section.

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

ARTICLE 2

CHEMICAL AND MENTAL HEALTH SERVICES

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

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

(1) client outreach;

(2) medication monitoring;

(3) assistance in independent living skills;

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

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

(6) psychosocial rehabilitation;

(7) help in applying for government benefits; and

(8) housing support services.

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

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

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

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

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

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

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

(1) the provision of locally available ~~emergency~~ crisis services;

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

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

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

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

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

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

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

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

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

(3) outpatient services in accordance with section 245.470;

- 21.1 (4) community support program services in accordance with section 245.4711;
- 21.2 (5) residential treatment services in accordance with section 245.472;
- 21.3 (6) acute care hospital inpatient treatment services in accordance with section 245.473;
- 21.4 (7) regional treatment center inpatient services in accordance with section 245.474;
- 21.5 (8) screening in accordance with section 245.476; and
- 21.6 (9) case management in accordance with sections 245.462, subdivision 3; and 245.4711.
- 21.7 **EFFECTIVE DATE.** This section is effective August 1, 2017.

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

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

- 21.11 (1) meet the professional qualifications contained in sections 245.461 to 245.486;
- 21.12 (2) use a multidisciplinary mental health professional staff including at a minimum,
21.13 arrangements for psychiatric consultation, licensed psychologist consultation, and other
21.14 necessary multidisciplinary mental health professionals;
- 21.15 (3) develop individual treatment plans;
- 21.16 (4) provide initial appointments within three weeks, except in emergencies where there
21.17 must be immediate access as described in section ~~245.469~~ 245.991; and
- 21.18 (5) establish fee schedules approved by the county board that are based on a client's
21.19 ability to pay.

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

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

21.22 Subd. 9a. **Crisis assistance planning.** "Crisis assistance planning" means ~~assistance to~~
21.23 ~~the child, the child's family, and all providers of services to the child to:~~ recognize factors
21.24 ~~precipitating a mental health crisis, identify behaviors related to the crisis, and be informed~~
21.25 ~~of available resources to resolve the crisis. Crisis assistance requires the development of a~~
21.26 ~~plan which addresses prevention and intervention strategies to be used in a potential crisis.~~
21.27 ~~Other interventions include: (1) arranging for admission to acute care hospital inpatient~~
21.28 ~~treatment; (2) crisis placement; (3) community resources for follow-up; and (4) emotional~~
21.29 ~~support to the family during crisis. Crisis assistance does not include services designed to~~
21.30 ~~secure the safety of a child who is at risk of abuse or neglect or necessary emergency services.~~

22.1 the development of a written plan to assist a child's family to contend with a potential crisis
22.2 and is distinct from the immediate provision of intervention services as defined in section
22.3 245.991, subdivision 2, paragraph (g). The plan must address prevention and intervention
22.4 strategies to be used in a crisis. The plan identify factors that might precipitate a crisis and
22.5 behaviors related to the emergence of a crisis, and the resources available to resolve a crisis.

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

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

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

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

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

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

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

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

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

22.18 (4) outpatient services according to section 245.488;

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

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

22.21 (7) residential treatment services according to section 245.4882;

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

22.23 (9) screening according to section 245.4885;

22.24 (10) case management according to section 245.4881;

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

22.26 (12) professional home-based family treatment according to section 245.4884, subdivision
22.27 4; and

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

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

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

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

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

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

23.9 (3) develops individual treatment plans; and

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

25.1 (15) be enrolled to provide mental health targeted case management under section
25.2 256B.0625, subdivision 20;

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

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

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

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

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

25.30 (e) The commissioner shall issue a list of required evidence-based practices to be
25.31 delivered by CCBHCs, and may also provide a list of recommended evidence-based practices.
25.32 The commissioner may update the list to reflect advances in outcomes research and medical
25.33 services for persons living with mental illnesses or substance use disorders. The commissioner
25.34 shall take into consideration the adequacy of evidence to support the efficacy of the practice,

the quality of workforce available, and the current availability of the practice in the state. At least 30 days before issuing the initial list and any revisions, the commissioner shall provide stakeholders with an opportunity to comment.

(f) The commissioner shall establish standards and methodologies for a prospective payment system for medical assistance payments for services delivered by certified community behavioral health clinics, in accordance with guidance issued by the Centers for Medicare and Medicaid Services. During the operation of the demonstration project, payments shall comply with federal requirements for an enhanced federal medical assistance percentage. The commissioner may include quality bonus payment in the prospective payment system based on federal criteria and on a clinic's provision of the evidence-based practices in paragraph (e). The prospective payment system does not apply to MinnesotaCare. Implementation of the prospective payment system is effective July 1, 2017, or upon federal approval, whichever is later.

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

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

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

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

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

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

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

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

27.4 (1) emergency services as defined in sections 245.4871, subdivision 14, and ~~245.4879~~
27.5 245.991;

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

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

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

27.9 (5) professional home-based family treatment as defined in sections 245.4871, subdivision
27.10 31, and 245.4884, subdivision 3; and

27.11 (6) mental health crisis services as defined in sections 245.4871, subdivision 24a, and
27.12 245.488, subdivision 3.

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

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

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

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

27.28 (b) Crisis services must:

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

27.30 (2) minimize further deterioration of a recipient;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(k) "Stabilization services" means individualized mental health services provided to a recipient following intervention services that are designed to restore the recipient to the recipient's prior functional level. Stabilization services does not include inpatient, partial hospitalization, or day treatment. Stabilization services include family psychoeducation.

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

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

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

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

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

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

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

(b) The commissioner shall establish a process for decertification of a provider entity and shall require corrective action, medical assistance repayment, or decertification of a provider entity that no longer meets the requirements in this section or that fails to meet the clinical quality standards or administrative standards provided by the commissioner in the application and certification process.

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

(1) operated by a county board;

(2) under a provider contract with the county board in the county where the potential crisis occurs. To provide services under this clause, the provider entity must directly provide

30.1 the service or, if the service is subcontracted, maintain responsibility for the service and
30.2 billing; or

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

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

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

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

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

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

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

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

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

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

30.23 (9) coordinate with and recommend the use of crisis services by other responders,
30.24 including 911 dispatch, community hospitals, ambulance services, transportation services,
30.25 social services, law enforcement, and schools through regularly scheduled interagency
30.26 meetings;

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

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

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

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

(14) submit information as required by the state;

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

(16) establish and maintain a quality assurance and evaluation plan to evaluate the outcomes of services and recipient satisfaction, including notifying recipients of the process by which the county accepts and responds to concerns;

(17) maintain records as required by applicable laws;

(18) comply with all applicable laws and statutes;

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

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

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

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

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

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

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

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

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

32.6 (1) mental health professional;

32.7 (2) mental health practitioner;

32.8 (3) certified peer specialist; or

32.9 (4) certified family peer specialist.

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

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

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

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

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

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

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

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

32.30 (5) document significant factors related to the determination of a crisis, including prior
32.31 calls to the crisis team, recent presentation at an emergency department, known calls to 911

33.1 or law enforcement, or the presence of third parties with knowledge of a potential recipient's
33.2 history or current needs;

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

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

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

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

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

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

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

33.19 (f) A crisis team shall consider input from a recipient, the recipient's guardian, or the
33.20 recipient's family whenever possible in determining if a potential crisis exists and face-to-face
33.21 assessment is necessary.

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

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

(c) A crisis team shall consider input from a recipient, the recipient's guardian, or the recipient's family whenever possible in determining if a crisis exists.

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

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

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

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

(2) include measurable short-term goals;

(3) address cultural considerations;

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

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

(c) If the crisis team refers a recipient to an acute setting, as described in subdivision 7, paragraph (d), a crisis team member must send a copy of the crisis intervention treatment plan by secure electronic transmission to the provider entity to which the recipient was

referred. This release shall occur with the recipient's consent, the recipient's legal guardian's consent, or as allowed by section 144.293, subdivision 5.

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

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

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

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

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

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

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

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

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

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

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

(1) a mental health professional;

(2) a mental health practitioner;

(3) a certified peer specialist;

(4) a certified family peer specialist; or

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

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

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

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

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

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

(4) the mental health professional must:

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

(ii) document the consultation; and

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

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

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

37.8 (7) specific consultation and approval must be obtained from the mental health
37.9 professional before a mental health practitioner acts as a health officer as defined in section
37.10 253B.02, subdivision 9.

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

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

37.19 (2) signed release forms;

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

37.21 (4) emergency contacts for the recipient;

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

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

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

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

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

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

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

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

- (1) problems identified in the assessment;
- (2) the recipient's strengths and resources;
- (3) concrete, measurable short-term goals to be achieved, including time frames for achievement;
- (4) specific objectives directed toward achieving each goal;
- (5) planned frequency and type of service initiated;
- (6) a crisis response action plan;
- (7) progress notes on the outcome of goals;
- (8) each specific provider, when applicable; and
- (9) a documentation of the participants involved in the service planning. The recipient, if possible, must be a participant.

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

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

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

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

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

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

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

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

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

Subd. 20. **Mental health crisis intervention team.** "Mental health crisis intervention team" means a mental health crisis response provider as identified in section ~~256B.0624~~, ~~subdivision 2, paragraph (d), for adults, and in section 256B.0944, subdivision 1, paragraph (d), for children~~ 245.991.

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

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

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

(1) a licensed physician;

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

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

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

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

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

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

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

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

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

256B.0615 MENTAL HEALTH CERTIFIED PEER SPECIALIST.

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

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

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

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

(3) is individualized to the consumer; and

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

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

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

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

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

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

41.3 **256B.0616 MENTAL HEALTH CERTIFIED FAMILY PEER SPECIALIST.**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Subd. 5. **Certified family peer specialist training and certification.** The commissioner shall develop a training and certification process for certified family peer specialists who must be at least 21 years of age and have a high school diploma or its equivalent. The candidates must have raised or be currently raising a child with a mental illness, have had experience navigating the children's mental health system, and must demonstrate leadership and advocacy skills and a strong dedication to family-driven and family-focused services. The training curriculum must teach ~~participating family peer specialists~~ specific skills ~~relevant to providing~~ provide peer support to other parents. In addition to initial training and certification, the commissioner shall develop ongoing continuing educational workshops on pertinent issues related to family peer support ~~counseling~~ services.

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

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

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

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

(c) "Assertive community treatment" means intensive nonresidential treatment and rehabilitative mental health services provided according to the assertive community treatment model. Assertive community treatment provides a single, fixed point of responsibility for treatment, rehabilitation, and support needs for clients. Services are offered 24 hours per day, seven days per week, in a community-based setting.

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

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

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

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

(h) "Crisis assessment and intervention" means mental health crisis response services as defined in section ~~256B.0624, subdivision 2, paragraphs (c) to (e)~~ 245.991, subdivisions 7 to 9.

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

(j) "Family psychoeducation and support" means services provided to the client's family and other natural supports to restore and strengthen the client's unique social and family relationships. Services include, but are not limited to, individualized psychoeducation about the client's illness and the role of the family and other significant people in the therapeutic process; family intervention to restore contact, resolve conflict, and maintain relationships with family and other significant people in the client's life; ongoing communication and collaboration between the ACT team and the family; introduction and referral to family

self-help programs and advocacy organizations that promote recovery and family engagement, individual supportive counseling, parenting training, and service coordination to help clients fulfill parenting responsibilities; coordinating services for the child and restoring relationships with children who are not in the client's custody; and coordinating with child welfare and family agencies, if applicable. These services must be provided with the client's agreement and consent.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Subd. 7a. **Assertive community treatment team staff requirements and roles.** (a)

The required treatment staff qualifications and roles for an ACT team are:

(1) the team leader:

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

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

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

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

(2) the psychiatric care provider:

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

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

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

47.1 nonpsychiatric medical conditions and nonpsychiatric medications; and conduct home and
47.2 community visits;

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

47.6 (v) shall have a minimum full-time equivalency that is prorated at a rate of 16 hours per
47.7 50 clients. Part-time psychiatric care providers shall have designated hours to work on the
47.8 team, with sufficient blocks of time on consistent days to carry out the provider's clinical,
47.9 supervisory, and administrative responsibilities. No more than two psychiatric care providers
47.10 may share this role;

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

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

47.16 (3) the lead mental health professional:

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

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

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

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

48.1 ~~(3)~~ (4) the nursing staff:

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

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

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

48.14 ~~(4)~~ (5) the co-occurring disorder specialist:

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

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

48.28 ~~(5)~~ (6) the employment and vocational specialist:

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

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

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

~~(6)~~ (7) the mental health certified peer specialist:

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

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

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

~~(7)~~ (8) the program administrative assistant shall be a full-time office-based program administrative assistant position assigned to solely work with the ACT team, providing a range of supports to the team, clients, and families; and

~~(8)~~ (9) additional staff:

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

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

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

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

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

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

Sec. 19. Minnesota Statutes 2016, section 256B.0622, subdivision 7b, is amended to read:

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

(1) a small ACT team must:

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

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

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

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

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

51.1 ACT team staff are available to see clients face-to-face when necessary or if requested by
51.2 the crisis-intervention services provider;

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

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

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

51.16 (2) a midsize ACT team shall:

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

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

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

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

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

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

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

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

(3) a large ACT team must:

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

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

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

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

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

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

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

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

Sec. 20. Minnesota Statutes 2016, section 256B.0623, subdivision 2, is amended to read:

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

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

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

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

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

(b) "Medication education services" means services provided individually or in groups which focus on educating the recipient about mental illness and symptoms; the role and effects of medications in treating symptoms of mental illness; and the side effects of medications. Medication education is coordinated with medication management services and does not duplicate it. Medication education services are provided by physicians, pharmacists, physician assistants, or registered nurses.

(c) "Transition to community living services" means services which maintain continuity of contact between the rehabilitation services provider and the recipient and which facilitate discharge from a hospital, residential treatment program under Minnesota Rules, chapter

9505, board and lodging facility, or nursing home. Transition to community living services are not intended to provide other areas of adult rehabilitative mental health services.

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

Sec. 21. Minnesota Statutes 2016, section 256B.0624, subdivision 1, is amended to read:

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

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

Sec. 22. Minnesota Statutes 2016, section 256B.0624, subdivision 2, is amended to read:

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

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

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

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

~~(c) "Mental health crisis assessment" means an immediate face-to-face assessment by a physician, a mental health professional, or mental health practitioner under the clinical supervision of a mental health professional, following a screening that suggests that the adult may be experiencing a mental health crisis or mental health emergency situation. It includes, when feasible, assessing whether the person might be willing to voluntarily accept~~

55.1 ~~treatment, determining whether the person has an advance directive, and obtaining~~
55.2 ~~information and history from involved family members or caretakers.~~

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

55.9 ~~(1) This service is provided on site by a mobile crisis intervention team outside of an~~
55.10 ~~inpatient hospital setting. Mental health mobile crisis intervention services must be available~~
55.11 ~~24 hours a day, seven days a week.~~

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

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

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

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

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

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

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

Sec. 23. Minnesota Statutes 2016, section 256B.0624, subdivision 3, is amended to read:

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

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

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

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

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

(1) is eligible for medical assistance;

(2) is 18 years of age or older;

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

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

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

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

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

(1) is eligible for medical assistance;

(2) is younger than 18 years of age;

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

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

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

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

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

57.2 Sec. 24. Minnesota Statutes 2016, section 256B.0624, subdivision 4, is amended to read:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

58.21 Sec. 25. Minnesota Statutes 2016, section 256B.0625, subdivision 35a, is amended to
58.22 read:

58.23 Subd. 35a. **Children's mental health crisis response services.** Medical assistance
58.24 covers children's mental health crisis response services according to section ~~256B.0944~~
58.25 256B.0624.

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

58.27 Sec. 26. Minnesota Statutes 2016, section 256B.092, subdivision 14, is amended to read:

58.28 Subd. 14. **Reduce avoidable behavioral crisis emergency room admissions,**
58.29 **psychiatric inpatient hospitalizations, and commitments to institutions.** (a) Persons
58.30 receiving home and community-based services authorized under this section who have had

two or more admissions within a calendar year to an emergency room, psychiatric unit, or institution must receive consultation from a mental health professional as defined in section 245.462, subdivision 18, or a behavioral professional as defined in the home and community-based services state plan within 30 days of discharge. The mental health professional or behavioral professional must:

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

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

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

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

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

Sec. 27. Minnesota Statutes 2016, section 256B.0943, subdivision 1, is amended to read:

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

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

(b) "Clinical supervision" means the overall responsibility of the mental health professional for the control and direction of individualized treatment planning, service

60.1 delivery, and treatment review for each client. A mental health professional who is an
60.2 enrolled Minnesota health care program provider accepts full professional responsibility
60.3 for a supervisee's actions and decisions, instructs the supervisee in the supervisee's work,
60.4 and oversees or directs the supervisee's work.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(2) administering standardized outcome measurement instruments, determined and updated by the commissioner, as periodically needed to evaluate the effectiveness of

62.1 treatment for children receiving clinical services and reporting outcome measures, as required
62.2 by the commissioner.

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

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

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

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

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

63.2 Sec. 28. Minnesota Statutes 2016, section 256B.0943, subdivision 2, is amended to read:

63.3 Subd. 2. **Covered service components of children's therapeutic services and supports.**

63.4 (a) Subject to federal approval, medical assistance covers medically necessary children's
63.5 therapeutic services and supports as defined in this section that an eligible provider entity
63.6 certified under subdivision 4 provides to a client eligible under subdivision 3.

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

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

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

63.12 (3) crisis ~~assistance~~ planning;

63.13 (4) mental health behavioral aide services;

63.14 (5) direction of a mental health behavioral aide;

63.15 (6) mental health service plan development; and

63.16 (7) children's day treatment.

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

63.18 Sec. 29. Minnesota Statutes 2016, section 256B.0943, subdivision 4, is amended to read:

63.19 Subd. 4. **Provider entity certification.** (a) The commissioner shall establish an initial
63.20 provider entity application and certification process and recertification process to determine
63.21 whether a provider entity has an administrative and clinical infrastructure that meets the
63.22 requirements in subdivisions 5 and 6. A provider entity must be certified for the three core
63.23 rehabilitation services of psychotherapy, skills training, and crisis ~~assistance~~ planning. The
63.24 commissioner shall recertify a provider entity at least every three years. The commissioner
63.25 shall establish a process for decertification of a provider entity and shall require corrective
63.26 action, medical assistance repayment, or decertification of a provider entity that no longer
63.27 meets the requirements in this section or that fails to meet the clinical quality standards or
63.28 administrative standards provided by the commissioner in the application and certification
63.29 process.

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

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

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

(3) a noncounty entity certified by the state.

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

Sec. 30. Minnesota Statutes 2016, section 256B.0943, subdivision 7, is amended to read:

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

(b) An individual provider must be qualified as:

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

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

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

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

(i) be at least 18 years old;

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

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

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

(i) be at least 18 years old;

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

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

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

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

Sec. 31. Minnesota Statutes 2016, section 256B.0943, subdivision 8, is amended to read:

Subd. 8. **Required ~~preservice~~ training and continuing education.** (a) A provider entity shall establish a ~~plan~~ training program to provide ~~preservice~~ training and continuing education for staff. The ~~plan~~ training program must ~~clearly~~ describe the ~~type of training provided by the entity necessary to obtain new skills and maintain current skills and obtain new skills and that relates to the provider entity's goals and objectives for services offered to provide~~ appropriate services.

(b) A provider entity that employs a mental health behavioral aide under this section must require the mental health behavioral aide to complete 30 hours of ~~preservice~~ training. ~~The preservice training must include parent team training. The preservice training must include 15 hours of in-person training of a mental health behavioral aide in mental health services delivery and eight hours of parent team training. Before providing services to a client, the aide must complete 24 hours of training, including training on the role and limitations of a behavioral aide, boundaries, ethics, confidentiality, the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA), child development, documentation, crisis de-escalation skills, and common medications, their side effects and impact on symptoms. A provider entity's policies are not considered part of the 24 hours of required training.~~

Within 60 days of employment, the aide must complete six hours of Department of Human Services approved or delivered parent team training. Curricula for parent team training must be approved in advance by the commissioner. Components of parent team training include:

(1) ~~partnering with parents~~ as partners;

(2) ~~fundamentals of family support~~ understanding and supporting families;

(3) ~~fundamentals of policy and decision making~~ impact on siblings;

- 66.1 (4) ~~defining equal partnership~~ the role of culture in family structures; and
- 66.2 ~~(5) complexities of the parent and service provider partnership in multiple service delivery~~
- 66.3 ~~systems due to system strengths and weaknesses;~~
- 66.4 ~~(6) sibling impacts;~~
- 66.5 ~~(7)~~ (5) community resources and support networks; and.
- 66.6 ~~(8) community resources.~~

66.7 (c) A provider entity that employs a mental health practitioner and a mental health

66.8 behavioral aide to provide children's therapeutic services and supports under this section

66.9 must require the mental health practitioner and mental health behavioral aide to complete

66.10 20 hours of continuing education every two calendar years. The continuing education must

66.11 be related to serving the needs of a child with emotional disturbance ~~in the child's home~~

66.12 ~~environment and the child's family.~~

66.13 (d) The provider entity must document the mental health practitioner's or mental health

66.14 behavioral aide's annual completion of the required continuing education. The documentation

66.15 must include the date, subject, ~~and~~ number of hours of the continuing education, and

66.16 attendance records, as verified by the staff member's signature, job title, and the instructor's

66.17 name. The provider entity must keep documentation for each employee, including records

66.18 of attendance at professional workshops and conferences, at a central location and in the

66.19 employee's personnel file.

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

66.21 Sec. 32. Minnesota Statutes 2016, section 256B.0943, subdivision 9, is amended to read:

66.22 Subd. 9. **Service delivery criteria.** (a) In delivering services under this section, a certified

66.23 provider entity must ensure that:

66.24 (1) each individual provider's caseload size permits the provider to deliver services to

66.25 both clients with severe, complex needs and clients with less intensive needs. The provider's

66.26 caseload size should reasonably enable the provider to play an active role in service planning,

66.27 monitoring, and delivering services to meet the client's and client's family's needs, as specified

66.28 in each client's individual treatment plan;

66.29 (2) site-based programs, including day treatment programs, provide staffing and facilities

66.30 to ensure the client's health, safety, and protection of rights, and that the programs are able

66.31 to implement each client's individual treatment plan; and

(3) a day treatment program is provided to a group of clients by a multidisciplinary team under the clinical supervision of a mental health professional. The day treatment program must be provided in and by: (i) an outpatient hospital accredited by the Joint Commission on Accreditation of Health Organizations and licensed under sections 144.50 to 144.55; (ii) a community mental health center under section 245.62; or (iii) an entity that is certified under subdivision 4 to operate a program that meets the requirements of section 245.4884, subdivision 2, and Minnesota Rules, parts 9505.0170 to 9505.0475. The day treatment program must stabilize the client's mental health status while developing and improving the client's independent living and socialization skills. The goal of the day treatment program must be to reduce or relieve the effects of mental illness and provide training to enable the client to live in the community. The program must be available year-round at least three to five days per week, two or three hours per day, unless the normal five-day school week is shortened by a holiday, weather-related cancellation, or other districtwide reduction in a school week. A child transitioning into or out of day treatment must receive a minimum treatment of one day a week for a two-hour time block. The two-hour time block must include at least one hour of patient and/or family or group psychotherapy. The remainder of the structured treatment program may include patient and/or family or group psychotherapy, and individual or group skills training, if included in the client's individual treatment plan. Day treatment programs are not part of inpatient or residential treatment services. When a day treatment group that meets the minimum group size requirement temporarily falls below the minimum group size because of a member's temporary absence, medical assistance covers a group session conducted for the group members in attendance. A day treatment program may provide fewer than the minimally required hours for a particular child during a billing period in which the child is transitioning into, or out of, the program.

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

(1) patient and/or family, family, and group psychotherapy must be delivered as specified in Minnesota Rules, part 9505.0372, subpart 6. Psychotherapy to address the child's underlying mental health disorder must be documented as part of the child's ongoing treatment. A provider must deliver, or arrange for, medically necessary psychotherapy, unless the child's parent or caregiver chooses not to receive it. When a provider delivering other services to a child under this section deems it not medically necessary to provide psychotherapy to the child for a period of 90 days or longer, the provider entity must

document the medical reasons why psychotherapy is not necessary. When a provider determines that a child needs psychotherapy but psychotherapy cannot be delivered due to a shortage of licensed mental health professionals in the child's community, the provider must document the lack of access in the child's medical record;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(iii) reinforcing the child's accomplishments;

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

(v) assigning further practice activities; and

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

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

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

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

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

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

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

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

Sec. 33. Minnesota Statutes 2016, section 256B.0946, subdivision 1, is amended to read:

Subdivision 1. **Required covered service components.** (a) Effective May 23, 2013, and subject to federal approval, medical assistance covers medically necessary intensive treatment services described under paragraph (b) that are provided by a provider entity eligible under subdivision 3 to a client eligible under subdivision 2 who is placed in a foster

71.1 home licensed under Minnesota Rules, parts 2960.3000 to 2960.3340, or placed in a foster
71.2 home licensed under the regulations established by a federally recognized Minnesota tribe.

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

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

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

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

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

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

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

71.17 Sec. 34. Minnesota Statutes 2016, section 256B.0946, subdivision 1a, is amended to read:

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

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

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

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

72.3 (d) "Clinical trainee" has the meaning given in Minnesota Rules, part 9505.0371, subpart
72.4 5, item C;

72.5 (e) "Crisis ~~assistance~~ planning" has the meaning given in section 245.4871, subdivision
72.6 9a, including the development of a plan that addresses prevention and intervention strategies
72.7 to be used in a potential crisis, but does not include actual crisis intervention.

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

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

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

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

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

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

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

72.26 (m) "Mental health practitioner" has the meaning given in Minnesota Rules, part
72.27 9505.0370, subpart 17.

72.28 (n) "Mental health professional" has the meaning given in Minnesota Rules, part
72.29 9505.0370, subpart 18.

72.30 (o) "Mental illness" has the meaning given in Minnesota Rules, part 9505.0370, subpart
72.31 20.

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

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

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

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

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

Sec. 35. Minnesota Statutes 2016, section 256B.0946, subdivision 4, is amended to read:

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

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

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

(d) Each previous and current mental health, school, and physical health treatment provider must be contacted to request documentation of treatment and assessments that the

74.1 eligible client has received. This information must be reviewed and incorporated into the
74.2 diagnostic assessment and team consultation and treatment planning review process.

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

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

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

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

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

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

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

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

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

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

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

75.1 Sec. 36. Minnesota Statutes 2016, section 256B.0946, subdivision 6, is amended to read:

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

75.5 (1) inpatient psychiatric hospital treatment;

75.6 (2) mental health targeted case management;

75.7 (3) partial hospitalization;

75.8 (4) medication management;

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

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

75.11 (7) transportation.

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

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

75.17 (2) mental health behavioral aide services as defined in section 256B.0943, subdivision
75.18 1, paragraph (m);

75.19 (3) home and community-based waiver services;

75.20 (4) mental health residential treatment; and

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

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

75.23 Sec. 37. Minnesota Statutes 2016, section 256B.0947, subdivision 3a, is amended to read:

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

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

(1) individual, family, and group psychotherapy;

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

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

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

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

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

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

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

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

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

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

(12) transition services as defined in this section;

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

(14) housing access support.

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

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

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

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

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

Sec. 38. Minnesota Statutes 2016, section 256B.0947, subdivision 7, is amended to read:

Subd. 7. **Medical assistance payment and rate setting.** (a) Payment for services in this section must be based on one daily encounter rate per provider inclusive of the following services received by an eligible client in a given calendar day: all rehabilitative services, supports, and ancillary activities under this section, staff travel time to provide rehabilitative services under this section, and crisis response services under section ~~256B.0944~~ 256B.0624.

(b) Payment must not be made to more than one entity for each client for services provided under this section on a given day. If services under this section are provided by a team that includes staff from more than one entity, the team shall determine how to distribute the payment among the members.

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

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

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

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

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

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

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

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

Sec. 39. Minnesota Statutes 2016, section 256B.49, subdivision 25, is amended to read:

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

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

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

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

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

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

Sec. 40. Minnesota Statutes 2016, section 256B.84, is amended to read:

256B.84 AMERICAN INDIAN CONTRACTING PROVISIONS.

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

79.1 tribes must meet the vendor of medical care requirements in section 256B.02, subdivision
79.2 7.

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

79.4 Sec. 41. **REVISOR'S INSTRUCTION.**

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

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

79.14 Sec. 42. **REPEALER.**

79.15 Minnesota Statutes 2016, sections 245.469; 245.4879; 256B.0624, subdivisions 4a, 5,
79.16 6, 7, 8, 9, 10, and 11; and 256B.0944, are repealed.

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

79.18 **ARTICLE 3**

79.19 **OPERATIONS**

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

79.21 **245.095 LIMITS ON RECEIVING PUBLIC FUNDS.**

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

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

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

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

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

(b) "Excluded" means disenrolled, subject to license revocation or suspension, disqualified, has a license that has been revoked or suspended under chapter 245A, or has been debarred or suspended ~~disqualified, or subject to vendor debarment~~ under Minnesota Rules, part 1230.1150, or excluded pursuant to section 256B.064, subdivision 3.

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

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

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

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

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

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

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

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

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

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

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

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

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

81.14 (b) Controlling individual does not include:

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

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

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

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

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

81.27 (4) an individual who is a member of an organization exempt from taxation under section
81.28 290.05, unless the individual is also an officer, owner, or managerial official of the program
81.29 or owns any of the beneficial interests not excluded in this subdivision. This clause does
81.30 not exclude from the definition of controlling individual an organization that is exempt from
81.31 taxation.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

83.4 Subd. 12a. **Provisional license.** "Provisional license" means a license of limited duration
83.5 not to exceed 15 months issued under section 245A.04, subdivision 7, paragraph (g), or
83.6 245A.045.

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

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

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

83.12 (1) operate a residential or a nonresidential program;

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

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

83.17 (4) advertise a residential or nonresidential program.

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

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

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

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

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

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

84.6 (1) an inspection of the physical plant;

84.7 (2) an inspection of records and documents;

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

84.9 (4) observation of the program in operation.

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

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

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

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

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

84.26 (1) the program's operation;

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

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

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

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

85.3 (b) The commissioner shall also evaluate the results of the study required in subdivision
85.4 3 and determine whether a risk of harm to the persons served by the program exists. In
85.5 conducting this evaluation, the commissioner shall apply the disqualification standards set
85.6 forth in chapter 245C.

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

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

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

85.14 (1) the name of the license holder;

85.15 (2) the address of the program;

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

85.17 (4) the type of license;

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

85.20 (6) any special conditions of licensure.

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

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

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

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

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

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

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

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

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

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

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

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

When a license issued under this chapter is revoked under clause (1) or (3), the license holder and controlling individual may not hold any license under chapter 245A or 245D for five years following the revocation, and other licenses held by the applicant, license holder, or controlling individual shall also be revoked.

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

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

~~(h)~~ (g) Notwithstanding paragraph ~~(g)~~ (f), when a revocation is based on the disqualification of a controlling individual or license holder, and the controlling individual or license holder is ordered under section 245C.17 to be immediately removed from direct contact with persons receiving services or is ordered to be under continuous, direct supervision when providing direct contact services, the program may continue to operate

only if the program complies with the order and submits documentation demonstrating compliance with the order. If the disqualified individual fails to submit a timely request for reconsideration, or if the disqualification is not set aside and no variance is granted, the order to immediately remove the individual from direct contact or to be under continuous, direct supervision remains in effect pending the outcome of a hearing and final order from the commissioner.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

89.3 A change in ownership occurs when:

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

89.5 (2) the license holder merges with another organization;

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

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

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

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

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

89.29 (c) The commissioner may develop streamlined application procedures for when the
89.30 party is an existing license holder under this chapter and is acquiring a program licensed
89.31 under this chapter or service in the same service class as one or more licensed programs or
89.32 services it operates and those licenses are in substantial compliance according to the licensing
89.33 standards in this chapter and applicable rules. For purposes of this subdivision, "substantial

90.1 compliance" means the commissioner did not issue, within the past 12 months, a sanction
90.2 under section 245A.045 or 245A.07 against a license held by the party or made a license
90.3 held by the party conditional according to section 245A.06 within the past 12 months.

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

90.8 (e) If a licensing inspection of the program or service was conducted within the previous
90.9 12 months and the existing license holder's license record demonstrates substantial
90.10 compliance with the applicable licensing requirements, the commissioner may waive the
90.11 party's inspection required by section 245A.04, subdivision 4. The party must submit to the
90.12 commissioner proof that the premises was inspected by a fire marshal or that the fire marshal
90.13 deemed that an inspection was not warranted and proof that the premises was inspected for
90.14 compliance with the building code or that no inspection was deemed warranted.

90.15 (f) If the party is seeking a license for a program or service that has an outstanding
90.16 correction order, the party must submit a letter with the license application identifying how
90.17 and within what length of time the party will resolve the outstanding correction order and
90.18 come into full compliance with the licensing requirements.

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

90.24 (h) The commissioner shall evaluate the application of the party according to section
90.25 245A.04, subdivision 6. Pursuant to section 245A.04, subdivision 7, if the commissioner
90.26 determines that the party complies with applicable laws and rules, the commissioner may
90.27 issue a license or a temporary change of ownership license.

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

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

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

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

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

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

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

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

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

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

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

91.32 (b) The commissioner may place terms and conditions on the provisional license as the
91.33 commissioner determines necessary until the applicant achieves full compliance with

92.1 applicable statutes and rules before the expiration of the provisional license. The decision
92.2 to issue a provisional license under this section instead of a license under section 245A.04,
92.3 subdivision 7, is not appealable.

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

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

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

92.15 (2) a revocation under this subdivision.

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

92.18 (1) a license holder failed to fully comply with applicable laws or rules including chapters
92.19 119B, 245A, and 245C;

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

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

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

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

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

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

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

(e) If a provisional license is revoked, the notice must inform the license holder of the right to a contested case hearing under chapter 14 and Minnesota Rules, parts 1400.8505 to 1400.8612. The license holder may appeal a revocation order. The appeal of a revocation order must be made in writing by certified mail or personal service. If mailed, the appeal must be postmarked and sent to the commissioner within ten calendar days after the license holder receives notice. If a request is made by personal service, it must be received by the commissioner within ten calendar days after the license holder received notice. Except as provided in subdivision 2, paragraph (c), if a license holder submits a timely appeal of a revocation order, the license holder may continue to operate the program as provided in section 245A.04, subdivision 7, paragraphs (f) and (g), until the commissioner issues a final order on the revocation. The hearing must be conducted according to section 245A.08.

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

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

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

245A.05 DENIAL OF APPLICATION.

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

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

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

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

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

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

94.9 (6) is associated with an individual who received a background study under section
94.10 245C.03, subdivision 1, paragraph (a), clause (6), who may have unsupervised access to
94.11 children or vulnerable adults, and who has a disqualification that has not been set aside
94.12 under section 245C.22, and no variance has been granted; ~~or~~

94.13 (7) fails to comply with section 245A.04, subdivision 1, paragraph (f) or (g);₂

94.14 (8) fails to demonstrate competent knowledge as required by section 245A.04, subdivision
94.15 6;

94.16 (9) has a history of noncompliance as a license holder or controlling individual with
94.17 applicable laws or rules including but not limited to this chapter and chapters 199B and
94.18 245C; or

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

94.20 (b) An applicant whose application has been denied by the commissioner must be given
94.21 notice of the denial. Notice must be given by certified mail or personal service. The notice
94.22 must state the reasons the application was denied and must inform the applicant of the right
94.23 to a contested case hearing under chapter 14 and Minnesota Rules, parts 1400.8505 to
94.24 1400.8612. The applicant may appeal the denial by notifying the commissioner in writing
94.25 by certified mail or personal service. If mailed, the appeal must be postmarked and sent to
94.26 the commissioner within 20 calendar days after the applicant received the notice of denial.
94.27 If an appeal request is made by personal service, it must be received by the commissioner
94.28 within 20 calendar days after the applicant received the notice of denial. Section 245A.08
94.29 applies to hearings held to appeal the commissioner's denial of an application.

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

Sec. 19. Minnesota Statutes 2016, section 256B.02, subdivision 7, is amended to read:

Subd. 7. **Vendor of medical care.** (a) "Vendor of medical care" means any person or persons furnishing, within the scope of the vendor's respective license, any or all of the following goods or services: medical, surgical, hospital, ambulatory surgical center services, optical, visual, dental and nursing services; drugs and medical supplies; appliances; laboratory, diagnostic, and therapeutic services; nursing home and convalescent care; screening and health assessment services provided by public health nurses as defined in section 145A.02, subdivision 18; health care services provided at the residence of the patient if the services are performed by a public health nurse and the nurse indicates in a statement submitted under oath that the services were actually provided; and such other medical services or supplies provided or prescribed by persons authorized by state law to give such services and supplies, including services under section 256B.4912. For purposes of this chapter, the term includes a person or entity that furnishes a good or service eligible for medical assistance or federally approved waiver plan payments under this chapter. The term includes, but is not limited to, directors and officers of corporations or members of partnerships who, either individually or jointly with another or others, have the legal control, supervision, or responsibility of submitting claims for reimbursement to the medical assistance program. The term only includes directors and officers of corporations who personally receive a portion of the distributed assets upon liquidation or dissolution, and their liability is limited to the portion of the claim that bears the same proportion to the total claim as their share of the distributed assets bears to the total distributed assets.

(b) "Vendor of medical care" also includes any person who is credentialed as a health professional under standards set by the governing body of a federally recognized Indian tribe authorized under an agreement with the federal government according to United States Code, title 25, section 450f, to provide health services to its members, and who through a tribal facility provides covered services to American Indian people within a contract health service delivery area of a Minnesota reservation, as defined under Code of Federal Regulations, title 42, section 36.22.

(c) A federally recognized Indian tribe that intends to implement standards for credentialing health professionals must submit the standards to the commissioner of human services, along with evidence of meeting, exceeding, or being exempt from corresponding state standards. The commissioner shall maintain a copy of the standards and supporting evidence, and shall use those standards to enroll tribal-approved health professionals as medical assistance providers. For purposes of this section, "Indian" and "Indian tribe" mean persons or entities that meet the definition in United States Code, title 25, section 450b.

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

96.2 Sec. 20. Minnesota Statutes 2016, section 256B.04, subdivision 21, is amended to read:

96.3 Subd. 21. **Provider enrollment.** (a) If the commissioner or the Centers for Medicare
96.4 and Medicaid Services determines that a provider is designated "high-risk," the commissioner
96.5 may withhold payment from providers within that category upon initial enrollment for a
96.6 90-day period. The withholding for each provider must begin on the date of the first
96.7 submission of a claim.

96.8 (b) An enrolled provider that is also licensed by the commissioner under chapter 245A,
96.9 or is licensed as a home care provider by the Department of Health under chapter 144A and
96.10 has a home and community-based services designation on the home care license under
96.11 section 144A.484, must designate an individual as the entity's compliance officer. The
96.12 compliance officer must:

96.13 (1) develop policies and procedures to assure adherence to medical assistance laws and
96.14 regulations and to prevent inappropriate claims submissions;

96.15 (2) train the employees of the provider entity, and any agents or subcontractors of the
96.16 provider entity including billers, on the policies and procedures under clause (1);

96.17 (3) respond to allegations of improper conduct related to the provision or billing of
96.18 medical assistance services, and implement action to remediate any resulting problems;

96.19 (4) use evaluation techniques to monitor compliance with medical assistance laws and
96.20 regulations;

96.21 (5) promptly report to the commissioner any identified violations of medical assistance
96.22 laws or regulations; and

96.23 (6) within 60 days of discovery by the provider of a medical assistance reimbursement
96.24 overpayment, report the overpayment to the commissioner and make arrangements with
96.25 the commissioner for the commissioner's recovery of the overpayment.

96.26 The commissioner may require, as a condition of enrollment in medical assistance, that a
96.27 provider within a particular industry sector or category establish a compliance program that
96.28 contains the core elements established by the Centers for Medicare and Medicaid Services.

96.29 (c) The commissioner may revoke the enrollment of an ordering or rendering provider
96.30 for a period of not more than one year, if the provider fails to maintain and, upon request
96.31 from the commissioner, provide access to documentation relating to written orders or requests
96.32 for payment for durable medical equipment, certifications for home health services, or

referrals for other items or services written or ordered by such provider, when the commissioner has identified a pattern of a lack of documentation. A pattern means a failure to maintain documentation or provide access to documentation on more than one occasion. Nothing in this paragraph limits the authority of the commissioner to sanction a provider under the provisions of section 256B.064.

(d) The commissioner shall terminate or deny the enrollment of any individual or entity if the individual or entity has been terminated from participation in Medicare or under the Medicaid program or Children's Health Insurance Program of any other state.

(e) As a condition of enrollment in medical assistance, the commissioner shall require that a provider designated "moderate" or "high-risk" by the Centers for Medicare and Medicaid Services or the commissioner permit the Centers for Medicare and Medicaid Services, its agents, or its designated contractors and the state agency, its agents, or its designated contractors to conduct unannounced on-site inspections of any provider location. The commissioner shall publish in the Minnesota Health Care Program Provider Manual a list of provider types designated "limited," "moderate," or "high-risk," based on the criteria and standards used to designate Medicare providers in Code of Federal Regulations, title 42, section 424.518. The list and criteria are not subject to the requirements of chapter 14. The commissioner's designations are not subject to administrative appeal.

(f) As a condition of enrollment in medical assistance, the commissioner shall require that a high-risk provider, or a person with a direct or indirect ownership interest in the provider of five percent or higher, consent to criminal background checks, including fingerprinting, when required to do so under state law or by a determination by the commissioner or the Centers for Medicare and Medicaid Services that a provider is designated high-risk for fraud, waste, or abuse.

(g)(1) Upon initial enrollment, reenrollment, and notification of revalidation, all durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) medical suppliers meeting the durable medical equipment provider and supplier definition in clause (3), operating in Minnesota and receiving Medicaid funds must purchase a surety bond that is annually renewed and designates the Minnesota Department of Human Services as the obligee, and must be submitted in a form approved by the commissioner. For purposes of this clause, the following medical suppliers are not required to obtain a surety bond: a federally qualified health center, a home health agency, the Indian Health Service, a pharmacy, and a rural health clinic.

(2) At the time of initial enrollment or reenrollment, durable medical equipment providers and suppliers defined in clause (3) must purchase a surety bond of \$50,000. If a revalidating provider's Medicaid revenue in the previous calendar year is up to and including \$300,000, the provider agency must purchase a surety bond of \$50,000. If a revalidating provider's Medicaid revenue in the previous calendar year is over \$300,000, the provider agency must purchase a surety bond of \$100,000. ~~The surety bond must allow for recovery of costs and fees in pursuing a claim on the bond.~~ The surety bond must be in a form approved by the commissioner, renewed annually, and allow for recovery of the entire value of the bond for up to five years from the date of submission of a claim for medical assistance payment if the enrolled provider violates this chapter or Minnesota Rules, chapter 9505, regardless of the actual loss.

(3) "Durable medical equipment provider or supplier" means a medical supplier that can purchase medical equipment or supplies for sale or rental to the general public and is able to perform or arrange for necessary repairs to and maintenance of equipment offered for sale or rental.

(h) The Department of Human Services may require a provider to purchase a surety bond as a condition of initial enrollment, reenrollment, reinstatement, or continued enrollment if: (1) the provider fails to demonstrate financial viability, (2) the department determines there is significant evidence of or potential for fraud and abuse by the provider, or (3) the provider or category of providers is designated high-risk pursuant to paragraph (a) and as per Code of Federal Regulations, title 42, section 455.450. The surety bond must be in an amount of \$100,000 or ten percent of the provider's payments from Medicaid during the immediately preceding 12 months, whichever is greater. The surety bond must name the Department of Human Services as an obligee and must allow for recovery of costs and fees in pursuing a claim on the bond. This paragraph does not apply if the provider currently maintains a surety bond under the requirements in section 256B.0659 or 256B.85.

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

Sec. 21. Minnesota Statutes 2016, section 256B.0622, subdivision 3a, is amended to read:

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

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

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

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

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

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

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

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

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

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

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

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

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

99.19 (10) comply with all applicable laws;

99.20 (11) be an enrolled Medicaid provider;

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

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

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

(d) A provider entity must specify in the provider entity's application what geographic area and populations will be served by the proposed program. A provider entity must document that the capacity or program specialties of existing programs are not sufficient to meet the service needs of the target population. A provider entity must submit evidence of ongoing relationships with other providers and levels of care to facilitate referrals to and from the proposed program.

(e) A provider entity must submit documentation that the provider entity requested a statement of need from each county board and tribal authority that serves as a local mental health authority in the proposed service area. The statement of need must specify if the local mental health authority supports or does not support the need for the proposed program and the basis for this determination. If a local mental health authority does not respond within 60 days of the receipt of the request, the commissioner shall determine the need for the program based on the documentation submitted by the provider entity.

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

Sec. 22. Minnesota Statutes 2016, section 256B.0622, subdivision 4, is amended to read:

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

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

(2) not exceed 16 beds per site; and

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

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

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

(c) A provider entity must specify in the provider entity's application what geographic area and populations will be served by the proposed program. A provider entity must document that the capacity or program specialties of existing programs are not sufficient to meet the service needs of the target population. A provider entity must submit evidence of ongoing relationships with other providers and levels of care to facilitate referrals to and from the proposed program.

(d) A provider entity must submit documentation that the provider entity requested a statement of need from each county board and tribal authority that serves as a local mental

health authority in the proposed service area. The statement of need must specify if the local mental health authority supports or does not support the need for the proposed program and the basis for this determination. If a local mental health authority does not respond within 60 days of the receipt of the request, the commissioner shall determine the need for the program based on the documentation submitted by the provider entity.

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

Sec. 23. Minnesota Statutes 2016, section 256B.0625, subdivision 43, is amended to read:

Subd. 43. **Mental health provider travel time.** (a) Medical assistance covers provider travel time if a recipient's individual treatment plan recipient requires the provision of mental health services outside of the provider's normal usual place of business. This does not include any travel time which is included in other billable services, and is only covered when the mental health service being provided to a recipient is covered under medical assistance.

(b) Mental health provider travel time under this subdivision covers the time the provider is in transit to deliver a mental health service to a recipient at a location that is not the provider's usual place of business or to the next location for delivery of a covered mental health service, and the time a provider is in transit returning from the location of the last recipient who received services on that day to the provider's usual place of business. A provider must travel the most direct route available. Mental health provider travel time does not include time for scheduled or unscheduled stops, meal breaks, or vehicle maintenance or repair, including refueling or vehicle emergencies. Recipient transport is not covered under this subdivision.

(c) Mental health provider travel time under this subdivision is only covered when the mental health service being provided is covered under medical assistance and only when the covered service is delivered and billed. Mental health provider travel time is not covered when the mental health service being provided otherwise includes provider travel time or when the service is site based.

(d) If the first occurrence of mental health provider travel time in a day begins at a location other than the provider's usual place of business, the provider shall bill for the lesser of the travel time between the location and the recipient and the travel time between the provider's usual place of business and the recipient. This provision does not apply to mental health crisis services provided under section 256B.0624 outside of normal business hours if on-call staff are being dispatched directly from a location other than the provider's usual place of business.

102.1 (e) Mental health provider travel time may be billed for not more than one round trip
102.2 per recipient per day.

102.3 (f) As a condition of payment, a provider must document each occurrence of mental
102.4 health provider travel time according to this subdivision. Program funds paid for mental
102.5 health provider travel time that is not documented according to this subdivision shall be
102.6 recovered by the department. The documentation may be collected and maintained
102.7 electronically or in paper form but must be made available and produced upon request. A
102.8 provider must compile records that meet the following requirements for each occurrence:

102.9 (1) the record must be in English and must be legible according to the standard of a
102.10 reasonable person;

102.11 (2) the recipient's name and date of birth or individual identification number must be on
102.12 each page of the record;

102.13 (3) the reason the provider must travel to provide services, if not otherwise documented
102.14 in the recipient's individual treatment plan; and

102.15 (4) each entry in the record must document:

102.16 (i) the date on which the entry is made;

102.17 (ii) the date the travel occurred;

102.18 (iii) the printed last name, first name, and middle initial of the provider and the provider's
102.19 identification number, if the provider has one;

102.20 (iv) the signature of the traveling provider stating that the provider understands that it
102.21 is a federal crime to provide false information on service billings for medical assistance
102.22 payments;

102.23 (v) the location of the provider's usual place of business;

102.24 (vi) the address, or the description if the address is not available, of both the origination
102.25 site and destination site and the travel time for the most direct route from the origination
102.26 site to the destination site;

102.27 (vii) any unusual travel conditions that may cause a need to bill for additional time over
102.28 and above what an electronic source document shows the mileage and time necessary to
102.29 travel from the origination site to destination site;

102.30 (viii) the time the provider left the origination site and the time the provider arrived at
102.31 the destination site, with a.m. and p.m. designations; and

103.1 (ix) the electronic source documentation used to calculate the most direct route detailing
103.2 driving directions, mileage, and time.

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

103.4 Sec. 24. Minnesota Statutes 2016, section 256B.064, subdivision 1b, is amended to read:

103.5 Subd. 1b. **Sanctions available.** The commissioner may impose the following sanctions
103.6 for the conduct described in subdivision 1a: suspension or withholding of payments to a
103.7 vendor and suspending or terminating participation in the program, or imposition of a fine
103.8 under subdivision 2, paragraph (f). When imposing sanctions under this section, the
103.9 commissioner shall consider the nature, chronicity, or severity of the conduct and the effect
103.10 of the conduct on the health and safety of persons served by the vendor. The commissioner
103.11 shall suspend a vendor's participation in the program for a minimum of five years if the
103.12 vendor is convicted of a crime, received a stay of adjudication, or entered a court-ordered
103.13 diversion program for an offense related to provision of a health service under medical
103.14 assistance or health care fraud. Regardless of imposition of sanctions, the commissioner
103.15 may make a referral to the appropriate state licensing board.

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

103.17 Sec. 25. Minnesota Statutes 2016, section 256B.0651, subdivision 17, is amended to read:

103.18 Subd. 17. **Recipient protection.** (a) Providers of home care services must provide each
103.19 recipient with a copy of the home care bill of rights under section 144A.44 at least 30 days
103.20 prior to terminating services to a recipient, if the termination results from provider sanctions
103.21 under section 256B.064, such as a payment withhold, a suspension of participation, or a
103.22 termination of participation. If a home care provider determines it is unable to continue
103.23 providing services to a recipient, the provider must notify the recipient, the recipient's
103.24 responsible party, and the commissioner 30 days prior to terminating services to the recipient
103.25 because of an action under section 256B.064, and must assist the commissioner and lead
103.26 agency in supporting the recipient in transitioning to another home care provider of the
103.27 recipient's choice.

103.28 (b) In the event of a payment withhold from a home care provider, a suspension of
103.29 participation, or a termination of participation of a home care provider under section
103.30 256B.064, the commissioner may inform the Office of Ombudsman for Long-Term Care
103.31 and the lead agencies for all recipients with active service agreements with the provider. At
103.32 the commissioner's request, the lead agencies must contact recipients to ensure that the
103.33 recipients are continuing to receive needed care, and that the recipients have been given

free choice of provider if they transfer to another home care provider. In addition, the commissioner or the commissioner's delegate may directly notify recipients who receive care from the provider that payments have been or will be withheld or that the provider's participation in medical assistance has been or will be suspended or terminated, if the commissioner determines that notification is necessary to protect the welfare of the recipients. For purposes of this subdivision, "lead agencies" means counties, tribes, and managed care organizations.

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

Sec. 26. Minnesota Statutes 2016, section 256B.0659, subdivision 3, is amended to read:

Subd. 3. ~~Noncovered~~ **Personal care assistance services not covered.** (a) Personal care assistance services are not eligible for medical assistance payment under this section when provided:

(1) by the recipient's spouse, parent of a recipient under the age of 18, paid legal guardian, licensed foster provider, except as allowed under section 256B.0652, subdivision 10, or responsible party;

(2) in order to meet staffing or license requirements in a residential or child care setting;

(3) solely as a child care or babysitting service; ~~or~~

(4) without authorization by the commissioner or the commissioner's designee; or

(5) on dates not within the frequency requirements of subdivision 14, paragraph (c), and subdivision 19, paragraph (a).

(b) The following personal care services are not eligible for medical assistance payment under this section when provided in residential settings:

(1) when the provider of home care services who is not related by blood, marriage, or adoption owns or otherwise controls the living arrangement, including licensed or unlicensed services; or

(2) when personal care assistance services are the responsibility of a residential or program license holder under the terms of a service agreement and administrative rules.

(c) Other specific tasks not covered under paragraph (a) or (b) that are not eligible for medical assistance reimbursement for personal care assistance services under this section include:

(1) sterile procedures;

- 105.1 (2) injections of fluids and medications into veins, muscles, or skin;
- 105.2 (3) home maintenance or chore services;
- 105.3 (4) homemaker services not an integral part of assessed personal care assistance services
- 105.4 needed by a recipient;
- 105.5 (5) application of restraints or implementation of procedures under section 245.825;
- 105.6 (6) instrumental activities of daily living for children under the age of 18, except when
- 105.7 immediate attention is needed for health or hygiene reasons integral to the personal care
- 105.8 services and the need is listed in the service plan by the assessor; and
- 105.9 (7) assessments for personal care assistance services by personal care assistance provider
- 105.10 agencies or by independently enrolled registered nurses.

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

105.12 Sec. 27. Minnesota Statutes 2016, section 256B.0659, subdivision 12, is amended to read:

105.13 Subd. 12. **Documentation of personal care assistance services provided.** (a) Personal

105.14 care assistance services for a recipient must be documented daily by each personal care

105.15 assistant, on a time sheet form approved by the commissioner. All documentation may be

105.16 Web-based, electronic, or paper documentation. The completed form must be submitted on

105.17 a monthly basis to the provider and kept in the recipient's health record.

105.18 (b) The activity documentation must correspond to the personal care assistance care plan

105.19 and be reviewed by the qualified professional.

105.20 (c) The personal care assistant time sheet must be on a form approved by the

105.21 commissioner documenting time the personal care assistant provides services in the home.

105.22 The following criteria must be included in the time sheet:

105.23 (1) full name of personal care assistant and individual provider number;

105.24 (2) provider name and telephone numbers;

105.25 (3) full name of recipient and either the recipient's medical assistance identification

105.26 number or date of birth;

105.27 (4) consecutive dates, including month, day, and year, and arrival and departure times

105.28 with a.m. or p.m. notations;

105.29 (5) signatures of recipient or the responsible party;

105.30 (6) personal signature of the personal care assistant;

(7) any shared care provided, if applicable;

(8) a statement that it is a federal crime to provide false information on personal care service billings for medical assistance payments; and

(9) dates and location of recipient stays in a hospital, care facility, or incarceration.

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

Sec. 28. Minnesota Statutes 2016, section 256B.0659, subdivision 14, is amended to read:

Subd. 14. **Qualified professional; duties.** (a) Effective January 1, 2010, all personal care assistants must be supervised by a qualified professional.

(b) Through direct training, observation, return demonstrations, and consultation with the staff and the recipient, the qualified professional must ensure and document that the personal care assistant is:

(1) capable of providing the required personal care assistance services;

(2) knowledgeable about the plan of personal care assistance services before services are performed; and

(3) able to identify conditions that should be immediately brought to the attention of the qualified professional.

(c) The qualified professional shall evaluate the personal care assistant within the first 14 days of starting to provide regularly scheduled services for a recipient, or sooner as determined by the qualified professional, except for the personal care assistance choice option under subdivision 19, paragraph (a), clause (4). For the initial evaluation, the qualified professional shall evaluate the personal care assistance services for a recipient through direct observation of a personal care assistant's work. The qualified professional may conduct additional training and evaluation visits, based upon the needs of the recipient and the personal care assistant's ability to meet those needs. Subsequent visits to evaluate the personal care assistance services provided to a recipient do not require direct observation of each personal care assistant's work and shall occur:

(1) at least every 90 days thereafter for the first year of a recipient's services;

(2) every 120 days after the first year of a recipient's service or whenever needed for response to a recipient's request for increased supervision of the personal care assistance staff; and

107.1 (3) after the first 180 days of a recipient's service, supervisory visits may alternate
107.2 between unscheduled phone or Internet technology and in-person visits, unless the in-person
107.3 visits are needed according to the care plan.

107.4 (d) Communication with the recipient is a part of the evaluation process of the personal
107.5 care assistance staff.

107.6 (e) At each supervisory visit, the qualified professional shall evaluate personal care
107.7 assistance services including the following information:

107.8 (1) satisfaction level of the recipient with personal care assistance services;

107.9 (2) review of the month-to-month plan for use of personal care assistance services;

107.10 (3) review of documentation of personal care assistance services provided;

107.11 (4) whether the personal care assistance services are meeting the goals of the service as
107.12 stated in the personal care assistance care plan and service plan;

107.13 (5) a written record of the results of the evaluation and actions taken to correct any
107.14 deficiencies in the work of a personal care assistant; and

107.15 (6) revision of the personal care assistance care plan as necessary in consultation with
107.16 the recipient or responsible party, to meet the needs of the recipient.

107.17 (f) The qualified professional shall complete the required documentation in the agency
107.18 recipient and employee files and the recipient's home, including the following documentation:

107.19 (1) the personal care assistance care plan based on the service plan and individualized
107.20 needs of the recipient;

107.21 (2) a month-to-month plan for use of personal care assistance services;

107.22 (3) changes in need of the recipient requiring a change to the level of service and the
107.23 personal care assistance care plan;

107.24 (4) evaluation results of supervision visits and identified issues with personal care
107.25 assistance staff with actions taken;

107.26 (5) all communication with the recipient and personal care assistance staff; ~~and~~

107.27 (6) hands-on training or individualized training for the care of the recipient;

107.28 (7) the month, day, and year, and arrival and departure times with a.m. or p.m.
107.29 designations of each visit or call to the recipient when services are provided; and

107.30 (8) the total amount of time of each service visit with the recipient.

108.1 (g) The documentation in paragraph (f) must be done on agency templates.

108.2 (h) The services that are not eligible for payment as qualified professional services
108.3 include:

108.4 (1) direct professional nursing tasks that could be assessed and authorized as skilled
108.5 nursing tasks;

108.6 (2) the time spent documenting services;

108.7 ~~(2)~~ (3) agency administrative activities;

108.8 ~~(3)~~ (4) training other than the individualized training required to provide care for a
108.9 recipient; and

108.10 ~~(4)~~ (5) any other activity that is not described in this section.

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

108.12 Sec. 29. Minnesota Statutes 2016, section 256B.0659, subdivision 21, is amended to read:

108.13 Subd. 21. **Requirements for provider enrollment of personal care assistance provider**
108.14 **agencies.** (a) All personal care assistance provider agencies must provide, at the time of
108.15 enrollment, reenrollment, and revalidation as a personal care assistance provider agency in
108.16 a format determined by the commissioner, information and documentation that includes,
108.17 but is not limited to, the following:

108.18 (1) the personal care assistance provider agency's current contact information including
108.19 address, telephone number, and e-mail address;

108.20 (2) proof of surety bond coverage. Upon new enrollment, or if the provider's Medicaid
108.21 revenue in the previous calendar year is up to and including \$300,000, the provider agency
108.22 must purchase a surety bond of \$50,000. If the Medicaid revenue in the previous year is
108.23 over \$300,000, the provider agency must purchase a surety bond of \$100,000. The surety
108.24 bond must be in a form approved by the commissioner, must be renewed annually, and must
108.25 allow for recovery of costs and fees in pursuing a claim on the bond the entire value of the
108.26 bond for up to five years from the date of submission of a claim for medical assistance
108.27 payment if the enrolled provider violates this chapter or Minnesota Rules, chapter 9505,
108.28 regardless of the actual loss;

108.29 (3) proof of fidelity bond coverage in the amount of \$20,000;

108.30 (4) proof of workers' compensation insurance coverage;

108.31 (5) proof of liability insurance;

(6) a description of the personal care assistance provider agency's organization identifying the names of all owners, managing employees, staff, board of directors, and the affiliations of the directors, owners, or staff to other service providers;

(7) a copy of the personal care assistance provider agency's written policies and procedures including: hiring of employees; training requirements; service delivery; and employee and consumer safety including process for notification and resolution of consumer grievances, identification and prevention of communicable diseases, and employee misconduct;

(8) copies of all other forms the personal care assistance provider agency uses in the course of daily business including, but not limited to:

(i) a copy of the personal care assistance provider agency's time sheet if the time sheet varies from the standard time sheet for personal care assistance services approved by the commissioner, and a letter requesting approval of the personal care assistance provider agency's nonstandard time sheet;

(ii) the personal care assistance provider agency's template for the personal care assistance care plan; and

(iii) the personal care assistance provider agency's template for the written agreement in subdivision 20 for recipients using the personal care assistance choice option, if applicable;

(9) a list of all training and classes that the personal care assistance provider agency requires of its staff providing personal care assistance services;

(10) documentation that the personal care assistance provider agency and staff have successfully completed all the training required by this section;

(11) documentation of the agency's marketing practices;

(12) disclosure of ownership, leasing, or management of all residential properties that is used or could be used for providing home care services;

(13) documentation that the agency will use the following percentages of revenue generated from the medical assistance rate paid for personal care assistance services for employee personal care assistant wages and benefits: 72.5 percent of revenue in the personal care assistance choice option and 72.5 percent of revenue from other personal care assistance providers. The revenue generated by the qualified professional and the reasonable costs associated with the qualified professional shall not be used in making this calculation; and

(14) effective May 15, 2010, documentation that the agency does not burden recipients' free exercise of their right to choose service providers by requiring personal care assistants to sign an agreement not to work with any particular personal care assistance recipient or for another personal care assistance provider agency after leaving the agency and that the agency is not taking action on any such agreements or requirements regardless of the date signed.

(b) Personal care assistance provider agencies shall provide the information specified in paragraph (a) to the commissioner at the time the personal care assistance provider agency enrolls as a vendor or upon request from the commissioner. The commissioner shall collect the information specified in paragraph (a) from all personal care assistance providers beginning July 1, 2009.

(c) All personal care assistance provider agencies shall require all employees in management and supervisory positions and owners of the agency who are active in the day-to-day management and operations of the agency to complete mandatory training as determined by the commissioner before enrollment of the agency as a provider. Employees in management and supervisory positions and owners who are active in the day-to-day operations of an agency who have completed the required training as an employee with a personal care assistance provider agency do not need to repeat the required training if they are hired by another agency, if they have completed the training within the past three years. By September 1, 2010, the required training must be available with meaningful access according to title VI of the Civil Rights Act and federal regulations adopted under that law or any guidance from the United States Health and Human Services Department. The required training must be available online or by electronic remote connection. The required training must provide for competency testing. Personal care assistance provider agency billing staff shall complete training about personal care assistance program financial management. This training is effective July 1, 2009. Any personal care assistance provider agency enrolled before that date shall, if it has not already, complete the provider training within 18 months of July 1, 2009. Any new owners or employees in management and supervisory positions involved in the day-to-day operations are required to complete mandatory training as a requisite of working for the agency. Personal care assistance provider agencies certified for participation in Medicare as home health agencies are exempt from the training required in this subdivision. When available, Medicare-certified home health agency owners, supervisors, or managers must successfully complete the competency test.

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

111.1 Sec. 30. Minnesota Statutes 2016, section 256B.4912, is amended by adding a subdivision
111.2 to read:

111.3 Subd. 11. **Service documentation and billing requirements.** (a) Only a service provided
111.4 as specified in a federally approved waiver plan, as authorized under sections 256B.0913,
111.5 256B.0915, 256B.092, and 256B.49, is eligible for payment. As a condition of payment, a
111.6 home and community-based waiver provider must document each time a service was
111.7 provided to a recipient. Payment for a service not documented according to this subdivision
111.8 or not specified in a federally approved waiver plan shall be recovered by the department
111.9 under section 256B.064. For payment of a service, documentation must meet the standards
111.10 in paragraphs (b) to (j).

111.11 (b) The service delivered to a recipient must be documented in the provider's record of
111.12 service delivery.

111.13 (c) The recipient's name and recipient identification number must be entered on each
111.14 document.

111.15 (d) The provider's record of service delivery must be in English and must be legible
111.16 according to the standard of a reasonable person.

111.17 (e) The provider's record of service delivery must contain a statement that it is a federal
111.18 crime to provide false information on service billings for medical assistance or services
111.19 under a federally approved waiver plan, as authorized under sections 256B.0913, 256B.0915,
111.20 256B.092, and 256B.49.

111.21 (f) If an entry is a time-based service, each entry in the provider's record of service
111.22 delivery must contain:

111.23 (1) the date that the entry was made;

111.24 (2) the day, month, and year when the service was provided;

111.25 (3) the service name or description of the service provided;

111.26 (4) the start and stop times with a.m. and p.m. designations, except for case management
111.27 services as defined under sections 256B.0913, subdivision 7, 256B.0915, subdivision 1a,
111.28 256B.092, subdivision 1a, and 256B.49, subdivision 13;

111.29 (5) the name, signature, and title, if any, of the provider of service. If the service is
111.30 provided by multiple staff members, the provider may designate a staff member responsible
111.31 for verifying services and completing the documentation required by this paragraph.

111.32 (g) For all other services each record must contain:

- 112.1 (1) the date the entry of service delivery was made;
- 112.2 (2) the day, month, and year when the service was provided;
- 112.3 (3) a service name or description of the service provided;
- 112.4 (4) the name, signature, and title, if any, of the person providing the service. If the service
112.5 is provided by multiple staff, the provider may designate a staff person responsible for
112.6 verifying services and completing the documentation required by this paragraph; and
- 112.7 (5) for services under section 245D.03, subdivision 1, paragraph (c), clause (3), entries
112.8 into the record under this subdivision shall occur at least monthly.
- 112.9 (h) If the service billed is transportation, each entry must contain the information from
112.10 paragraphs (b) to (e) and (g). A provider must:
- 112.11 (1) maintain odometer and other records pursuant to section 256B.0625, subdivision
112.12 17b, clause (3), sufficient to distinguish an individual trip with a specific vehicle and driver
112.13 for a transportation service that is billed by mileage, except if the provider is a common
112.14 carrier as defined by Minnesota Rules, part 9505.0315, subpart 1, item B, or publicly operated
112.15 transit systems. This documentation may be collected and maintained electronically or in
112.16 paper form, but must be made available and produced upon request;
- 112.17 (2) maintain documentation demonstrating that a vehicle and a driver meets the standards
112.18 determined by the Department of Human Services on vehicle and driver qualifications;
- 112.19 (3) only bill a waived transportation service if the transportation is not to or from a
112.20 health care service available through the Medicaid state plan; and
- 112.21 (4) only bill a waived transportation service when the rate for waiver service does not
112.22 include transportation.
- 112.23 (i) If the service provided is equipment or supplies, the documentation must contain the
112.24 information from paragraphs (b) to (e) and:
- 112.25 (1) the recipient's assessed need for the equipment or supplies and the reason the
112.26 equipment or supplies are not covered by the Medicaid state plan;
- 112.27 (2) the type and brand name of equipment or supplies delivered to or purchased by the
112.28 recipient, including whether the equipment or supplies were rented or purchased;
- 112.29 (3) the quantity of supplies delivered or purchased;

(4) the shipping invoice or a delivery service tracking log or other documentation showing the date of delivery that proves the equipment or supplies were delivered to the recipient or a receipt if the equipment or supplies were purchased by the recipient; and

(5) the cost of equipment or supplies if the amount paid for the service depends on the cost.

(j) A service defined as "adult day care" under section 245A.02, subdivision 2a, must meet the documentation standards specified in paragraphs (b) to (f) and must comply with the following:

(1) individual recipient's service records must contain the following:

(i) the recipient's needs assessment and current plan of care according to section 245A.143, subdivisions 4 to 7, or Minnesota Rules, part 9555.9700, if applicable; and

(ii) the day, month, and year the service was provided, including arrival and departure times with a.m. and p.m. designations and the first and last name of the individual making the entry;

(2) entity records must contain the following:

(i) the monthly and quarterly program requirements in Minnesota Rules, part 9555.9710, subparts 1, items E and H, and 3, 4, and 6, if applicable;

(ii) the names and qualifications of the registered physical therapists, registered nurses, and registered dietitian who provide services to the adult day care or nonresidential program;

(iii) the location where the service was provided and, if the location is an alternate location than the primary place of service, the record must contain the address, or the description if the address is not available, of both the origin and destination location, the length of time at the alternate location with a.m. and p.m. designations, and a list of participants who went to the alternate location; and

(iv) documentation that the program is maintaining the appropriate staffing levels according to licensing standards and the federally approved waiver plan.

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

Sec. 31. Minnesota Statutes 2016, section 256G.01, subdivision 4, is amended to read:

Subd. 4. **Additional coverage.** The provisions in sections 256G.02, subdivision 4, paragraphs (a) to (d); 256G.02, subdivisions 5 to 8; 256G.03; 256G.04; 256G.05; and 256G.07, subdivisions 1 to 3, apply to the following financial assistance programs: the aid

to families with dependent children program formerly codified in sections 256.72 to 256.87, Minnesota family investment program; medical assistance; general assistance; the family general assistance program formerly codified in sections 256D.01 to 256D.23; general assistance medical care formerly codified in chapter 256D; and Minnesota supplemental aid.

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

Sec. 32. Minnesota Statutes 2016, section 256G.02, subdivision 4, is amended to read:

Subd. 4. **County of financial responsibility.** (a) "County of financial responsibility" has the meanings in paragraphs (b) to (f).

(b) For an applicant who resides in the state and is not in a facility described in subdivision 6, it means the county in which the applicant resides at the time of application.

(c) For an applicant who resides in a facility described in subdivision 6, it means the county in which the applicant last resided in nonexcluded status immediately before entering the facility.

(d) For an applicant who has not resided in this state for any time other than the excluded time, and subject to the limitations in section 256G.03, subdivision 2, it means the county in which the applicant resides at the time of making application.

(e) For an individual already having a social service case open in one county, financial responsibility for any additional social services attaches to the case that has the earliest date of application and has been open without interruption. This provision does not apply to financial assistance programs listed in section 256G.01, subdivision 4.

(f) Notwithstanding paragraphs (b) to (e), the county of financial responsibility for semi-independent living services provided under section 252.275, and chapter 245D, is the county of residence in nonexcluded status immediately before the placement into or request for those services.

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

Sec. 33. Minnesota Statutes 2016, section 256G.09, subdivision 2, is amended to read:

Subd. 2. **Financial disputes.** (a) If the county receiving the transmittal does not believe it is financially responsible, it ~~should provide~~ shall submit to the department and provide to the initially responsible county a request for department resolution of financial responsibility dispute form, with a statement of all facts and documents necessary for the

department to make the requested determination of financial responsibility. The submission must clearly state the program area in dispute, the application date or commitment date for the program in dispute, and ~~must state~~ the specific basis upon which the submitting county is denying financial responsibility. If the receiving county fails to submit the dispute resolution form to the department, the initially responsible county may submit the form to the department and provide a copy to the receiving county.

(b) The ~~initially responsible~~ county responding to the dispute resolution request then has ~~45~~ 30 calendar days to submit its position and any supporting evidence to the department. The absence of a submission by the initially responsible county or the responding county does not limit the right of the department to issue a binding opinion based on the evidence actually submitted.

(c) The department shall not issue an advisory opinion. A county may not submit a case ~~must not be submitted~~ to the department under the dispute resolution process until the local agency taking the application or making the commitment has made an initial determination about eligibility and financial responsibility, and services have been initiated. This paragraph does not prohibit the submission of closed cases that otherwise meet the applicable statute of limitations.

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

Sec. 34. Minnesota Statutes 2016, section 256G.10, is amended to read:

256G.10 DERIVATIVE SETTLEMENT.

The residence of the parent of a minor child, ~~with whom that child last lived in a nonexcluded time setting~~, or guardian of a ward shall determine the residence of the child or ward for all social services governed by this chapter. If the child lived with each parent separately, then the residence of the parent with whom the child lived most recently shall determine the residence of the child for all social services governed by this chapter.

For purposes of this chapter, a minor child is defined as being under 18 years of age unless otherwise specified in a program administered by the commissioner.

Physical or legal custody has no bearing on residence determinations. This section does not, however, apply to situations involving another state, limit the application of an interstate compact, or apply to situations involving state wards where the commissioner is defined by law as the guardian.

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

ARTICLE 4**HEALTH CARE**

Section 1. Minnesota Statutes 2016, section 256.01, subdivision 29, is amended to read:

Subd. 29. **State medical review team.** (a) To ensure the timely processing of determinations of disability by the commissioner's state medical review team under sections 256B.055, ~~subdivision~~ subdivisions 7, paragraph (b), and 12; 256B.057, subdivision 9, ~~and 256B.055, subdivision 12,~~ the commissioner shall review all medical evidence ~~submitted by county agencies with a referral~~ and seek additional information from providers, applicants, and enrollees to support the determination of disability where necessary. Disability shall be determined according to the rules of title XVI and title XIX of the Social Security Act and pertinent rules and policies of the Social Security Administration.

(b) Prior to a denial or withdrawal of a requested determination of disability due to insufficient evidence, the commissioner shall (1) ensure that the missing evidence is necessary and appropriate to a determination of disability, and (2) assist applicants and enrollees to obtain the evidence, including, but not limited to, medical examinations and electronic medical records.

(c) The commissioner shall provide the chairs of the legislative committees with jurisdiction over health and human services finance and budget the following information on the activities of the state medical review team by February 1 of each year:

(1) the number of applications to the state medical review team that were denied, approved, or withdrawn;

(2) the average length of time from receipt of the application to a decision;

(3) the number of appeals, appeal results, and the length of time taken from the date the person involved requested an appeal for a written decision to be made on each appeal;

(4) for applicants, their age, health coverage at the time of application, hospitalization history within three months of application, and whether an application for Social Security or Supplemental Security Income benefits is pending; and

(5) specific information on the medical certification, licensure, or other credentials of the person or persons performing the medical review determinations and length of time in that position.

(d) Any appeal made under section 256.045, subdivision 3, of a disability determination made by the state medical review team must be decided according to the timelines under

section 256.0451, subdivision 22, paragraph (a). If a written decision is not issued within the timelines under section 256.0451, subdivision 22, paragraph (a), the appeal must be immediately reviewed by the chief human services judge.

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

Sec. 2. Minnesota Statutes 2016, section 256B.0659, subdivision 21, is amended to read:

Subd. 21. **Requirements for provider enrollment of personal care assistance provider agencies.** (a) All personal care assistance provider agencies must provide, at the time of enrollment, reenrollment, and revalidation as a personal care assistance provider agency in a format determined by the commissioner, information and documentation that includes, but is not limited to, the following:

(1) the personal care assistance provider agency's current contact information including address, telephone number, and e-mail address;

(2) proof of surety bond coverage. Upon new enrollment, or if the provider's Medicaid revenue in the previous calendar year is up to and including \$300,000, the provider agency must purchase a surety bond of \$50,000. If the Medicaid revenue in the previous year is over \$300,000, the provider agency must purchase a surety bond of \$100,000. The surety bond must be in a form approved by the commissioner, must be renewed annually, and must allow for recovery of costs and fees in pursuing a claim on the bond;

(3) proof of fidelity bond coverage in the amount of \$20,000;

(4) proof of workers' compensation insurance coverage;

(5) proof of liability insurance;

(6) a description of the personal care assistance provider agency's organization identifying the names of all owners, managing employees, staff, board of directors, and the affiliations of the directors, owners, or staff to other service providers;

(7) a copy of the personal care assistance provider agency's written policies and procedures including: hiring of employees; training requirements; service delivery; and employee and consumer safety including process for notification and resolution of consumer grievances, identification and prevention of communicable diseases, and employee misconduct;

(8) copies of all other forms the personal care assistance provider agency uses in the course of daily business including, but not limited to:

(i) a copy of the personal care assistance provider agency's time sheet if the time sheet varies from the standard time sheet for personal care assistance services approved by the commissioner, and a letter requesting approval of the personal care assistance provider agency's nonstandard time sheet;

(ii) the personal care assistance provider agency's template for the personal care assistance care plan; and

(iii) the personal care assistance provider agency's template for the written agreement in subdivision 20 for recipients using the personal care assistance choice option, if applicable;

(9) a list of all training and classes that the personal care assistance provider agency requires of its staff providing personal care assistance services;

(10) documentation that the personal care assistance provider agency and staff have successfully completed all the training required by this section;

(11) documentation of the agency's marketing practices;

(12) disclosure of ownership, leasing, or management of all residential properties that is used or could be used for providing home care services;

(13) documentation that the agency will use the following percentages of revenue generated from the medical assistance rate paid for personal care assistance services for employee personal care assistant wages and benefits: 72.5 percent of revenue in the personal care assistance choice option and 72.5 percent of revenue from other personal care assistance providers. The revenue generated by the qualified professional and the reasonable costs associated with the qualified professional shall not be used in making this calculation; and

(14) effective May 15, 2010, documentation that the agency does not burden recipients' free exercise of their right to choose service providers by requiring personal care assistants to sign an agreement not to work with any particular personal care assistance recipient or for another personal care assistance provider agency after leaving the agency and that the agency is not taking action on any such agreements or requirements regardless of the date signed.

(b) Personal care assistance provider agencies shall provide the information specified in paragraph (a) to the commissioner at the time the personal care assistance provider agency enrolls as a vendor or upon request from the commissioner. The commissioner shall collect the information specified in paragraph (a) from all personal care assistance providers beginning July 1, 2009.

(c) All personal care assistance provider agencies shall require all employees in management and supervisory positions and owners of the agency who are active in the day-to-day management and operations of the agency to complete mandatory training as determined by the commissioner before submitting an application for enrollment of the agency as a provider. All personal care provider agencies shall also require qualified professionals to complete the training required by subdivision 13 before submitting an application for enrollment of the agency as a provider. Employees in management and supervisory positions and owners who are active in the day-to-day operations of an agency who have completed the required training as an employee with a personal care assistance provider agency do not need to repeat the required training if they are hired by another agency, if they have completed the training within the past three years. By September 1, 2010, the required training must be available with meaningful access according to title VI of the Civil Rights Act and federal regulations adopted under that law or any guidance from the United States Health and Human Services Department. The required training must be available online or by electronic remote connection. The required training must provide for competency testing. Personal care assistance provider agency billing staff shall complete training about personal care assistance program financial management. This training is effective July 1, 2009. Any personal care assistance provider agency enrolled before that date shall, if it has not already, complete the provider training within 18 months of July 1, 2009. Any new owners or employees in management and supervisory positions involved in the day-to-day operations are required to complete mandatory training as a requisite of working for the agency. Personal care assistance provider agencies certified for participation in Medicare as home health agencies are exempt from the training required in this subdivision. When available, Medicare-certified home health agency owners, supervisors, or managers must successfully complete the competency test.

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

Sec. 3. Minnesota Statutes 2016, section 256B.0659, subdivision 23, is amended to read:

Subd. 23. Enrollment requirements following termination. (a) A terminated personal care assistance provider agency, including all named individuals on the current enrollment disclosure form and known or discovered affiliates of the personal care assistance provider agency, is not eligible to enroll as a personal care assistance provider agency for two years following the termination.

(b) After the two-year period in paragraph (a), if the provider seeks to reenroll as a personal care assistance provider agency, the personal care assistance provider agency must be placed on a one-year probation period, beginning after completion of the following:

(1) the department's provider trainings under this section; and

(2) initial enrollment requirements under subdivision 21.

(c) During the probationary period the commissioner shall complete site visits and request submission of documentation to review compliance with program policy.

(d) This subdivision does not apply to a personal care assistance provider agency terminated solely for failure to timely and completely comply with the requirements of revalidation required by section 256B.04, subdivision 22.

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

ARTICLE 5

COMMUNITY SUPPORTS

Section 1. Minnesota Statutes 2016, section 144D.04, subdivision 2, is amended to read:

Subd. 2. **Contents of contract.** A housing with services contract, which need not be entitled as such to comply with this section, shall include at least the following elements in itself or through supporting documents or attachments:

(1) the name, street address, and mailing address of the establishment;

(2) the name and mailing address of the owner or owners of the establishment and, if the owner or owners is not a natural person, identification of the type of business entity of the owner or owners;

(3) the name and mailing address of the managing agent, through management agreement or lease agreement, of the establishment, if different from the owner or owners;

(4) the name and address of at least one natural person who is authorized to accept service of process on behalf of the owner or owners and managing agent;

(5) a statement describing the registration and licensure status of the establishment and any provider providing health-related or supportive services under an arrangement with the establishment;

(6) the term of the contract;

121.1 (7) a description of the services to be provided to the resident in the base rate to be paid
 121.2 by resident, including a delineation of the portion of the base rate that constitutes rent and
 121.3 a delineation of charges for each service included in the base rate;

121.4 (8) a description of any additional services, including home care services, available for
 121.5 an additional fee from the establishment directly or through arrangements with the
 121.6 establishment, and a schedule of fees charged for these services;

121.7 (9) a description of the process through which the contract may be modified, amended,
 121.8 or terminated, including whether a move to a different room or sharing a room would be
 121.9 required in the event that the tenant can no longer pay the current rent;

121.10 (10) a description of the establishment's complaint resolution process available to residents
 121.11 including the toll-free complaint line for the Office of Ombudsman for Long-Term Care;

121.12 (11) the resident's designated representative, if any;

121.13 (12) the establishment's referral procedures if the contract is terminated;

121.14 (13) requirements of residency used by the establishment to determine who may reside
 121.15 or continue to reside in the housing with services establishment;

121.16 (14) billing and payment procedures and requirements;

121.17 (15) a statement regarding the ability of ~~residents~~ a resident to receive services from
 121.18 service providers with whom the establishment does not have an arrangement;

121.19 (16) a statement regarding the availability of public funds for payment for residence or
 121.20 services in the establishment; and

121.21 (17) a statement regarding the availability of and contact information for long-term care
 121.22 consultation services under section 256B.0911 in the county in which the establishment is
 121.23 located.

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

121.25 Sec. 2. Minnesota Statutes 2016, section 144D.04, is amended by adding a subdivision to
 121.26 read:

121.27 Subd. 2a. **Additional contract requirements.** (a) For a resident receiving one or more
 121.28 health-related services from the establishment's arranged home care provider, as defined in
 121.29 section 144D.01, subdivision 6, the contract must include the requirements in paragraph
 121.30 (b), clauses (1) to (5). A restriction of a resident's rights under this subdivision is allowed
 121.31 only if determined necessary for health and safety reasons identified by the home care

122.1 provider's registered nurse in an initial assessment or reassessment, as defined under section
 122.2 144A.4791, subdivision 8, and documented in the written service plan under section
 122.3 144A.4791, subdivision 9. Any restrictions of those rights for people served under sections
 122.4 256B.0915 and 256B.49 must be documented in the resident's coordinated service and
 122.5 support plan (CSSP), as defined under sections 256B.49, subdivision 15, and 256B.0915,
 122.6 subdivision 6.

122.7 (b) The contract must include a statement:

122.8 (1) regarding the ability of a resident to furnish and decorate the resident's unit within
 122.9 the terms of the lease;

122.10 (2) regarding the resident's right to access food at any time;

122.11 (3) regarding a resident's right to choose the resident's visitors and times of visits;

122.12 (4) regarding the resident's right to choose a roommate if sharing a unit; and

122.13 (5) notifying the resident of the resident's right to have and use a lockable door to the
 122.14 resident's unit. The landlord shall provide the locks on the unit. Only a staff member with
 122.15 a specific need to enter the unit shall have keys, and advance notice must be given to the
 122.16 resident before entrance, when possible.

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

122.18 Sec. 3. Minnesota Statutes 2016, section 245A.03, subdivision 7, is amended to read:

122.19 Subd. 7. **Licensing moratorium.** (a) The commissioner shall not issue an initial license
 122.20 for child foster care licensed under Minnesota Rules, parts 2960.3000 to 2960.3340, or adult
 122.21 foster care licensed under Minnesota Rules, parts 9555.5105 to 9555.6265, under this chapter
 122.22 for a physical location that will not be the primary residence of the license holder for the
 122.23 entire period of licensure. If a license is issued during this moratorium, and the license
 122.24 holder changes the license holder's primary residence away from the physical location of
 122.25 the foster care license, the commissioner shall revoke the license according to section
 122.26 245A.07. The commissioner shall not issue an initial license for a community residential
 122.27 setting licensed under chapter 245D. Exceptions to the moratorium include:

122.28 (1) foster care settings that are required to be registered under chapter 144D;

122.29 (2) foster care licenses replacing foster care licenses in existence on May 15, 2009, or
 122.30 community residential setting licenses replacing adult foster care licenses in existence on
 122.31 December 31, 2013, and determined to be needed by the commissioner under paragraph
 122.32 (b);

123.1 (3) new foster care licenses or community residential setting licenses determined to be
123.2 needed by the commissioner under paragraph (b) for the closure of a nursing facility, ICF/DD,
123.3 or regional treatment center; restructuring of state-operated services that limits the capacity
123.4 of state-operated facilities; or allowing movement to the community for people who no
123.5 longer require the level of care provided in state-operated facilities as provided under section
123.6 256B.092, subdivision 13, or 256B.49, subdivision 24;

123.7 (4) new foster care licenses or community residential setting licenses determined to be
123.8 needed by the commissioner under paragraph (b) for persons requiring hospital level care;
123.9 or

123.10 (5) new foster care licenses or community residential setting licenses determined to be
123.11 needed by the commissioner for the transition of people from personal care assistance to
123.12 the home and community-based services.

123.13 When approving an exception under this paragraph, the commissioner shall consider the
123.14 resource need determination process in paragraph (d), the availability of foster care licensed
123.15 beds in the geographic area in which the licensee seeks to operate, and the recommendation
123.16 of the local county board. The determination by the commissioner is final and not subject
123.17 to appeal.

123.18 (b) The commissioner shall determine the need for newly licensed foster care homes or
123.19 community residential settings as defined under this subdivision. As part of the determination,
123.20 the commissioner shall consider the availability of foster care capacity in the area in which
123.21 the licensee seeks to operate, and the recommendation of the local county board. The
123.22 determination by the commissioner must be final. A determination of need is not required
123.23 for a change in ownership at the same address.

123.24 (c) When an adult resident served by the program moves out of a foster home that is not
123.25 the primary residence of the license holder according to section 256B.49, subdivision 15,
123.26 paragraph (f), or the adult community residential setting, the county shall immediately
123.27 inform the Department of Human Services Licensing Division. ~~The department shall decrease~~
123.28 ~~the statewide licensed capacity for adult foster care settings where the physical location is~~
123.29 ~~not the primary residence of the license holder, or for adult community residential settings,~~
123.30 ~~if the voluntary changes described in paragraph (e) are not sufficient to meet the savings~~
123.31 ~~required by reductions in licensed bed capacity under Laws 2011, First Special Session~~
123.32 ~~chapter 9, article 7, sections 1 and 40, paragraph (f), and maintain statewide long-term care~~
123.33 ~~residential services capacity within budgetary limits. Implementation of the statewide~~
123.34 ~~licensed capacity reduction shall begin on July 1, 2013. The commissioner shall delicense~~

124.1 ~~up to 128 beds by June 30, 2014, using the needs determination process. Prior to any~~
124.2 ~~involuntary reduction of licensed capacity, the commissioner shall consult with lead agencies~~
124.3 ~~and license holders to determine which adult foster care settings, where the physical location~~
124.4 ~~is not the primary residence of the license holder, or community residential settings, are~~
124.5 ~~licensed for up to five beds, but have operated at less than full capacity for 12 or more~~
124.6 ~~months as of March 1, 2014. The settings that meet these criteria must be the first to be~~
124.7 ~~considered for an involuntary decrease in statewide licensed capacity, up to a maximum of~~
124.8 ~~35 beds. If more than 35 beds are identified that meet these criteria, the commissioner shall~~
124.9 ~~prioritize the selection of those beds to be closed based on the length of time the beds have~~
124.10 ~~been vacant. The longer a bed has been vacant, the higher priority it must be given for~~
124.11 ~~closure. Under this paragraph, the commissioner has the authority to reduce unused licensed~~
124.12 ~~capacity of a current foster care program, or the community residential settings, to accomplish~~
124.13 ~~the consolidation or closure of settings. Under this paragraph, the commissioner has the~~
124.14 ~~authority to manage statewide capacity, including adjusting the capacity available to each~~
124.15 ~~county and adjusting statewide available capacity, to meet the statewide needs identified~~
124.16 ~~through the resource need determination process in paragraph (e) (d). A decreased licensed~~
124.17 ~~capacity according to this paragraph is not subject to appeal under this chapter.~~

124.18 ~~(d) Residential settings that would otherwise be subject to the decreased license capacity~~
124.19 ~~established in paragraph (c) shall be exempt if the license holder's beds are occupied by~~
124.20 ~~residents whose primary diagnosis is mental illness and the license holder is certified under~~
124.21 ~~the requirements in subdivision 6a or section 245D.33.~~

124.22 ~~(e) (d)~~ A resource need determination process, managed at the state level, using the
124.23 available reports required by section 144A.351, and other data and information shall be
124.24 used to determine where the reduced capacity required under paragraph (c) will be
124.25 implemented. The commissioner shall consult with the stakeholders described in section
124.26 144A.351, and employ a variety of methods to improve the state's capacity to meet long-term
124.27 care service needs within budgetary limits, including seeking proposals from service providers
124.28 or lead agencies to change service type, capacity, or location to improve services, increase
124.29 the independence of residents, and better meet needs identified by the long-term care services
124.30 reports and statewide data and information. By February 1, 2013, and August 1, 2014, and
124.31 each following year, the commissioner shall provide information and data on the overall
124.32 capacity of licensed long-term care services, actions taken under this subdivision to manage
124.33 statewide long-term care services and supports resources, and any recommendations for
124.34 change to the legislative committees with jurisdiction over health and human services budget.

125.1 (e) The commissioner must notify a license holder when its corporate foster care or
125.2 community residential setting licensed beds are reduced under this section. The notice of
125.3 reduction of licensed beds must be in writing and delivered to the license holder by certified
125.4 mail or personal service. The notice must state why the licensed beds are reduced and must
125.5 inform the license holder of its right to request reconsideration by the commissioner. The
125.6 license holder's request for reconsideration must be in writing. If mailed, the request for
125.7 reconsideration must be postmarked and sent to the commissioner within 20 calendar days
125.8 after the license holder's receipt of the notice of reduction of licensed beds. If a request for
125.9 reconsideration is made by personal service, it must be received by the commissioner within
125.10 20 calendar days after the license holder's receipt of the notice of reduction of licensed beds.

125.11 (f) At the time of application and reapplication for licensure, the applicant and the license
125.12 holder that are subject to the moratorium or an exclusion established in paragraph (a) are
125.13 required to inform the commissioner whether the physical location where the foster care
125.14 will be provided is or will be the primary residence of the license holder for the entire period
125.15 of licensure. If the primary residence of the applicant or license holder changes, the applicant
125.16 or license holder must notify the commissioner immediately. The commissioner shall print
125.17 on the foster care license certificate whether or not the physical location is the primary
125.18 residence of the license holder.

125.19 (g) License holders of foster care homes identified under paragraph (f) that are not the
125.20 primary residence of the license holder and that also provide services in the foster care home
125.21 that are covered by a federally approved home and community-based services waiver, as
125.22 authorized under section 256B.0915, 256B.092, or 256B.49, must inform the human services
125.23 licensing division that the license holder provides or intends to provide these waiver-funded
125.24 services.

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

125.26 Sec. 4. Minnesota Statutes 2016, section 245A.04, subdivision 14, is amended to read:

125.27 Subd. 14. **Policies and procedures for program administration required and**
125.28 **enforceable.** (a) The license holder shall develop program policies and procedures necessary
125.29 to maintain compliance with licensing requirements under Minnesota Statutes and Minnesota
125.30 Rules.

125.31 (b) The license holder shall:

125.32 (1) provide training to program staff related to their duties in implementing the program's
125.33 policies and procedures developed under paragraph (a);

(2) document the provision of this training; and

(3) monitor implementation of policies and procedures by program staff.

(c) The license holder shall keep program policies and procedures readily accessible to staff and index the policies and procedures with a table of contents or another method approved by the commissioner.

(d) An adult foster care license holder that provides foster care services to a resident under section 256B.0915 must annually provide a copy of the resident termination policy under section 245A.11, subdivision 11, to a resident covered by the policy.

Sec. 5. Minnesota Statutes 2016, section 245A.11, is amended by adding a subdivision to read:

Subd. 9. **Adult foster care bedrooms.** (a) A resident receiving services must have a choice of roommate. Each roommate must consent in writing to sharing a bedroom with one another. The license holder is responsible for notifying a resident of the resident's right to request a change of roommate.

(b) The license holder must provide a lock for each resident's bedroom door, unless otherwise indicated for the resident's health, safety, or well-being. A restriction on the use of the lock must be documented and justified in the resident's individual abuse prevention plan required by sections 626.557, subdivision 14, and 245A.65, subdivision 2, paragraph (b). For a resident served under section 256B.0915, the case manager must be part of the interdisciplinary team under section 245A.65, subdivision 2, paragraph (b).

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

Sec. 6. Minnesota Statutes 2016, section 245A.11, is amended by adding a subdivision to read:

Subd. 10. **Adult foster care resident rights.** (a) The license holder shall ensure that a resident and a resident's legal representative are given, at admission:

(1) an explanation and copy of the resident's rights specified in paragraph (b);

(2) a written summary of the Vulnerable Adults Protection Act prepared by the department; and

(3) the name, address, and telephone number of the local agency to which a resident or a resident's legal representative may submit an oral or written complaint.

(b) Adult foster care resident rights include the right to:

- 127.1 (1) have daily, private access to and use of a non-coin-operated telephone for local and
127.2 long-distance telephone calls made collect or paid for by the resident;
- 127.3 (2) receive and send, without interference, uncensored, unopened mail or electronic
127.4 correspondence or communication;
- 127.5 (3) have use of and free access to common areas in the residence and the freedom to
127.6 come and go from the residence at will;
- 127.7 (4) have privacy for visits with the resident's spouse, next of kin, legal counsel, religious
127.8 adviser, or others, according to section 363A.09 of the Human Rights Act, including privacy
127.9 in the resident's bedroom;
- 127.10 (5) keep, use, and access the resident's personal clothing and possessions as space permits,
127.11 unless this right infringes on the health, safety, or rights of another resident or household
127.12 member, including the right to access the resident's personal possessions at any time;
- 127.13 (6) choose the resident's visitors and time of visits and participate in activities of
127.14 commercial, religious, political, and community groups without interference if the activities
127.15 do not infringe on the rights of another resident or household member;
- 127.16 (7) if married, privacy for visits by the resident's spouse, and, if both spouses are residents
127.17 of the adult foster home, the residents have the right to share a bedroom and bed;
- 127.18 (8) privacy, including use of the lock on the resident's bedroom door or unit door. A
127.19 resident's privacy must be respected by license holders, caregivers, household members,
127.20 and volunteers by knocking on the door of a resident's bedroom or bathroom and seeking
127.21 consent before entering, except in an emergency;
- 127.22 (9) furnish and decorate the resident's bedroom or living unit;
- 127.23 (10) engage in chosen activities and have an individual schedule supported by the license
127.24 holder that meets the resident's preferences;
- 127.25 (11) freedom and support to access food at any time;
- 127.26 (12) have personal, financial, service, health, and medical information kept private, and
127.27 be advised of disclosure of this information by the license holder;
- 127.28 (13) access records and recorded information about the resident according to applicable
127.29 state and federal law, regulation, or rule;
- 127.30 (14) be free from maltreatment;

128.1 (15) be treated with courtesy and respect and receive respectful treatment of the resident's
128.2 property;

128.3 (16) reasonable observance of cultural and ethnic practice and religion;

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

128.6 (18) be informed of and use the license holder's grievance policy and procedures,
128.7 including how to contact the highest level of authority in the program;

128.8 (19) assert the resident's rights personally, or have the rights asserted by the resident's
128.9 family, authorized representative, or legal representative, without retaliation; and

128.10 (20) give or withhold written informed consent to participate in any research or
128.11 experimental treatment.

128.12 (c) A restriction of a resident's rights under paragraph (b), clauses (1) to (4), (6), (8),
128.13 (10), and (11), is allowed only if determined necessary to ensure the health, safety, and
128.14 well-being of the resident. Any restriction of a resident's right must be documented and
128.15 justified in the resident's individual abuse prevention plan required by sections 626.557,
128.16 subdivision 14, and 245A.65, subdivision 2, paragraph (b). For a resident served under
128.17 section 256B.0915, the case manager must be part of the interdisciplinary team under section
128.18 245A.65, subdivision 2, paragraph (b). The restriction must be implemented in the least
128.19 restrictive manner necessary to protect the resident and provide support to reduce or eliminate
128.20 the need for the restriction.

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

128.22 Sec. 7. Minnesota Statutes 2016, section 245A.11, is amended by adding a subdivision to
128.23 read:

128.24 **Subd. 11. Adult foster care service termination for elderly waiver participants.** (a)
128.25 This subdivision applies to foster care services for a resident served under section 256B.0915.

128.26 (b) The foster care license holder must establish policies and procedures for service
128.27 termination that promote continuity of care and service coordination with the resident and
128.28 the case manager and with another licensed caregiver, if any, who also provides support to
128.29 the resident. The policy must include the requirements specified in paragraphs (c) to (h).

128.30 (c) The license holder must allow a resident to remain in the program and cannot terminate
128.31 services unless:

129.1 (1) the termination is necessary for the resident's health, safety, and well-being and the
129.2 resident's needs cannot be met in the facility;

129.3 (2) the safety of the resident or another resident in the program is endangered and positive
129.4 support strategies were attempted and have not achieved and effectively maintained safety
129.5 for the resident or another resident in the program;

129.6 (3) the health, safety, and well-being of the resident or another resident in the program
129.7 would otherwise be endangered;

129.8 (4) the program was not paid for services;

129.9 (5) the program ceases to operate; or

129.10 (6) the resident was terminated by the lead agency from waiver eligibility.

129.11 (d) Before giving notice of service termination, the license holder must document the
129.12 action taken to minimize or eliminate the need for termination. The action taken by the
129.13 license holder must include, at a minimum:

129.14 (1) consultation with the resident's interdisciplinary team to identify and resolve issues
129.15 leading to a notice of service termination; and

129.16 (2) a request to the case manager or other professional consultation or intervention
129.17 services to support the resident in the program. This requirement does not apply to a notice
129.18 of service termination issued under paragraph (c), clause (4) or (5).

129.19 (e) If, based on the best interests of the resident, the circumstances at the time of notice
129.20 were such that the license holder was unable to take the action specified in paragraph (d),
129.21 the license holder must document the specific circumstances and the reason the license
129.22 holder was unable to take the action.

129.23 (f) The license holder must notify the resident or the resident's legal representative and
129.24 the case manager in writing of the intended service termination. The notice must include:

129.25 (1) the reason for the action;

129.26 (2) except for service termination under paragraph (c), clause (4) or (5), a summary of
129.27 the action taken to minimize or eliminate the need for termination and the reason the action
129.28 failed to prevent the termination;

129.29 (3) the resident's right to appeal the service termination under section 256.045, subdivision
129.30 3, paragraph (a); and

(4) the resident's right to seek a temporary order staying the service termination according to the procedures in section 256.045, subdivision 4a, or subdivision 6, paragraph (c).

(g) Notice of the proposed service termination must be given at least 30 days before terminating a resident's service.

(h) After the resident receives the notice of service termination and before the services are terminated, the license holder must:

(1) work with the support team or expanded support team to develop reasonable alternatives to support continuity of care and to protect the resident;

(2) provide information requested by the resident or case manager; and

(3) maintain information about the service termination, including the written notice of service termination, in the resident's record.

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

Sec. 8. Minnesota Statutes 2016, section 245D.03, subdivision 1, is amended to read:

Subdivision 1. **Applicability.** (a) The commissioner shall regulate the provision of home and community-based services to persons with disabilities and persons age 65 and older pursuant to this chapter. The licensing standards in this chapter govern the provision of basic support services and intensive support services.

(b) Basic support services provide the level of assistance, supervision, and care that is necessary to ensure the health and welfare of the person and do not include services that are specifically directed toward the training, treatment, habilitation, or rehabilitation of the person. Basic support services include:

(1) in-home and out-of-home respite care services as defined in section 245A.02, subdivision 15, and under the brain injury, community alternative care, community access for disability inclusion, developmental disability, and elderly waiver plans, excluding out-of-home respite care provided to children in a family child foster care home licensed under Minnesota Rules, parts 2960.3000 to 2960.3100, when the child foster care license holder complies with the requirements under section 245D.06, subdivisions 5, 6, 7, and 8, or successor provisions; and section 245D.061 or successor provisions, which must be stipulated in the statement of intended use required under Minnesota Rules, part 2960.3000, subpart 4;

(2) adult companion services as defined under the brain injury, community access for disability inclusion, and elderly waiver plans, excluding adult companion services provided

131.1 under the Corporation for National and Community Services Senior Companion Program
131.2 established under the Domestic Volunteer Service Act of 1973, Public Law 98-288;

131.3 (3) personal support as defined under the developmental disability waiver plan;

131.4 (4) 24-hour emergency assistance, personal emergency response as defined under the
131.5 community access for disability inclusion and developmental disability waiver plans;

131.6 (5) night supervision services as defined under the brain injury waiver plan; and

131.7 (6) homemaker services as defined under the community access for disability inclusion,
131.8 brain injury, community alternative care, developmental disability, and elderly waiver plans,
131.9 excluding providers licensed by the Department of Health under chapter 144A and those
131.10 providers providing cleaning services only.

131.11 (c) Intensive support services provide assistance, supervision, and care that is necessary
131.12 to ensure the health and welfare of the person and services specifically directed toward the
131.13 training, habilitation, or rehabilitation of the person. Intensive support services include:

131.14 (1) intervention services, including:

131.15 (i) behavioral support services as defined under the brain injury and community access
131.16 for disability inclusion waiver plans;

131.17 (ii) in-home or out-of-home crisis respite services as defined under the developmental
131.18 disability waiver plan; and

131.19 (iii) specialist services as defined under the current developmental disability waiver
131.20 plan;

131.21 (2) in-home support services, including:

131.22 (i) in-home family support and supported living services as defined under the
131.23 developmental disability waiver plan;

131.24 (ii) independent living services training as defined under the brain injury and community
131.25 access for disability inclusion waiver plans; ~~and~~

131.26 (iii) semi-independent living services; and

131.27 (iv) individualized home supports services as defined under the brain injury, community
131.28 alternative care, and community access for disability inclusion waiver plans;

131.29 (3) residential supports and services, including:

(i) supported living services as defined under the developmental disability waiver plan provided in a family or corporate child foster care residence, a family adult foster care residence, a community residential setting, or a supervised living facility;

(ii) foster care services as defined in the brain injury, community alternative care, and community access for disability inclusion waiver plans provided in a family or corporate child foster care residence, a family adult foster care residence, or a community residential setting; and

(iii) residential services provided to more than four persons with developmental disabilities in a supervised living facility, including ICFs/DD;

(4) day services, including:

(i) structured day services as defined under the brain injury waiver plan;

(ii) day training and habilitation services under sections 252.41 to 252.46, and as defined under the developmental disability waiver plan; and

(iii) prevocational services as defined under the brain injury and community access for disability inclusion waiver plans; and

(5) supported employment as defined under the brain injury, developmental disability, and community access for disability inclusion waiver plans.

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

Sec. 9. Minnesota Statutes 2016, section 245D.04, subdivision 3, is amended to read:

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

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

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

(3) be free from maltreatment;

(4) be free from restraint, time out, seclusion, restrictive intervention, or other prohibited procedure identified in section 245D.06, subdivision 5, or successor provisions, except for:

(i) emergency use of manual restraint to protect the person from imminent danger to self or others according to the requirements in section 245D.061 or successor provisions; or (ii)

133.1 the use of safety interventions as part of a positive support transition plan under section
133.2 245D.06, subdivision 8, or successor provisions;

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

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

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

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

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

133.13 (10) know the name, telephone number, and the Web site, e-mail, and street addresses
133.14 of protection and advocacy services, including the appropriate state-appointed ombudsman,
133.15 and a brief description of how to file a complaint with these offices;

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

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

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

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

133.23 (15) engage in chosen activities; and

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

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

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

133.30 (2) receive and send, without interference, uncensored, unopened mail or electronic
133.31 correspondence or communication;

(3) have use of and free access to common areas in the residence and the freedom to come and go from the residence at will; ~~and~~

(4) choose the person's visitors and time of visits and have privacy for visits with the person's spouse, next of kin, legal counsel, religious ~~advisor~~ adviser, or others, in accordance with section 363A.09 of the Human Rights Act, including privacy in the person's bedroom;

(5) the freedom and support to access food at any time;

(6) the freedom to furnish and decorate the person's bedroom or living unit;

(7) a setting that is clean and free from accumulation of dirt, grease, garbage, peeling paint, mold, vermin, and insects;

(8) a setting that is free from hazards that threaten the person's health or safety;

(9) a setting that meets state and local building and zoning definitions of a dwelling unit in a residential occupancy; and

(10) have access to potable water and three nutritionally balanced meals and nutritious snacks between meals each day.

(c) Restriction of a person's rights under paragraph (a), clauses (13) to ~~(15)~~ (16), or paragraph (b) is allowed only if determined necessary to ensure the health, safety, and well-being of the person. Any restriction of those rights must be documented in the person's coordinated service and support plan or coordinated service and support plan addendum. The restriction must be implemented in the least restrictive alternative manner necessary to protect the person and provide support to reduce or eliminate the need for the restriction in the most integrated setting and inclusive manner. The documentation must include the following information:

(1) the justification for the restriction based on an assessment of the person's vulnerability related to exercising the right without restriction;

(2) the objective measures set as conditions for ending the restriction;

(3) a schedule for reviewing the need for the restriction based on the conditions for ending the restriction to occur semiannually from the date of initial approval, at a minimum, or more frequently if requested by the person, the person's legal representative, if any, and case manager; and

(4) signed and dated approval for the restriction from the person, or the person's legal representative, if any. A restriction may be implemented only when the required approval

135.1 has been obtained. Approval may be withdrawn at any time. If approval is withdrawn, the
135.2 right must be immediately and fully restored.

135.3 **EFFECTIVE DATE.** This section is effective the day following final enactment.

135.4 Sec. 10. Minnesota Statutes 2016, section 245D.071, subdivision 1, is amended to read:

135.5 Subdivision 1. **Requirements for intensive support services.** Except for services
135.6 identified in section 245D.03, subdivision 1, paragraph (c), ~~clauses clause (1) and (2)~~, a
135.7 license holder providing intensive support services identified in section 245D.03, subdivision
135.8 1, paragraph (c), must comply with the requirements in this section and section 245D.07,
135.9 subdivisions 1, 1a, and 3. Services identified in section 245D.03, subdivision 1, paragraph
135.10 (c), ~~clauses clause (1) and (2)~~, must comply with the requirements in section 245D.07,
135.11 subdivision 2.

135.12 **EFFECTIVE DATE.** This section is effective the day following final enactment.

135.13 Sec. 11. Minnesota Statutes 2016, section 245D.071, subdivision 3, is amended to read:

135.14 Subd. 3. **Assessment and initial service planning.** (a) Within 15 days of service initiation
135.15 the license holder must complete a preliminary coordinated service and support plan
135.16 addendum based on the coordinated service and support plan.

135.17 (b) Within the scope of services, the license holder must, at a minimum, complete
135.18 assessments in the following areas before the 45-day planning meeting:

135.19 (1) the person's ability to self-manage health and medical needs to maintain or improve
135.20 physical, mental, and emotional well-being, including, when applicable, allergies, seizures,
135.21 choking, special dietary needs, chronic medical conditions, self-administration of medication
135.22 or treatment orders, preventative screening, and medical and dental appointments;

135.23 (2) the person's ability to self-manage personal safety to avoid injury or accident in the
135.24 service setting, including, when applicable, risk of falling, mobility, regulating water
135.25 temperature, community survival skills, water safety skills, and sensory disabilities; and

135.26 (3) the person's ability to self-manage symptoms or behavior that may otherwise result
135.27 in an incident as defined in section 245D.02, subdivision 11, clauses (4) to (7), suspension
135.28 or termination of services by the license holder, or other symptoms or behaviors that may
135.29 jeopardize the health and welfare of the person or others.

135.30 Assessments must produce information about the person that describes the person's overall
135.31 strengths, functional skills and abilities, and behaviors or symptoms. Assessments must be

based on the person's status within the last 12 months at the time of service initiation.

Assessments based on older information must be documented and justified. Assessments must be conducted annually at a minimum or within 30 days of a written request from the person or the person's legal representative or case manager. The results must be reviewed by the support team or expanded support team as part of a service plan review.

(c) Within 45 days of service initiation, the license holder must meet with the person, the person's legal representative, the case manager, and other members of the support team or expanded support team to determine the following based on information obtained from the assessments identified in paragraph (b), the person's identified needs in the coordinated service and support plan, and the requirements in subdivision 4 and section 245D.07, subdivision 1a:

(1) the scope of the services to be provided to support the person's daily needs and activities;

(2) the person's desired outcomes and the supports necessary to accomplish the person's desired outcomes;

(3) the person's preferences for how services and supports are provided, including how the provider will support the person to have control of the person's schedule;

(4) whether the current service setting is the most integrated setting available and appropriate for the person; and

(5) how services must be coordinated across other providers licensed under this chapter serving the person and members of the support team or expanded support team to ensure continuity of care and coordination of services for the person.

EFFECTIVE DATE. This section is effective the day following final enactment.

Sec. 12. Minnesota Statutes 2016, section 245D.09, subdivision 5a, is amended to read:

Subd. 5a. **Alternative sources of training.** The commissioner may approve online training and competency-based assessments in place of a specific number of hours of training in the topics covered in subdivision 4.

Orientation or training received by the staff person from sources other than the license holder in the same subjects as identified in subdivision 4 may count toward the orientation and annual training requirements if received in the 12-month period before the staff person's date of hire. The license holder must maintain documentation of the training received from

137.1 other sources and of each staff person's competency in the required area according to the
137.2 requirements in subdivision 3.

137.3 **EFFECTIVE DATE.** This section is effective the day following final enactment.

137.4 Sec. 13. Minnesota Statutes 2016, section 245D.11, subdivision 4, is amended to read:

137.5 Subd. 4. **Admission criteria.** The license holder must establish policies and procedures
137.6 that promote continuity of care by ensuring that admission or service initiation criteria:

137.7 (1) is consistent with the service-related rights identified in section 245D.04, subdivisions
137.8 2, clauses (4) to (7), and 3, clause (8);

137.9 (2) identifies the criteria to be applied in determining whether the license holder can
137.10 develop services to meet the needs specified in the person's coordinated service and support
137.11 plan;

137.12 (3) requires a license holder providing services in a health care facility to comply with
137.13 the requirements in section 243.166, subdivision 4b, to provide notification to residents
137.14 when a registered predatory offender is admitted into the program or to a potential admission
137.15 when the facility was already serving a registered predatory offender. For purposes of this
137.16 clause, "health care facility" means a facility licensed by the commissioner as a residential
137.17 facility under chapter 245A to provide adult foster care or residential services to persons
137.18 with disabilities; ~~and~~

137.19 (4) requires that when a person or the person's legal representative requests services
137.20 from the license holder, a refusal to admit the person must be based on an evaluation of the
137.21 person's assessed needs and the license holder's lack of capacity to meet the needs of the
137.22 person. The license holder must not refuse to admit a person based solely on the type of
137.23 residential services the person is receiving, or solely on the person's severity of disability,
137.24 orthopedic or neurological handicaps, sight or hearing impairments, lack of communication
137.25 skills, physical disabilities, toilet habits, behavioral disorders, or past failure to make progress.
137.26 Documentation of the basis for refusal must be provided to the person or the person's legal
137.27 representative and case manager upon request; and

137.28 (5) requires the person or the person's legal representative and license holder to sign and
137.29 date the residency agreement when the license holder provides foster care or supported
137.30 living services under section 245D.03, subdivision 1, paragraph (c), clause (3), item (i) or
137.31 (ii), to a person living in a community residential setting defined in section 245D.02,
137.32 subdivision 4a; an adult foster home defined in Minnesota Rules, part 9555.5105, subpart
137.33 5; or a foster family home defined in Minnesota Rules, part 9560.0521, subpart 12. The

138.1 residency agreement must include service termination requirements specified in section
138.2 245D.10, subdivision 3a, paragraphs (b) to (f). The residency agreement must be reviewed
138.3 annually, dated, and signed by the person or the person's legal representative and license
138.4 holder.

138.5 **EFFECTIVE DATE.** This section is effective the day following final enactment.

138.6 Sec. 14. Minnesota Statutes 2016, section 245D.24, subdivision 3, is amended to read:

138.7 Subd. 3. **Bedrooms.** (a) ~~People~~ Each person receiving services must have a choice of
138.8 roommate and must mutually consent, in writing, to sharing a bedroom with one another.
138.9 No more than two people receiving services may share one bedroom.

138.10 (b) A single occupancy bedroom must have at least 80 square feet of floor space with a
138.11 7-1/2 foot ceiling. A double occupancy room must have at least 120 square feet of floor
138.12 space with a 7-1/2 foot ceiling. Bedrooms must be separated from halls, corridors, and other
138.13 habitable rooms by floor-to-ceiling walls containing no openings except doorways and must
138.14 not serve as a corridor to another room used in daily living.

138.15 (c) A person's personal possessions and items for the person's own use are the only items
138.16 permitted to be stored in a person's bedroom.

138.17 (d) Unless otherwise documented through assessment as a safety concern for the person,
138.18 each person must be provided with the following furnishings:

138.19 (1) a separate bed of proper size and height for the convenience and comfort of the
138.20 person, with a clean mattress in good repair;

138.21 (2) clean bedding appropriate for the season for each person;

138.22 (3) an individual cabinet, or dresser, shelves, and a closet, for storage of personal
138.23 possessions and clothing; and

138.24 (4) a mirror for grooming.

138.25 (e) When possible, a person must be allowed to have items of furniture that the person
138.26 personally owns in the bedroom, unless doing so would interfere with safety precautions,
138.27 violate a building or fire code, or interfere with another person's use of the bedroom. A
138.28 person may choose not to have a cabinet, dresser, shelves, or a mirror in the bedroom, as
138.29 otherwise required under paragraph (d), clause (3) or (4). A person may choose to use a
138.30 mattress other than an innerspring mattress and may choose not to have the mattress on a
138.31 mattress frame or support. If a person chooses not to have a piece of required furniture, the
138.32 license holder must document this choice and is not required to provide the item. If a person

139.1 chooses to use a mattress other than an innerspring mattress or chooses not to have a mattress
139.2 frame or support, the license holder must document this choice and allow the alternative
139.3 desired by the person.

139.4 (f) A person must be allowed to bring personal possessions into the bedroom and other
139.5 designated storage space, if such space is available, in the residence. The person must be
139.6 allowed to accumulate possessions to the extent the residence is able to accommodate them,
139.7 unless doing so is contraindicated for the person's physical or mental health, would interfere
139.8 with safety precautions or another person's use of the bedroom, or would violate a building
139.9 or fire code. The license holder must allow for locked storage of personal items. Any
139.10 restriction on the possession or locked storage of personal items, including requiring a
139.11 person to use a lock provided by the license holder, must comply with section 245D.04,
139.12 subdivision 3, paragraph (c), and allow the person to be present if and when the license
139.13 holder opens the lock.

139.14 (g) A person must be allowed to lock the person's bedroom door. The license holder
139.15 must document and assess the physical plant and the environment, and the population served,
139.16 and identify the risk factors that require using locked doors, and the specific action taken
139.17 to minimize the safety risk to a person receiving services at the site.

139.18 **EFFECTIVE DATE.** This section is effective the day following final enactment.

139.19 Sec. 15. Minnesota Statutes 2016, section 256.045, subdivision 3, is amended to read:

139.20 Subd. 3. **State agency hearings.** (a) State agency hearings are available for the following:

139.21 (1) any person applying for, receiving or having received public assistance, medical
139.22 care, or a program of social services granted by the state agency or a county agency or the
139.23 federal Food Stamp Act whose application for assistance is denied, not acted upon with
139.24 reasonable promptness, or whose assistance is suspended, reduced, terminated, or claimed
139.25 to have been incorrectly paid;

139.26 (2) any patient or relative aggrieved by an order of the commissioner under section
139.27 252.27;

139.28 (3) a party aggrieved by a ruling of a prepaid health plan;

139.29 (4) except as provided under chapter 245C, any individual or facility determined by a
139.30 lead investigative agency to have maltreated a vulnerable adult under section 626.557 after
139.31 they have exercised their right to administrative reconsideration under section 626.557;

(5) any person whose claim for foster care payment according to a placement of the child resulting from a child protection assessment under section 626.556 is denied or not acted upon with reasonable promptness, regardless of funding source;

(6) any person to whom a right of appeal according to this section is given by other provision of law;

(7) an applicant aggrieved by an adverse decision to an application for a hardship waiver under section 256B.15;

(8) an applicant aggrieved by an adverse decision to an application or redetermination for a Medicare Part D prescription drug subsidy under section 256B.04, subdivision 4a;

(9) except as provided under chapter 245A, an individual or facility determined to have maltreated a minor under section 626.556, after the individual or facility has exercised the right to administrative reconsideration under section 626.556;

(10) except as provided under chapter 245C, an individual disqualified under sections 245C.14 and 245C.15, following a reconsideration decision issued under section 245C.23, on the basis of serious or recurring maltreatment; a preponderance of the evidence that the individual has committed an act or acts that meet the definition of any of the crimes listed in section 245C.15, subdivisions 1 to 4; or for failing to make reports required under section 626.556, subdivision 3, or 626.557, subdivision 3. Hearings regarding a maltreatment determination under clause (4) or (9) and a disqualification under this clause in which the basis for a disqualification is serious or recurring maltreatment, shall be consolidated into a single fair hearing. In such cases, the scope of review by the human services judge shall include both the maltreatment determination and the disqualification. The failure to exercise the right to an administrative reconsideration shall not be a bar to a hearing under this section if federal law provides an individual the right to a hearing to dispute a finding of maltreatment;

(11) any person with an outstanding debt resulting from receipt of public assistance, medical care, or the federal Food Stamp Act who is contesting a setoff claim by the Department of Human Services or a county agency. The scope of the appeal is the validity of the claimant agency's intention to request a setoff of a refund under chapter 270A against the debt;

(12) a person issued a notice of service termination under section 245D.10, subdivision 3a, from residential supports and services as defined in section 245D.03, subdivision 1, paragraph (c), clause (3), that is not otherwise subject to appeal under subdivision 4a; ~~or~~

(13) an individual disability waiver recipient based on a denial of a request for a rate exception under section 256B.4914; or

(14) a person issued a notice of service termination under section 245A.11, subdivision 11, that is not otherwise subject to appeal under subdivision 4a.

(b) The hearing for an individual or facility under paragraph (a), clause (4), (9), or (10), is the only administrative appeal to the final agency determination specifically, including a challenge to the accuracy and completeness of data under section 13.04. Hearings requested under paragraph (a), clause (4), apply only to incidents of maltreatment that occur on or after October 1, 1995. Hearings requested by nursing assistants in nursing homes alleged to have maltreated a resident prior to October 1, 1995, shall be held as a contested case proceeding under the provisions of chapter 14. Hearings requested under paragraph (a), clause (9), apply only to incidents of maltreatment that occur on or after July 1, 1997. A hearing for an individual or facility under paragraph (a), clauses (4), (9), and (10), is only available when there is no district court action pending. If such action is filed in district court while an administrative review is pending that arises out of some or all of the events or circumstances on which the appeal is based, the administrative review must be suspended until the judicial actions are completed. If the district court proceedings are completed, dismissed, or overturned, the matter may be considered in an administrative hearing.

(c) For purposes of this section, bargaining unit grievance procedures are not an administrative appeal.

(d) The scope of hearings involving claims to foster care payments under paragraph (a), clause (5), shall be limited to the issue of whether the county is legally responsible for a child's placement under court order or voluntary placement agreement and, if so, the correct amount of foster care payment to be made on the child's behalf and shall not include review of the propriety of the county's child protection determination or child placement decision.

(e) The scope of hearings under paragraph (a), ~~clause~~ clauses (12) and (14), shall be limited to whether the proposed termination of services is authorized under section 245D.10, subdivision 3a, paragraph (b), or 245A.11, subdivision 11, and whether the requirements of section 245D.10, subdivision 3a, ~~paragraph~~ paragraphs (c) to (e), or 245A.11, subdivision 2a, paragraphs (d) to (f), were met. If the appeal includes a request for a temporary stay of termination of services, the scope of the hearing shall also include whether the case management provider has finalized arrangements for a residential facility, a program, or services that will meet the assessed needs of the recipient by the effective date of the service termination.

(f) A vendor of medical care as defined in section 256B.02, subdivision 7, or a vendor under contract with a county agency to provide social services is not a party and may not request a hearing under this section, except if assisting a recipient as provided in subdivision 4.

(g) An applicant or recipient is not entitled to receive social services beyond the services prescribed under chapter 256M or other social services the person is eligible for under state law.

(h) The commissioner may summarily affirm the county or state agency's proposed action without a hearing when the sole issue is an automatic change due to a change in state or federal law.

(i) Unless federal or Minnesota law specifies a different time frame in which to file an appeal, an individual or organization specified in this section may contest the specified action, decision, or final disposition before the state agency by submitting a written request for a hearing to the state agency within 30 days after receiving written notice of the action, decision, or final disposition, or within 90 days of such written notice if the applicant, recipient, patient, or relative shows good cause, as defined in section 256.0451, subdivision 13, why the request was not submitted within the 30-day time limit. The individual filing the appeal has the burden of proving good cause by a preponderance of the evidence.

EFFECTIVE DATE. This section is effective the day following final enactment.

Sec. 16. Minnesota Statutes 2016, section 256B.0659, subdivision 24, is amended to read:

Subd. 24. **Personal care assistance provider agency; general duties.** A personal care assistance provider agency shall:

(1) enroll as a Medicaid provider meeting all provider standards, including completion of the required provider training;

(2) comply with general medical assistance coverage requirements;

(3) demonstrate compliance with law and policies of the personal care assistance program to be determined by the commissioner;

(4) comply with background study requirements;

(5) verify and keep records of hours worked by the personal care assistant and qualified professional;

(6) not engage in any agency-initiated direct contact or marketing in person, by phone, or other electronic means to potential recipients, guardians, or family members;

- 143.1 (7) pay the personal care assistant and qualified professional based on actual hours of
143.2 services provided;
- 143.3 (8) withhold and pay all applicable federal and state taxes;
- 143.4 (9) effective January 1, 2010, document that the agency uses a minimum of 72.5 percent
143.5 of the revenue generated by the medical assistance rate for personal care assistance services
143.6 for employee personal care assistant wages and benefits. The revenue generated by the
143.7 qualified professional and the reasonable costs associated with the qualified professional
143.8 shall not be used in making this calculation;
- 143.9 (10) make the arrangements and pay unemployment insurance, taxes, workers'
143.10 compensation, liability insurance, and other benefits, if any;
- 143.11 (11) enter into a written agreement under subdivision 20 before services are provided;
- 143.12 (12) report suspected neglect and abuse to the common entry point according to section
143.13 256B.0651;
- 143.14 (13) provide the recipient with a copy of the home care bill of rights at start of service;
143.15 ~~and~~
- 143.16 (14) request reassessments at least 60 days prior to the end of the current authorization
143.17 for personal care assistance services, on forms provided by the commissioner; and
- 143.18 (15) provide written notice to a recipient at least 30 calendar days before the service
143.19 termination becomes effective except when:
- 143.20 (i) the recipient engages in conduct that significantly alters the terms of the recipient's
143.21 personal care assistance care plan with the agency;
- 143.22 (ii) the recipient or another person present at the setting where services are provided
143.23 engage in conduct that creates an imminent risk of harm to the personal care assistant or
143.24 other agency staff;
- 143.25 (iii) the agency cannot safely meet the recipient's needs because an emergency or a
143.26 significant change in the recipient's condition occurred within a 24-hour period causing the
143.27 recipient's service needs to exceed the recipient's identified needs in the personal care
143.28 assistance care plan; or
- 143.29 (iv) a recipient initiates a request to terminate personal care assistance services, the
143.30 agency must give the recipient a written acknowledgment of the recipient's service
143.31 termination request that includes the date the request was received by the agency and the
143.32 requested date of termination.

144.1 **EFFECTIVE DATE.** This section is effective the day following final enactment.

144.2 Sec. 17. Minnesota Statutes 2016, section 256B.0911, subdivision 3a, is amended to read:

144.3 Subd. 3a. **Assessment and support planning.** (a) Persons requesting assessment, services
144.4 planning, or other assistance intended to support community-based living, including persons
144.5 who need assessment in order to determine waiver or alternative care program eligibility,
144.6 must be visited by a long-term care consultation team within 20 calendar days after the date
144.7 on which an assessment was requested or recommended. Upon statewide implementation
144.8 of subdivisions 2b, 2c, and 5, this requirement also applies to an assessment of a person
144.9 requesting personal care assistance services and home care nursing. The commissioner shall
144.10 provide at least a 90-day notice to lead agencies prior to the effective date of this requirement.
144.11 Face-to-face assessments must be conducted according to paragraphs (b) to (i).

144.12 (b) Upon implementation of subdivisions 2b, 2c, and 5, lead agencies shall use certified
144.13 assessors to conduct the assessment. For a person with complex health care needs, a public
144.14 health or registered nurse from the team must be consulted.

144.15 (c) The MnCHOICES assessment provided by the commissioner to lead agencies must
144.16 be used to complete a comprehensive, person-centered assessment. The assessment must
144.17 include the health, psychological, functional, environmental, and social needs of the
144.18 individual necessary to develop a community support plan that meets the individual's needs
144.19 and preferences.

144.20 (d) The assessment must be conducted in a face-to-face interview with the person being
144.21 assessed and the person's legal representative. At the request of the person, other individuals
144.22 may participate in the assessment to provide information on the needs, strengths, and
144.23 preferences of the person necessary to develop a community support plan that ensures the
144.24 person's health and safety. Except for legal representatives or family members invited by
144.25 the person, persons participating in the assessment may not be a provider of service or have
144.26 any financial interest in the provision of services. For persons who are to be assessed for
144.27 elderly waiver customized living services under section 256B.0915, with the permission of
144.28 the person being assessed or the person's designated or legal representative, the client's
144.29 current or proposed provider of services may submit a copy of the provider's nursing
144.30 assessment or written report outlining its recommendations regarding the client's care needs.
144.31 The person conducting the assessment must notify the provider of the date by which this
144.32 information is to be submitted. This information shall be provided to the person conducting
144.33 the assessment prior to the assessment. For a person who is to be assessed for waiver services
144.34 under section 256B.092 or 256B.49, with the permission of the person being assessed or

the person's designated legal representative, the person's current provider of services may submit a written report outlining recommendations regarding the person's care needs prepared by a direct service employee with at least 20 hours of service to that client. The person conducting the assessment or reassessment must notify the provider of the date by which this information is to be submitted. This information shall be provided to the person conducting the assessment and the person or the person's legal representative, and must be considered prior to the finalization of the assessment or reassessment.

(e) The person or the person's legal representative must be provided with a written community support plan within 40 calendar days of the assessment visit, regardless of whether the individual is eligible for Minnesota health care programs. The written community support plan must include:

(1) a summary of assessed needs as defined in paragraphs (c) and (d);

(2) the individual's options and choices to meet identified needs, including all available options for case management services and providers, including service provided in a non-disability-specific setting;

(3) identification of health and safety risks and how those risks will be addressed, including personal risk management strategies;

(4) referral information; and

(5) informal caregiver supports, if applicable.

For a person determined eligible for state plan home care under subdivision 1a, paragraph (b), clause (1), the person or person's representative must also receive a copy of the home care service plan developed by the certified assessor.

(f) A person may request assistance in identifying community supports without participating in a complete assessment. Upon a request for assistance identifying community support, the person must be transferred or referred to long-term care options counseling services available under sections 256.975, subdivision 7, and 256.01, subdivision 24, for telephone assistance and follow up.

(g) The person has the right to make the final decision between institutional placement and community placement after the recommendations have been provided, except as provided in section 256.975, subdivision 7a, paragraph (d).

(h) The lead agency must give the person receiving assessment or support planning, or the person's legal representative, materials, and forms supplied by the commissioner containing the following information:

146.1 (1) written recommendations for community-based services and consumer-directed
146.2 options;

146.3 (2) documentation that the most cost-effective alternatives available were offered to the
146.4 individual. For purposes of this clause, "cost-effective" means community services and
146.5 living arrangements that cost the same as or less than institutional care. For an individual
146.6 found to meet eligibility criteria for home and community-based service programs under
146.7 section 256B.0915 or 256B.49, "cost-effectiveness" has the meaning found in the federally
146.8 approved waiver plan for each program;

146.9 (3) the need for and purpose of preadmission screening conducted by long-term care
146.10 options counselors according to section 256.975, subdivisions 7a to 7c, if the person selects
146.11 nursing facility placement. If the individual selects nursing facility placement, the lead
146.12 agency shall forward information needed to complete the level of care determinations and
146.13 screening for developmental disability and mental illness collected during the assessment
146.14 to the long-term care options counselor using forms provided by the commissioner;

146.15 (4) the role of long-term care consultation assessment and support planning in eligibility
146.16 determination for waiver and alternative care programs, and state plan home care, case
146.17 management, and other services as defined in subdivision 1a, paragraphs (a), clause (6),
146.18 and (b);

146.19 (5) information about Minnesota health care programs;

146.20 (6) the person's freedom to accept or reject the recommendations of the team;

146.21 (7) the person's right to confidentiality under the Minnesota Government Data Practices
146.22 Act, chapter 13;

146.23 (8) the certified assessor's decision regarding the person's need for institutional level of
146.24 care as determined under criteria established in subdivision 4e and the certified assessor's
146.25 decision regarding eligibility for all services and programs as defined in subdivision 1a,
146.26 paragraphs (a), clause (6), and (b); and

146.27 (9) the person's right to appeal the certified assessor's decision regarding eligibility for
146.28 all services and programs as defined in subdivision 1a, paragraphs (a), clauses (6), (7), and
146.29 (8), and (b), and incorporating the decision regarding the need for institutional level of care
146.30 or the lead agency's final decisions regarding public programs eligibility according to section
146.31 256.045, subdivision 3.

146.32 (i) Face-to-face assessment completed as part of eligibility determination for the
146.33 alternative care, elderly waiver, community access for disability inclusion, community

147.1 alternative care, and brain injury waiver programs under sections 256B.0913, 256B.0915,
147.2 and 256B.49 is valid to establish service eligibility for no more than 60 calendar days after
147.3 the date of assessment.

147.4 (j) The effective eligibility start date for programs in paragraph (i) can never be prior to
147.5 the date of assessment. If an assessment was completed more than 60 days before the
147.6 effective waiver or alternative care program eligibility start date, assessment and support
147.7 plan information must be updated and documented in the department's Medicaid Management
147.8 Information System (MMIS). Notwithstanding retroactive medical assistance coverage of
147.9 state plan services, the effective date of eligibility for programs included in paragraph (i)
147.10 cannot be prior to the date the most recent updated assessment is completed.

147.11 **EFFECTIVE DATE.** This section is effective the day following final enactment.

147.12 Sec. 18. Minnesota Statutes 2016, section 256B.092, subdivision 1a, is amended to read:

147.13 Subd. 1a. **Case management services.** (a) Each recipient of a home and community-based
147.14 waiver shall be provided case management services by qualified vendors as described in
147.15 the federally approved waiver application.

147.16 (b) Case management service activities provided to or arranged for a person include:

147.17 (1) development of the coordinated service and support plan under subdivision 1b;

147.18 (2) informing the individual or the individual's legal guardian or conservator, or parent
147.19 if the person is a minor, of service options;

147.20 (3) consulting with relevant medical experts or service providers;

147.21 (4) assisting the person in the identification of potential providers, including services
147.22 provided in a non-disability-specific setting;

147.23 (5) assisting the person to access services and assisting in appeals under section 256.045;

147.24 (6) coordination of services, if coordination is not provided by another service provider;

147.25 (7) evaluation and monitoring of the services identified in the coordinated service and
147.26 support plan, which must incorporate at least one annual face-to-face visit by the case
147.27 manager with each person; and

147.28 (8) reviewing coordinated service and support plans and providing the lead agency with
147.29 recommendations for service authorization based upon the individual's needs identified in
147.30 the coordinated service and support plan.

(c) Case management service activities that are provided to the person with a developmental disability shall be provided directly by county agencies or under contract. Case management services must be provided by a public or private agency that is enrolled as a medical assistance provider determined by the commissioner to meet all of the requirements in the approved federal waiver plans. Case management services must not be provided to a recipient by a private agency that has a financial interest in the provision of any other services included in the recipient's coordinated service and support plan. For purposes of this section, "private agency" means any agency that is not identified as a lead agency under section 256B.0911, subdivision 1a, paragraph (e).

(d) Case managers are responsible for service provisions listed in paragraphs (a) and (b). Case managers shall collaborate with consumers, families, legal representatives, and relevant medical experts and service providers in the development and annual review of the coordinated service and support plan and habilitation plan.

(e) For persons who need a positive support transition plan as required in chapter 245D, the case manager shall participate in the development and ongoing evaluation of the plan with the expanded support team. At least quarterly, the case manager, in consultation with the expanded support team, shall evaluate the effectiveness of the plan based on progress evaluation data submitted by the licensed provider to the case manager. The evaluation must identify whether the plan has been developed and implemented in a manner to achieve the following within the required timelines:

(1) phasing out the use of prohibited procedures;

(2) acquisition of skills needed to eliminate the prohibited procedures within the plan's timeline; and

(3) accomplishment of identified outcomes.

If adequate progress is not being made, the case manager shall consult with the person's expanded support team to identify needed modifications and whether additional professional support is required to provide consultation.

(f) The Department of Human Services shall offer ongoing education in case management to case managers. Case managers shall receive no less than ten hours of case management education and disability-related training each year.

EFFECTIVE DATE. This section is effective the day following final enactment.

149.1 Sec. 19. Minnesota Statutes 2016, section 256B.49, subdivision 13, is amended to read:

149.2 Subd. 13. **Case management.** (a) Each recipient of a home and community-based waiver
149.3 shall be provided case management services by qualified vendors as described in the federally
149.4 approved waiver application. The case management service activities provided must include:

149.5 (1) finalizing the written coordinated service and support plan within ten working days
149.6 after the case manager receives the plan from the certified assessor;

149.7 (2) informing the recipient or the recipient's legal guardian or conservator of service
149.8 options;

149.9 (3) assisting the recipient in the identification of potential service providers and available
149.10 options for case management service and providers, including services provided in
149.11 non-disability-specific setting;

149.12 (4) assisting the recipient to access services and assisting with appeals under section
149.13 256.045; and

149.14 (5) coordinating, evaluating, and monitoring of the services identified in the service
149.15 plan.

149.16 (b) The case manager may delegate certain aspects of the case management service
149.17 activities to another individual provided there is oversight by the case manager. The case
149.18 manager may not delegate those aspects which require professional judgment including:

149.19 (1) finalizing the coordinated service and support plan;

149.20 (2) ongoing assessment and monitoring of the person's needs and adequacy of the
149.21 approved coordinated service and support plan; and

149.22 (3) adjustments to the coordinated service and support plan.

149.23 (c) Case management services must be provided by a public or private agency that is
149.24 enrolled as a medical assistance provider determined by the commissioner to meet all of
149.25 the requirements in the approved federal waiver plans. Case management services must not
149.26 be provided to a recipient by a private agency that has any financial interest in the provision
149.27 of any other services included in the recipient's coordinated service and support plan. For
149.28 purposes of this section, "private agency" means any agency that is not identified as a lead
149.29 agency under section 256B.0911, subdivision 1a, paragraph (e).

149.30 (d) For persons who need a positive support transition plan as required in chapter 245D,
149.31 the case manager shall participate in the development and ongoing evaluation of the plan
149.32 with the expanded support team. At least quarterly, the case manager, in consultation with

150.1 the expanded support team, shall evaluate the effectiveness of the plan based on progress
150.2 evaluation data submitted by the licensed provider to the case manager. The evaluation must
150.3 identify whether the plan has been developed and implemented in a manner to achieve the
150.4 following within the required timelines:

150.5 (1) phasing out the use of prohibited procedures;

150.6 (2) acquisition of skills needed to eliminate the prohibited procedures within the plan's
150.7 timeline; and

150.8 (3) accomplishment of identified outcomes.

150.9 If adequate progress is not being made, the case manager shall consult with the person's
150.10 expanded support team to identify needed modifications and whether additional professional
150.11 support is required to provide consultation.

150.12 **EFFECTIVE DATE.** This section is effective the day following final enactment.

150.13 Sec. 20. Minnesota Statutes 2016, section 256B.4913, is amended by adding a subdivision
150.14 to read:

150.15 **Subd. 7. New services.** A service added to section 256B.4914 after January 1, 2014, is
150.16 not subject to rate stabilization adjustment in this section.

150.17 **EFFECTIVE DATE.** This section is effective the day following final enactment.

150.18 Sec. 21. Minnesota Statutes 2016, section 256B.4914, subdivision 3, is amended to read:

150.19 Subd. 3. **Applicable services.** Applicable services are those authorized under the state's
150.20 home and community-based services waivers under sections 256B.092 and 256B.49,
150.21 including the following, as defined in the federally approved home and community-based
150.22 services plan:

150.23 (1) 24-hour customized living;

150.24 (2) adult day care;

150.25 (3) adult day care bath;

150.26 (4) behavioral programming;

150.27 (5) companion services;

150.28 (6) customized living;

150.29 (7) day training and habilitation;

- 151.1 (8) housing access coordination;
- 151.2 (9) independent living skills;
- 151.3 (10) in-home family support;
- 151.4 (11) night supervision;
- 151.5 (12) personal support;
- 151.6 (13) prevocational services;
- 151.7 (14) residential care services;
- 151.8 (15) residential support services;
- 151.9 (16) respite services;
- 151.10 (17) structured day services;
- 151.11 (18) supported employment services;
- 151.12 (19) supported living services;
- 151.13 (20) transportation services; ~~and~~
- 151.14 (21) individualized home supports; and
- 151.15 (22) other services as approved by the federal government in the state home and
- 151.16 community-based services plan.
- 151.17 **EFFECTIVE DATE.** This section is effective the day following final enactment.

151.18 Sec. 22. Minnesota Statutes 2016, section 256B.4914, subdivision 5, is amended to read:

151.19 Subd. 5. **Base wage index and standard component values.** (a) The base wage index
 151.20 is established to determine staffing costs associated with providing services to individuals
 151.21 receiving home and community-based services. For purposes of developing and calculating
 151.22 the proposed base wage, Minnesota-specific wages taken from job descriptions and standard
 151.23 occupational classification (SOC) codes from the Bureau of Labor Statistics as defined in
 151.24 the most recent edition of the Occupational Handbook must be used. The base wage index
 151.25 must be calculated as follows:

151.26 (1) for residential direct care staff, the sum of:

151.27 (i) 15 percent of the subtotal of 50 percent of the median wage for personal and home
 151.28 health aide (SOC code 39-9021); 30 percent of the median wage for nursing aide (SOC

152.1 code 31-1012); and 20 percent of the median wage for social and human services aide (SOC
152.2 code 21-1093); and

152.3 (ii) 85 percent of the subtotal of 20 percent of the median wage for home health aide
152.4 (SOC code 31-1011); 20 percent of the median wage for personal and home health aide
152.5 (SOC code 39-9021); 20 percent of the median wage for nursing aide (SOC code 31-1012);
152.6 20 percent of the median wage for psychiatric technician (SOC code 29-2053); and 20
152.7 percent of the median wage for social and human services aide (SOC code 21-1093);

152.8 (2) for day services, 20 percent of the median wage for nursing aide (SOC code 31-1012);
152.9 20 percent of the median wage for psychiatric technician (SOC code 29-2053); and 60
152.10 percent of the median wage for social and human services aide (SOC code 21-1093);

152.11 (3) for residential asleep-overnight staff, the wage will be \$7.66 per hour, except in a
152.12 family foster care setting, the wage is \$2.80 per hour;

152.13 (4) for behavior program analyst staff, 100 percent of the median wage for mental health
152.14 counselors (SOC code 21-1014);

152.15 (5) for behavior program professional staff, 100 percent of the median wage for clinical
152.16 counseling and school psychologist (SOC code 19-3031);

152.17 (6) for behavior program specialist staff, 100 percent of the median wage for psychiatric
152.18 technicians (SOC code 29-2053);

152.19 (7) for supportive living services staff, 20 percent of the median wage for nursing aide
152.20 (SOC code 31-1012); 20 percent of the median wage for psychiatric technician (SOC code
152.21 29-2053); and 60 percent of the median wage for social and human services aide (SOC code
152.22 21-1093);

152.23 (8) for housing access coordination staff, 50 percent of the median wage for community
152.24 and social services specialist (SOC code 21-1099); and 50 percent of the median wage for
152.25 social and human services aide (SOC code 21-1093);

152.26 (9) for in-home family support staff, 20 percent of the median wage for nursing aide
152.27 (SOC code 31-1012); 30 percent of the median wage for community social service specialist
152.28 (SOC code 21-1099); 40 percent of the median wage for social and human services aide
152.29 (SOC code 21-1093); and ten percent of the median wage for psychiatric technician (SOC
152.30 code 29-2053);

152.31 (10) for independent living skills staff, 40 percent of the median wage for community
152.32 social service specialist (SOC code 21-1099); 50 percent of the median wage for social and

153.1 human services aide (SOC code 21-1093); and ten percent of the median wage for psychiatric
153.2 technician (SOC code 29-2053);

153.3 (11) for individualized home supports services staff, 40 percent of the median wage for
153.4 community social service specialist (SOC code 21-1099); 50 percent of the median wage
153.5 for social and human services aide (SOC code 21-1093); and ten percent of the median
153.6 wage for psychiatric technician (SOC code 29-2053).

153.7 ~~(11)~~ (12) for supported employment staff, 20 percent of the median wage for nursing
153.8 aide (SOC code 31-1012); 20 percent of the median wage for psychiatric technician (SOC
153.9 code 29-2053); and 60 percent of the median wage for social and human services aide (SOC
153.10 code 21-1093);

153.11 ~~(12)~~ (13) for adult companion staff, 50 percent of the median wage for personal and
153.12 home care aide (SOC code 39-9021); and 50 percent of the median wage for nursing aides,
153.13 orderlies, and attendants (SOC code 31-1012);

153.14 ~~(13)~~ (14) for night supervision staff, 20 percent of the median wage for home health
153.15 aide (SOC code 31-1011); 20 percent of the median wage for personal and home health
153.16 aide (SOC code 39-9021); 20 percent of the median wage for nursing aide (SOC code
153.17 31-1012); 20 percent of the median wage for psychiatric technician (SOC code 29-2053);
153.18 and 20 percent of the median wage for social and human services aide (SOC code 21-1093);

153.19 ~~(14)~~ (15) for respite staff, 50 percent of the median wage for personal and home care
153.20 aide (SOC code 39-9021); and 50 percent of the median wage for nursing aides, orderlies,
153.21 and attendants (SOC code 31-1012);

153.22 ~~(15)~~ (16) for personal support staff, 50 percent of the median wage for personal and
153.23 home care aide (SOC code 39-9021); and 50 percent of the median wage for nursing aides,
153.24 orderlies, and attendants (SOC code 31-1012);

153.25 ~~(16)~~ (17) for supervisory staff, the basic wage is \$17.43 per hour with exception of the
153.26 supervisor of behavior analyst and behavior specialists, which must be \$30.75 per hour;

153.27 ~~(17)~~ (18) for registered nurse, the basic wage is \$30.82 per hour; and

153.28 ~~(18)~~ (19) for licensed practical nurse, the basic wage is \$18.64 per hour.

153.29 (b) Component values for residential support services are:

153.30 (1) supervisory span of control ratio: 11 percent;

153.31 (2) employee vacation, sick, and training allowance ratio: 8.71 percent;

153.32 (3) employee-related cost ratio: 23.6 percent;

- 154.1 (4) general administrative support ratio: 13.25 percent;
- 154.2 (5) program-related expense ratio: 1.3 percent; and
- 154.3 (6) absence and utilization factor ratio: 3.9 percent.
- 154.4 (c) Component values for family foster care are:
- 154.5 (1) supervisory span of control ratio: 11 percent;
- 154.6 (2) employee vacation, sick, and training allowance ratio: 8.71 percent;
- 154.7 (3) employee-related cost ratio: 23.6 percent;
- 154.8 (4) general administrative support ratio: 3.3 percent;
- 154.9 (5) program-related expense ratio: 1.3 percent; and
- 154.10 (6) absence factor: 1.7 percent.
- 154.11 (d) Component values for day services for all services are:
- 154.12 (1) supervisory span of control ratio: 11 percent;
- 154.13 (2) employee vacation, sick, and training allowance ratio: 8.71 percent;
- 154.14 (3) employee-related cost ratio: 23.6 percent;
- 154.15 (4) program plan support ratio: 5.6 percent;
- 154.16 (5) client programming and support ratio: ten percent;
- 154.17 (6) general administrative support ratio: 13.25 percent;
- 154.18 (7) program-related expense ratio: 1.8 percent; and
- 154.19 (8) absence and utilization factor ratio: 3.9 percent.
- 154.20 (e) Component values for unit-based services with programming are:
- 154.21 (1) supervisory span of control ratio: 11 percent;
- 154.22 (2) employee vacation, sick, and training allowance ratio: 8.71 percent;
- 154.23 (3) employee-related cost ratio: 23.6 percent;
- 154.24 (4) program plan supports ratio: 3.1 percent;
- 154.25 (5) client programming and supports ratio: 8.6 percent;
- 154.26 (6) general administrative support ratio: 13.25 percent;
- 154.27 (7) program-related expense ratio: 6.1 percent; and

155.1 (8) absence and utilization factor ratio: 3.9 percent.

155.2 (f) Component values for unit-based services without programming except respite are:

155.3 (1) supervisory span of control ratio: 11 percent;

155.4 (2) employee vacation, sick, and training allowance ratio: 8.71 percent;

155.5 (3) employee-related cost ratio: 23.6 percent;

155.6 (4) program plan support ratio: 3.1 percent;

155.7 (5) client programming and support ratio: 8.6 percent;

155.8 (6) general administrative support ratio: 13.25 percent;

155.9 (7) program-related expense ratio: 6.1 percent; and

155.10 (8) absence and utilization factor ratio: 3.9 percent.

155.11 (g) Component values for unit-based services without programming for respite are:

155.12 (1) supervisory span of control ratio: 11 percent;

155.13 (2) employee vacation, sick, and training allowance ratio: 8.71 percent;

155.14 (3) employee-related cost ratio: 23.6 percent;

155.15 (4) general administrative support ratio: 13.25 percent;

155.16 (5) program-related expense ratio: 6.1 percent; and

155.17 (6) absence and utilization factor ratio: 3.9 percent.

155.18 (h) On July 1, 2017, the commissioner shall update the base wage index in paragraph

155.19 (a) based on the wage data by standard occupational code (SOC) from the Bureau of Labor

155.20 Statistics available on December 31, 2016. The commissioner shall publish these updated

155.21 values and load them into the rate management system. This adjustment occurs every five

155.22 years. For adjustments in 2021 and beyond, the commissioner shall use the data available

155.23 on December 31 of the calendar year five years prior.

155.24 (i) On July 1, 2017, the commissioner shall update the framework components in

155.25 paragraphs (b) to (g); subdivision 6, clauses (8) and (9); and subdivision 7, clauses (16) and

155.26 (17), for changes in the Consumer Price Index. The commissioner will adjust these values

155.27 higher or lower by the percentage change in the Consumer Price Index-All Items, United

155.28 States city average (CPI-U) from January 1, 2014, to January 1, 2017. The commissioner

155.29 shall publish these updated values and load them into the rate management system. This

155.30 adjustment occurs every five years. For adjustments in 2021 and beyond, the commissioner

156.1 shall use the data available on January 1 of the calendar year four years prior and January
156.2 1 of the current calendar year.

156.3 **EFFECTIVE DATE.** This section is effective the day following final enactment.

156.4 Sec. 23. Minnesota Statutes 2016, section 256B.4914, subdivision 8, is amended to read:

156.5 Subd. 8. **Payments for unit-based services with programming.** Payments for unit-based
156.6 services with programming, including behavior programming, housing access coordination,
156.7 in-home family support, independent living skills training, individualized home supports,
156.8 hourly supported living services, and supported employment provided to an individual
156.9 outside of any day or residential service plan must be calculated as follows, unless the
156.10 services are authorized separately under subdivision 6 or 7:

156.11 (1) determine the number of units of service to meet a recipient's needs;

156.12 (2) personnel hourly wage rate must be based on the 2009 Bureau of Labor Statistics
156.13 Minnesota-specific rates or rates derived by the commissioner as provided in subdivision
156.14 5;

156.15 (3) for a recipient requiring customization for deaf and hard-of-hearing language
156.16 accessibility under subdivision 12, add the customization rate provided in subdivision 12
156.17 to the result of clause (2). This is defined as the customized direct-care rate;

156.18 (4) multiply the number of direct staff hours by the appropriate staff wage in subdivision
156.19 5, paragraph (a), or the customized direct-care rate;

156.20 (5) multiply the number of direct staff hours by the product of the supervision span of
156.21 control ratio in subdivision 5, paragraph (e), clause (1), and the appropriate supervision
156.22 wage in subdivision 5, paragraph (a), clause (16);

156.23 (6) combine the results of clauses (4) and (5), and multiply the result by one plus the
156.24 employee vacation, sick, and training allowance ratio in subdivision 5, paragraph (e), clause
156.25 (2). This is defined as the direct staffing rate;

156.26 (7) for program plan support, multiply the result of clause (6) by one plus the program
156.27 plan supports ratio in subdivision 5, paragraph (e), clause (4);

156.28 (8) for employee-related expenses, multiply the result of clause (7) by one plus the
156.29 employee-related cost ratio in subdivision 5, paragraph (e), clause (3);

156.30 (9) for client programming and supports, multiply the result of clause (8) by one plus
156.31 the client programming and supports ratio in subdivision 5, paragraph (e), clause (5);

157.1 (10) this is the subtotal rate;

157.2 (11) sum the standard general and administrative rate, the program-related expense ratio,
157.3 and the absence and utilization factor ratio;

157.4 (12) divide the result of clause (10) by one minus the result of clause (11). This is the
157.5 total payment amount;

157.6 (13) for supported employment provided in a shared manner, divide the total payment
157.7 amount in clause (12) by the number of service recipients, not to exceed three. For
157.8 independent living skills training and individualized home supports provided in a shared
157.9 manner, divide the total payment amount in clause (12) by the number of service recipients,
157.10 not to exceed two; and

157.11 (14) adjust the result of clause (13) by a factor to be determined by the commissioner
157.12 to adjust for regional differences in the cost of providing services.

157.13 **EFFECTIVE DATE.** This section is effective the day following final enactment.

157.14 Sec. 24. Minnesota Statutes 2016, section 256B.4914, subdivision 16, is amended to read:

157.15 Subd. 16. **Budget neutrality adjustments.** (a) The commissioner shall use the following
157.16 adjustments to the rate generated by the framework to assure budget neutrality until the rate
157.17 information is available to implement paragraph (b). The rate generated by the framework
157.18 shall be multiplied by the appropriate factor, as designated below:

157.19 (1) for residential services: 1.003;

157.20 (2) for day services: 1.000;

157.21 (3) for unit-based services with programming: 0.941; and

157.22 (4) for unit-based services without programming: 0.796.

157.23 (b) Within 12 months of January 1, 2014, the commissioner shall compare estimated
157.24 spending for all home and community-based waiver services under the new payment rates
157.25 defined in subdivisions 6 to 9 with estimated spending for the same recipients and services
157.26 under the rates in effect on July 1, 2013. This comparison must distinguish spending under
157.27 each of subdivisions 6, 7, 8, and 9. The comparison must be based on actual recipients and
157.28 services for one or more service months after the new rates have gone into effect. The
157.29 commissioner shall consult with the commissioner of management and budget on this
157.30 analysis to ensure budget neutrality. If estimated spending under the new rates for services
157.31 under one or more subdivisions differs in this comparison by 0.3 percent or more, the
157.32 commissioner shall assure aggregate budget neutrality across all service areas by adjusting

the budget neutrality factor in paragraph (a) in each subdivision so that total estimated spending for each subdivision under the new rates matches estimated spending under the rates in effect on July 1, 2013.

(c) A service rate developed using values in subdivision 5, paragraph (a), clause (11), is not subject to budget neutrality adjustments.

EFFECTIVE DATE. This section is effective the day following final enactment.

Sec. 25. Minnesota Statutes 2016, section 256B.85, subdivision 12b, is amended to read:

Subd. 12b. **CFSS agency-provider requirements; notice regarding termination of services.** (a) An agency-provider must provide written notice when it intends to terminate services with a participant at least ~~ten~~ 30 calendar days before the proposed service termination is to become effective, except in cases where:

(1) the participant engages in conduct that significantly alters the terms of the CFSS service delivery plan with the agency-provider;

(2) the participant or other persons at the setting where services are being provided engage in conduct that creates an imminent risk of harm to the support worker or other agency-provider staff; or

(3) an emergency or a significant change in the participant's condition occurs within a 24-hour period that results in the participant's service needs exceeding the participant's identified needs in the current CFSS service delivery plan so that the agency-provider cannot safely meet the participant's needs.

(b) When a participant initiates a request to terminate CFSS services with the agency-provider, the agency-provider must give the participant a written ~~acknowledgement~~ acknowledgment of the participant's service termination request that includes the date the request was received by the agency-provider and the requested date of termination.

(c) The agency-provider must participate in a coordinated transfer of the participant to a new agency-provider to ensure continuity of care.

EFFECTIVE DATE. This section is effective the day following final enactment.

Sec. 26. **REPEALER.**

Minnesota Rules, part 9555.6255, is repealed.

EFFECTIVE DATE. This section is effective the day following final enactment.

159.1 **ARTICLE 6**

159.2 **TECHNICAL CORRECTIONS**

159.3 Section 1. Minnesota Statutes 2016, section 245.4871, is amended by adding a subdivision
159.4 to read:

159.5 Subd. 11a. **Diagnostic assessment.** "Diagnostic assessment" has the meaning given in
159.6 Minnesota Rules, part 9505.0370, subpart 11, and is delivered according to part 9505.0372,
159.7 subpart 1.

159.8 **EFFECTIVE DATE.** This section is effective the day following final enactment.

159.9 Sec. 2. Minnesota Statutes 2016, section 245.735, subdivision 3, is amended to read:

159.10 Subd. 3. **Certified community behavioral health clinics.** (a) The commissioner shall
159.11 establish a state certification process for a certified community behavioral health clinics
159.12 (CCBHCs) clinic (CCBHC) to be eligible for the prospective payment system in paragraph
159.13 (f). Entities that choose to be ~~CCBHCs~~ a CCBHC must:

159.14 (1) comply with the CCBHC criteria published by the United States Department of
159.15 Health and Human Services;

159.16 (2) employ or contract for clinic staff who have backgrounds in diverse disciplines,
159.17 including licensed mental health professionals, and staff who are culturally and linguistically
159.18 trained to serve the needs of the clinic's patient population;

159.19 (3) ensure that clinic services are available and accessible to patients of all ages and
159.20 genders and that crisis management services are available 24 hours per day;

159.21 (4) establish fees for clinic services for nonmedical assistance patients using a sliding
159.22 fee scale that ensures that services to patients are not denied or limited due to a patient's
159.23 inability to pay for services;

159.24 (5) comply with quality assurance reporting requirements and other reporting
159.25 requirements, including any required reporting of encounter data, clinical outcomes data,
159.26 and quality data;

159.27 (6) provide crisis mental health services, withdrawal management services, emergency
159.28 crisis intervention services, and stabilization services; screening, assessment, and diagnosis
159.29 services, including risk assessments and level of care determinations; patient-centered
159.30 treatment planning; outpatient mental health and substance use services; targeted case
159.31 management; psychiatric rehabilitation services; peer support and counselor services and

160.1 family support services; and intensive community-based mental health services, including
160.2 mental health services for members of the armed forces and veterans;

160.3 (7) provide coordination of care across settings and providers to ensure seamless
160.4 transitions for patients across the full spectrum of health services, including acute, chronic,
160.5 and behavioral needs. Care coordination may be accomplished through partnerships or
160.6 formal contracts with:

160.7 (i) counties, health plans, pharmacists, pharmacies, rural health clinics, federally qualified
160.8 health centers, inpatient psychiatric facilities, substance use and detoxification facilities, or
160.9 community-based mental health providers; and

160.10 (ii) other community services, supports, and providers, including schools, child welfare
160.11 agencies, juvenile and criminal justice agencies, Indian health services clinics, tribally
160.12 licensed health care and mental health facilities, urban Indian health clinics, Department of
160.13 Veterans Affairs medical centers, outpatient clinics, drop-in centers, acute care hospitals,
160.14 and hospital outpatient clinics;

160.15 (8) be certified as mental health clinics under section 245.69, subdivision 2;

160.16 (9) be certified to provide integrated treatment for co-occurring mental illness and
160.17 substance use disorders in adults or children under Minnesota Rules, chapter 9533, effective
160.18 July 1, 2017;

160.19 (10) comply with standards relating to mental health services in Minnesota Rules, parts
160.20 9505.0370 to 9505.0372;

160.21 (11) be licensed to provide chemical dependency treatment under Minnesota Rules, parts
160.22 9530.6405 to 9530.6505;

160.23 (12) be certified to provide children's therapeutic services and supports under section
160.24 256B.0943;

160.25 (13) be certified to provide adult rehabilitative mental health services under section
160.26 256B.0623;

160.27 (14) be enrolled to provide mental health crisis response services under section
160.28 256B.0624;

160.29 (15) be enrolled to provide mental health targeted case management under section
160.30 256B.0625, subdivision 20;

160.31 (16) comply with standards relating to mental health case management in Minnesota
160.32 Rules, parts 9520.0900 to 9520.0926; and

161.1 (17) provide services that comply with the evidence-based practices described in
161.2 paragraph (e).

161.3 (b) If an entity is unable to provide one or more of the services listed in paragraph (a),
161.4 clauses (6) to (17), the commissioner may certify the entity as a CCBHC, if the entity has
161.5 a current contract with another entity that has the required authority to provide that service
161.6 and that meets federal CCBHC criteria as a designated collaborating organization, or, to
161.7 the extent allowed by the federal CCBHC criteria, the commissioner may approve a referral
161.8 arrangement. The CCBHC must meet federal requirements regarding the type and scope of
161.9 services to be provided directly by the CCBHC.

161.10 (c) Notwithstanding any other law that requires a county contract or other form of county
161.11 approval for certain services listed in paragraph (a), clause (6), a clinic that otherwise meets
161.12 CCBHC requirements may receive the prospective payment under paragraph (f) for those
161.13 services without a county contract or county approval. There is no county share when
161.14 medical assistance pays the CCBHC prospective payment. As part of the certification process
161.15 in paragraph (a), the commissioner shall require a letter of support from the CCBHC's host
161.16 county confirming that the CCBHC and the county or counties it serves have an ongoing
161.17 relationship to facilitate access and continuity of care, especially for individuals who are
161.18 uninsured or who may go on and off medical assistance.

161.19 (d) When the standards listed in paragraph (a) or other applicable standards conflict or
161.20 address similar issues in duplicative or incompatible ways, the commissioner may grant
161.21 variances to state requirements if the variances do not conflict with federal requirements.
161.22 If standards overlap, the commissioner may substitute all or a part of a licensure or
161.23 certification that is substantially the same as another licensure or certification. The
161.24 commissioner shall consult with stakeholders, as described in subdivision 4, before granting
161.25 variances under this provision.

161.26 (e) The commissioner shall issue a list of required evidence-based practices to be
161.27 delivered by ~~CCBHCs~~ a CCBHC, and may also provide a list of recommended
161.28 evidence-based practices. The commissioner may update the list to reflect advances in
161.29 outcomes research and medical services for persons living with mental illnesses or substance
161.30 use disorders. The commissioner shall take into consideration the adequacy of evidence to
161.31 support the efficacy of the practice, the quality of workforce available, and the current
161.32 availability of the practice in the state. At least 30 days before issuing the initial list and
161.33 any revisions, the commissioner shall provide stakeholders with an opportunity to comment.

(f) The commissioner shall establish standards and methodologies for a prospective payment system for medical assistance payments for services delivered by ~~certified community behavioral health clinics~~ a CCBHC, in accordance with guidance issued by the Centers for Medicare and Medicaid Services. During the operation of the demonstration project, payments shall comply with federal requirements for an enhanced federal medical assistance percentage. The commissioner may include quality bonus payment in the prospective payment system based on federal criteria and on a clinic's provision of the evidence-based practices in paragraph (e). The prospective payment system does not apply to MinnesotaCare. Implementation of the prospective payment system is effective July 1, 2017, or upon federal approval, whichever is later.

(g) The commissioner shall seek federal approval to continue federal financial participation in payment for CCBHC services after the federal demonstration period ends for clinics that were certified as ~~CCBHCs~~ a CCBHC during the demonstration period and that continue to meet the CCBHC certification standards in paragraph (a). Payment for CCBHC services shall cease effective July 1, 2019, if continued federal financial participation for the payment of CCBHC services cannot be obtained.

(h) The commissioner may certify at least one CCBHC located in an urban area and at least one CCBHC located in a rural area, as defined by federal criteria. To the extent allowed by federal law, the commissioner may limit the number of certified clinics so that the projected claims for certified clinics will not exceed the funds budgeted for this purpose. The commissioner shall give preference to clinics that:

(1) provide a comprehensive range of services and evidence-based practices for all age groups, with services being fully coordinated and integrated; and

(2) enhance the state's ability to meet the federal priorities to be selected as a CCBHC demonstration state.

(i) The commissioner shall recertify ~~CCBHCs~~ a CCBHC at least every three years. The commissioner shall establish a process for decertification and shall require corrective action, medical assistance repayment, or decertification of a CCBHC that no longer meets the requirements in this section or that fails to meet the standards provided by the commissioner in the application and certification process.

EFFECTIVE DATE. This section is effective the day following final enactment.

163.1 Sec. 3. Minnesota Statutes 2016, section 254B.15, subdivision 4, is amended to read:

163.2 Subd. 4. **Legislative update.** No later than February 1, 2017, the commissioner shall
163.3 present an update on the progress of the proposal to members of the legislative committees
163.4 in the house of representatives and senate with jurisdiction over health and human services
163.5 policy and finance ~~on the progress of the proposal~~ and shall make recommendations on any
163.6 legislative changes and state appropriations necessary to implement the proposal.

163.7 **EFFECTIVE DATE.** This section is effective the day following final enactment.

163.8 Sec. 4. Minnesota Statutes 2016, section 254B.15, subdivision 5, is amended to read:

163.9 Subd. 5. **Stakeholder input.** In developing the proposal, the commissioner shall consult
163.10 with consumers, providers, counties, tribes, ~~health plans~~ managed care organizations, and
163.11 other stakeholders.

163.12 **EFFECTIVE DATE.** This section is effective the day following final enactment.

163.13 Sec. 5. Minnesota Statutes 2016, section 256B.055, subdivision 12, is amended to read:

163.14 Subd. 12. **Disabled children.** (a) A person is eligible for medical assistance if the person
163.15 is under age 19 and qualifies as a disabled individual under United States Code, title 42,
163.16 section 1382c(a), and would be eligible for medical assistance under the state plan if residing
163.17 in a medical institution, and the child requires a level of care provided in a hospital, nursing
163.18 facility, or intermediate care facility for persons with developmental disabilities, for whom
163.19 home care is appropriate, provided that the cost to medical assistance under this section is
163.20 not more than the amount that medical assistance would pay for if the child resides in an
163.21 institution. After the child is determined to be eligible under this section, the commissioner
163.22 shall review the child's disability under United States Code, title 42, section 1382c(a) and
163.23 level of care defined under this section no more often than annually and may elect, based
163.24 on the recommendation of health care professionals under contract with the state medical
163.25 review team, to extend the review of disability and level of care up to a maximum of four
163.26 years. The commissioner's decision on the frequency of continuing review of disability and
163.27 level of care is not subject to administrative appeal under section 256.045. The county
163.28 agency shall send a notice of disability review to the enrollee six months prior to the date
163.29 the recertification of disability is due. Nothing in this subdivision shall be construed as
163.30 affecting other redeterminations of medical assistance eligibility under this chapter and
163.31 annual cost-effective reviews under this section.

(b) For purposes of this subdivision, "hospital" means an institution as defined in section 144.696, subdivision 3, 144.55, subdivision 3, or Minnesota Rules, part 4640.3600, and licensed pursuant to sections 144.50 to 144.58. For purposes of this subdivision, a child requires a level of care provided in a hospital if the child is determined by the commissioner to need an extensive array of health services, including mental health services, for an undetermined period of time, whose health condition requires frequent monitoring and treatment by a health care professional or by a person supervised by a health care professional, who would reside in a hospital or require frequent hospitalization if these services were not provided, and the daily care needs are more complex than a nursing facility level of care.

A child with serious emotional disturbance requires a level of care provided in a hospital if the commissioner determines that the individual requires 24-hour supervision because the person exhibits recurrent or frequent suicidal or homicidal ideation or behavior, recurrent or frequent psychosomatic disorders or somatopsychic disorders that may become life threatening, recurrent or frequent severe socially unacceptable behavior associated with psychiatric disorder, ongoing and chronic psychosis or severe, ongoing and chronic developmental problems requiring continuous skilled observation, or severe disabling symptoms for which office-centered outpatient treatment is not adequate, and which overall severely impact the individual's ability to function.

(c) For purposes of this subdivision, "nursing facility" means a facility which provides nursing care as defined in section 144A.01, subdivision 5, licensed pursuant to sections 144A.02 to 144A.10, which is appropriate if a person is in active restorative treatment; is in need of special treatments provided or supervised by a licensed nurse; or has unpredictable episodes of active disease processes requiring immediate judgment by a licensed nurse. For purposes of this subdivision, a child requires the level of care provided in a nursing facility if the child is determined by the commissioner to meet the requirements of the preadmission screening assessment document under section 256B.0911, adjusted to address age-appropriate standards for children age 18 and under.

(d) For purposes of this subdivision, "intermediate care facility for persons with developmental disabilities" or "ICF/DD" means a program licensed to provide services to persons with developmental disabilities under section 252.28, and chapter 245A, and a physical plant licensed as a supervised living facility under chapter 144, which together are certified by the Minnesota Department of Health as meeting the standards in Code of Federal Regulations, title 42, part 483, for an intermediate care facility which provides services for persons with developmental disabilities who require 24-hour supervision and active treatment

for medical, behavioral, or habilitation needs. For purposes of this subdivision, a child requires a level of care provided in an ICF/DD if the commissioner finds that the child has a developmental disability in accordance with section 256B.092, is in need of a 24-hour plan of care and active treatment similar to persons with developmental disabilities, and there is a reasonable indication that the child will need ICF/DD services.

(e) For purposes of this subdivision, a person requires the level of care provided in a nursing facility if the person requires 24-hour monitoring or supervision and a plan of mental health treatment because of specific symptoms or functional impairments associated with a serious mental illness or disorder diagnosis, which meet severity criteria for mental health established by the commissioner and published in March 1997 as the Minnesota Mental Health Level of Care for Children and Adolescents with Severe Emotional Disorders.

(f) The determination of the level of care needed by the child shall be made by the commissioner based on information supplied to the commissioner by the parent or guardian, the child's physician or physicians, and other professionals as requested by the commissioner. The commissioner shall establish a screening team to conduct the level of care determinations according to this subdivision.

(g) If a child meets the conditions in paragraph (b), (c), (d), or (e), the commissioner must assess the case to determine whether:

(1) the child qualifies as a disabled individual under United States Code, title 42, section 1382c(a), and would be eligible for medical assistance if residing in a medical institution; and

(2) the cost of medical assistance services for the child, if eligible under this subdivision, would not be more than the cost to medical assistance if the child resides in a medical institution ~~to be determined as follows:~~. The commissioner shall presume that the cost of medical assistance services for a child who meets the conditions in paragraph (b), (c), (d), or (e) is not more than the cost to medical assistance if the child resides in a medical institution.

~~(i) for a child who requires a level of care provided in an ICF/DD, the cost of care for the child in an institution shall be determined using the average payment rate established for the regional treatment centers that are certified as ICF's/DD;~~

~~(ii) for a child who requires a level of care provided in an inpatient hospital setting according to paragraph (b), cost-effectiveness shall be determined according to Minnesota Rules, part 9505.3520, items F and G; and~~

~~(iii) for a child who requires a level of care provided in a nursing facility according to paragraph (c) or (e), cost-effectiveness shall be determined according to Minnesota Rules, part 9505.3040, except that the nursing facility average rate shall be adjusted to reflect rates which would be paid for children under age 16. The commissioner may authorize an amount up to the amount medical assistance would pay for a child referred to the commissioner by the preadmission screening team under section 256B.0911.~~

EFFECTIVE DATE. This section is effective the day following final enactment.

Sec. 6. Minnesota Statutes 2016, section 256B.0622, subdivision 2, is amended to read:

Subd. 2. **Definitions.** (a) For purposes of this section, the following terms have the meanings given them.

(b) "ACT team" means the group of interdisciplinary mental health staff who work as a team to provide assertive community treatment.

(c) "Assertive community treatment" means intensive nonresidential treatment and rehabilitative mental health services provided according to the assertive community treatment model. Assertive community treatment provides a single, fixed point of responsibility for treatment, rehabilitation, and support needs for clients. Services are offered 24 hours per day, seven days per week, in a community-based setting.

(d) "Individual treatment plan" means the document that results from a person-centered planning process of determining real-life outcomes with clients and developing strategies to achieve those outcomes.

(e) "Assertive engagement" means the use of collaborative strategies to engage clients to receive services.

(f) "Benefits and finance support" means assisting clients in capably managing financial affairs. Services include, but are not limited to, assisting clients in applying for benefits; assisting with redetermination of benefits; providing financial crisis management; teaching and supporting budgeting skills and asset development; and coordinating with a client's representative payee, if applicable.

(g) "Co-occurring disorder treatment" means the treatment of co-occurring mental illness and substance use disorders and is characterized by assertive outreach, stage-wise comprehensive treatment, treatment goal setting, and flexibility to work within each stage of treatment. Services include, but are not limited to, assessing and tracking clients' stages of change readiness and treatment; applying the appropriate treatment based on stages of change, such as outreach and motivational interviewing techniques to work with clients in

167.1 earlier stages of change readiness and cognitive behavioral approaches and relapse prevention
167.2 to work with clients in later stages of change; and facilitating access to community supports.

167.3 (h) "Crisis assessment and intervention" means mental health crisis response services
167.4 as defined in section 256B.0624, subdivision 2, paragraphs (c) to (e).

167.5 (i) "Employment services" means assisting clients to work at jobs of their choosing.
167.6 Services must follow the principles of the individual placement and support (IPS)
167.7 employment model, including focusing on competitive employment; emphasizing individual
167.8 client preferences and strengths; ensuring employment services are integrated with mental
167.9 health services; conducting rapid job searches and systematic job development according
167.10 to client preferences and choices; providing benefits counseling; and offering all services
167.11 in an individualized and time-unlimited manner. Services shall also include educating clients
167.12 about opportunities and benefits of work and school and assisting the client in learning job
167.13 skills, navigating the work place, and managing work relationships.

167.14 (j) "Family psychoeducation and support" means services provided to the client's family
167.15 and other natural supports to restore and strengthen the client's unique social and family
167.16 relationships. Services include, but are not limited to, individualized psychoeducation about
167.17 the client's illness and the role of the family and other significant people in the therapeutic
167.18 process; family intervention to restore contact, resolve conflict, and maintain relationships
167.19 with family and other significant people in the client's life; ongoing communication and
167.20 collaboration between the ACT team and the family; introduction and referral to family
167.21 self-help programs and advocacy organizations that promote recovery and family
167.22 engagement, individual supportive counseling, parenting training, and service coordination
167.23 to help clients fulfill parenting responsibilities; coordinating services for the child and
167.24 restoring relationships with children who are not in the client's custody; and coordinating
167.25 with child welfare and family agencies, if applicable. These services must be provided with
167.26 the client's agreement and consent.

167.27 (k) "Housing access support" means assisting clients to find, obtain, retain, and move
167.28 to safe and adequate housing of ~~their~~ the client's choice. Housing access support includes,
167.29 but is not limited to, locating housing options with a focus on integrated independent settings;
167.30 applying for housing subsidies, programs, or resources; assisting the client in developing
167.31 relationships with local landlords; providing tenancy support and advocacy for the individual's
167.32 tenancy rights at the client's home; and assisting with relocation.

168.1 (l) "Individual treatment team" means a minimum of three members of the ACT team
168.2 who are responsible for consistently carrying out most of a client's assertive community
168.3 treatment services.

168.4 (m) "Intensive residential treatment services treatment team" means all staff who provide
168.5 intensive residential treatment services under this section to clients. At a minimum, this
168.6 includes the clinical supervisor; mental health professionals as defined in section 245.462,
168.7 subdivision 18, clauses (1) to (6); mental health practitioners as defined in section 245.462,
168.8 subdivision 17; mental health rehabilitation workers under section 256B.0623, subdivision
168.9 5, clause (4); and mental health certified peer specialists under section 256B.0615.

168.10 (n) "Intensive residential treatment services" means short-term, time-limited services
168.11 provided in a residential setting to clients who are in need of more restrictive settings and
168.12 are at risk of significant functional deterioration if they do not receive these services. Services
168.13 are designed to develop and enhance psychiatric stability, personal and emotional adjustment,
168.14 self-sufficiency, and skills to live in a more independent setting. Services must be directed
168.15 toward a targeted discharge date with specified client outcomes.

168.16 (o) "Medication assistance and support" means assisting clients in accessing medication,
168.17 developing the ability to take medications with greater independence, and providing
168.18 medication setup. This includes the prescription, administration, and order of medication
168.19 by appropriate medical staff.

168.20 (p) "Medication education" means educating clients on the role and effects of medications
168.21 in treating symptoms of mental illness and the side effects of medications.

168.22 (q) "Overnight staff" means a member of the intensive residential treatment services
168.23 team who is responsible during hours when clients are typically asleep.

168.24 (r) "Mental health certified peer specialist services" has the meaning given in section
168.25 256B.0615.

168.26 (s) "Physical health services" means any service or treatment to meet the physical health
168.27 needs of the client to support the client's mental health recovery. Services include, but are
168.28 not limited to, education on primary health issues, including wellness education; medication
168.29 administration and monitoring; providing and coordinating medical screening and follow-up;
168.30 scheduling routine and acute medical and dental care visits; tobacco cessation strategies;
168.31 assisting clients in attending appointments; communicating with other providers; and
168.32 integrating all physical and mental health treatment.

(t) "Primary team member" means the person who leads and coordinates the activities of the individual treatment team and is the individual treatment team member who has primary responsibility for establishing and maintaining a therapeutic relationship with the client on a continuing basis.

(u) "Rehabilitative mental health services" means mental health services that are rehabilitative and enable the client to develop and enhance psychiatric stability, social competencies, personal and emotional adjustment, independent living, parenting skills, and community skills, when these abilities are impaired by the symptoms of mental illness.

(v) "Symptom management" means supporting clients in identifying and targeting the symptoms and occurrence patterns of their mental illness and developing strategies to reduce the impact of those symptoms.

(w) "Therapeutic interventions" means empirically supported techniques to address specific symptoms and behaviors such as anxiety, psychotic symptoms, emotional dysregulation, and trauma symptoms. Interventions include empirically supported psychotherapies including, but not limited to, cognitive behavioral therapy, exposure therapy, acceptance and commitment therapy, interpersonal therapy, and motivational interviewing.

(x) "Wellness self-management and prevention" means a combination of approaches to working with the client to build and apply skills related to recovery, and to support the client in participating in leisure and recreational activities, civic participation, and meaningful structure.

EFFECTIVE DATE. This section is effective the day following final enactment.

Sec. 7. Minnesota Statutes 2016, section 256B.0622, subdivision 2b, is amended to read:

Subd. 2b. **Continuing stay and discharge criteria for assertive community treatment.**

(a) A client receiving assertive community treatment is eligible to continue receiving services if:

(1) the client has not achieved the desired outcomes of ~~their~~ the client's individual treatment plan;

(2) the client's level of functioning has not been restored, improved, or sustained over the time frame outlined in the individual treatment plan;

(3) the client continues to be at risk for relapse based on current clinical assessment, history, or the tenuous nature of the functional gains; or

170.1 (4) the client is functioning effectively with this service and discharge would otherwise
170.2 be indicated but without continued services the client's functioning would decline; and

170.3 (5) one of the following must also apply:

170.4 (i) the client has achieved current individual treatment plan goals but additional goals
170.5 are indicated as evidenced by documented symptoms;

170.6 (ii) the client is making satisfactory progress toward meeting goals and there is
170.7 documentation that supports that continuation of this service shall be effective in addressing
170.8 the goals outlined in the individual treatment plan;

170.9 (iii) the client is making progress, but the specific interventions in the individual treatment
170.10 plan need to be modified so that greater gains, which are consistent with the client's potential
170.11 level of functioning, are possible; or

170.12 (iv) the client fails to make progress or demonstrates regression in meeting goals through
170.13 the interventions outlined in the individual treatment plan.

170.14 (b) Clients receiving assertive community treatment are eligible to be discharged if they
170.15 meet at least one of the following criteria:

170.16 (1) the client and the ACT team determine that assertive community treatment services
170.17 are no longer needed based on the attainment of goals as identified in the individual treatment
170.18 plan and a less intensive level of care would adequately address current goals;

170.19 (2) the client moves out of the ACT team's service area and the ACT team has facilitated
170.20 the referral to either a new ACT team or other appropriate mental health service and has
170.21 assisted the individual in the transition process;

170.22 (3) the client, or the client's legal guardian when applicable, chooses to withdraw from
170.23 assertive community treatment services and documented attempts by the ACT team to
170.24 re-engage the client with the service have not been successful;

170.25 (4) the client has a demonstrated need for a medical nursing home placement lasting
170.26 more than three months, as determined by a physician;

170.27 (5) the client is hospitalized, in residential treatment, or in jail for a period of greater
170.28 than three months. However, the ACT team must make provisions for the client to return
170.29 to the ACT team upon their discharge or release from the hospital or jail if the client still
170.30 meets eligibility criteria for assertive community treatment and the team is not at full capacity;

170.31 (6) the ACT team is unable to locate, contact, and engage the client for a period of greater
170.32 than three months after persistent efforts by the ACT team to locate the client; or

171.1 (7) the client requests a discharge, despite repeated and proactive efforts by the ACT
171.2 team to engage the client in service planning. The ACT team must develop a transition plan
171.3 to arrange for alternate treatment for clients in this situation who have a history of suicide
171.4 attempts, assault, or forensic involvement.

171.5 (c) For all clients who are discharged from assertive community treatment to another
171.6 service provider within the ACT team's service area there is a three-month transfer period,
171.7 from the date of discharge, during which a client who does not adjust well to the new service,
171.8 may voluntarily return to the ACT team. During this period, the ACT team must maintain
171.9 contact with the client's new service provider.

171.10 **EFFECTIVE DATE.** This section is effective the day following final enactment.

171.11 Sec. 8. Minnesota Statutes 2016, section 256B.0622, subdivision 7a, is amended to read:

171.12 Subd. 7a. **Assertive community treatment team staff requirements and roles.** (a)

171.13 The required treatment staff qualifications and roles for an ACT team are:

171.14 (1) the team leader:

171.15 (i) shall be a licensed mental health professional who is qualified under Minnesota Rules,
171.16 part 9505.0371, subpart 5, item A. Individuals who are not licensed but who are eligible
171.17 for licensure and are otherwise qualified may also fulfill this role but must obtain full
171.18 licensure within 24 months of assuming the role of team leader;

171.19 (ii) must be an active member of the ACT team and provide some direct services to
171.20 clients;

171.21 (iii) must be a single full-time staff member, dedicated to the ACT team, who is
171.22 responsible for overseeing the administrative operations of the team, providing clinical
171.23 oversight of services in conjunction with the psychiatrist or psychiatric care provider, and
171.24 supervising team members to ensure delivery of best and ethical practices; and

171.25 (iv) must be available to provide overall clinical oversight to the ACT team after regular
171.26 business hours and on weekends and holidays. The team leader may delegate this duty to
171.27 another qualified member of the ACT team;

171.28 (2) the psychiatric care provider:

171.29 (i) must be a licensed psychiatrist certified by the American Board of Psychiatry and
171.30 Neurology or eligible for board certification or certified by the American Osteopathic Board
171.31 of Neurology and Psychiatry or eligible for board certification, or a psychiatric nurse who
171.32 is qualified under Minnesota Rules, part 9505.0371, subpart 5, item A. The psychiatric care

172.1 provider must have demonstrated clinical experience working with individuals with serious
172.2 and persistent mental illness;

172.3 (ii) shall collaborate with the team leader in sharing overall clinical responsibility for
172.4 screening and admitting clients; monitoring clients' treatment and team member service
172.5 delivery; educating staff on psychiatric and nonpsychiatric medications, their side effects,
172.6 and health-related conditions; actively collaborating with nurses; and helping provide clinical
172.7 supervision to the team;

172.8 (iii) shall fulfill the following functions for assertive community treatment clients:
172.9 provide assessment and treatment of clients' symptoms and response to medications, including
172.10 side effects; provide brief therapy to clients; provide diagnostic and medication education
172.11 to clients, with medication decisions based on shared decision making; monitor clients'
172.12 nonpsychiatric medical conditions and nonpsychiatric medications; and conduct home and
172.13 community visits;

172.14 (iv) shall serve as the point of contact for psychiatric treatment if a client is hospitalized
172.15 for mental health treatment and shall communicate directly with the client's inpatient
172.16 psychiatric care providers to ensure continuity of care;

172.17 (v) shall have a minimum full-time equivalency that is prorated at a rate of 16 hours per
172.18 50 clients. Part-time psychiatric care providers shall have designated hours to work on the
172.19 team, with sufficient blocks of time on consistent days to carry out the provider's clinical,
172.20 supervisory, and administrative responsibilities. No more than two psychiatric care providers
172.21 may share this role;

172.22 (vi) may not provide specific roles and responsibilities by telemedicine unless approved
172.23 by the commissioner; and

172.24 (vii) shall provide psychiatric backup to the program after regular business hours and
172.25 on weekends and holidays. The psychiatric care provider may delegate this duty to another
172.26 qualified psychiatric provider;

172.27 (3) the nursing staff:

172.28 (i) shall consist of one to three registered nurses or advanced practice registered nurses,
172.29 of whom at least one has a minimum of one-year experience working with adults with
172.30 serious mental illness and a working knowledge of psychiatric medications. No more than
172.31 two individuals can share a full-time equivalent position;

172.32 (ii) are responsible for managing medication, administering and documenting medication
172.33 treatment, and managing a secure medication room; and

(iii) shall develop strategies, in collaboration with clients, to maximize taking medications as prescribed; screen and monitor clients' mental and physical health conditions and medication side effects; engage in health promotion, prevention, and education activities; communicate and coordinate services with other medical providers; facilitate the development of the individual treatment plan for clients assigned; and educate the ACT team in monitoring psychiatric and physical health symptoms and medication side effects;

(4) the co-occurring disorder specialist:

(i) shall be a full-time equivalent co-occurring disorder specialist who has received specific training on co-occurring disorders that is consistent with national evidence-based practices. The training must include practical knowledge of common substances and how they affect mental illnesses, the ability to assess substance use disorders and the client's stage of treatment, motivational interviewing, and skills necessary to provide counseling to clients at all different stages of change and treatment. The co-occurring disorder specialist may also be an individual who is a licensed alcohol and drug counselor as described in section 148F.01, subdivision 5, or a counselor who otherwise meets the training, experience, and other requirements in Minnesota Rules, part 9530.6450, subpart 5. No more than two co-occurring disorder specialists may occupy this role; and

(ii) shall provide or facilitate the provision of co-occurring disorder treatment to clients. The co-occurring disorder specialist shall serve as a consultant and educator to fellow ACT team members on co-occurring disorders;

(5) the vocational specialist:

(i) shall be a full-time vocational specialist who has at least one-year experience providing employment services or advanced education that involved field training in vocational services to individuals with mental illness. An individual who does not meet these qualifications may also serve as the vocational specialist upon completing a training plan approved by the commissioner;

(ii) shall provide or facilitate the provision of vocational services to clients. The vocational specialist serves as a consultant and educator to fellow ACT team members on these services; and

(iii) should not refer individuals to receive any type of vocational services or linkage by providers outside of the ACT team;

(6) the mental health certified peer specialist:

(i) shall be a full-time equivalent mental health certified peer specialist as defined in section 256B.0615. No more than two individuals can share this position. The mental health certified peer specialist is a fully integrated team member who provides highly individualized services in the community and promotes the self-determination and shared decision-making abilities of clients. This requirement may be waived due to workforce shortages upon approval of the commissioner;

(ii) must provide coaching, mentoring, and consultation to the clients to promote recovery, self-advocacy, and self-direction, promote wellness management strategies, and assist clients in developing advance directives; and

(iii) must model recovery values, attitudes, beliefs, and personal action to encourage wellness and resilience, provide consultation to team members, promote a culture where the clients' points of view and preferences are recognized, understood, respected, and integrated into treatment, and serve in a manner equivalent to other team members;

(7) the program administrative assistant shall be a full-time office-based program administrative assistant position assigned to solely work with the ACT team, providing a range of supports to the team, clients, and families; and

(8) additional staff:

(i) shall be based on team size. Additional treatment team staff may include licensed mental health professionals as defined in Minnesota Rules, part 9505.0371, subpart 5, item A; mental health practitioners as defined in Minnesota Rules, part 9505.0370, subpart 17; or mental health rehabilitation workers as defined in section 256B.0623, subdivision 5, clause (4). These individuals shall have the knowledge, skills, and abilities required by the population served to carry out rehabilitation and support functions; and

(ii) shall be selected based on specific program needs or the population served.

(b) Each ACT team must clearly document schedules for all ACT team members.

(c) Each ACT team member must serve as a primary team member for clients assigned by the team leader and are responsible for facilitating the individual treatment plan process for those clients. The primary team member for a client is the responsible team member knowledgeable about the client's life and circumstances and writes the individual treatment plan. The primary team member provides individual supportive therapy or counseling, and provides primary support and education to the client's family and support system.

(d) Members of the ACT team must have strong clinical skills, professional qualifications, experience, and competency to provide a full breadth of rehabilitation services. Each staff

175.1 member shall be proficient in ~~their~~ the staff member's respective discipline and be able to
175.2 work collaboratively as a member of a multidisciplinary team to deliver the majority of the
175.3 treatment, rehabilitation, and support services clients require to fully benefit from receiving
175.4 assertive community treatment.

175.5 (e) Each ACT team member must fulfill training requirements established by the
175.6 commissioner.

175.7 **EFFECTIVE DATE.** This section is effective the day following final enactment.

175.8 Sec. 9. Minnesota Statutes 2016, section 256B.0625, subdivision 60a, is amended to read:

175.9 Subd. 60a. **Community emergency medical technician services.** (a) Medical assistance
175.10 covers services provided by a ~~community emergency medical technician~~ community medical
175.11 response emergency medical technician (CEMT) who is certified under section 144E.275,
175.12 subdivision 7, when the services are provided in accordance with this subdivision.

175.13 (b) A CEMT may provide a posthospital discharge visit when ordered by a treating
175.14 physician. The posthospital discharge visit includes:

175.15 (1) verbal or visual reminders of discharge orders;

175.16 (2) recording and reporting of vital signs to the patient's primary care provider;

175.17 (3) medication access confirmation;

175.18 (4) food access confirmation; and

175.19 (5) identification of home hazards.

175.20 (c) An individual who has repeat ambulance calls due to falls, has been discharged from
175.21 a nursing home, or has been identified by the individual's primary care provider as at risk
175.22 for nursing home placement, may receive a safety evaluation visit from a CEMT when
175.23 ordered by a primary care provider in accordance with the individual's care plan. A safety
175.24 evaluation visit includes:

175.25 (1) medication access confirmation;

175.26 (2) food access confirmation; and

175.27 (3) identification of home hazards.

175.28 (d) A CEMT shall be paid at \$9.75 per 15-minute increment. A safety evaluation visit
175.29 may not be billed for the same day as a posthospital discharge visit for the same individual.

175.30 **EFFECTIVE DATE.** This section is effective the day following final enactment.

176.1 Sec. 10. Minnesota Statutes 2016, section 256P.08, subdivision 4, is amended to read:

176.2 Subd. 4. **Recovering general assistance and Minnesota supplemental aid**

176.3 **overpayments.** (a) If an amount of assistance is paid to an assistance unit in excess of the
176.4 payment due, it shall be recoverable by the agency. The agency shall give written notice to
176.5 the participant of its intention to recover the overpayment.

176.6 (b) If the individual is no longer receiving assistance, the agency may request voluntary
176.7 repayment or pursue civil recovery.

176.8 (c) If the individual is receiving assistance, except as provided for interim assistance in
176.9 section 256D.06, subdivision 5, when an overpayment occurs the agency shall recover the
176.10 overpayment by withholding an amount equal to:

176.11 (1) three percent of the assistance unit's standard of need for all Minnesota supplemental
176.12 aid assistance units, and nonfraud cases for general assistance; ~~and~~ or

176.13 (2) ten percent where fraud has occurred in general assistance cases; or

176.14 (3) the amount of the monthly general assistance or Minnesota supplemental aid payment,
176.15 whichever is less.

176.16 (d) In cases when there is both an overpayment and underpayment, the county agency
176.17 shall offset one against the other in correcting the payment.

176.18 (e) Overpayments may also be voluntarily repaid, in part or in full, by the individual, in
176.19 addition to the assistance reductions provided in this subdivision, to include further voluntary
176.20 reductions in the grant level agreed to in writing by the individual, until the total amount
176.21 of the overpayment is repaid.

176.22 (f) The county agency shall make reasonable efforts to recover overpayments to
176.23 individuals no longer on assistance. The agency need not attempt to recover overpayments
176.24 of less than \$35 paid to an individual no longer on assistance if the individual does not
176.25 receive assistance again within three years, unless the individual has been convicted of
176.26 violating section 256.98.

176.27 (g) Establishment of an overpayment is limited to 12 months prior to the month of
176.28 discovery due to agency error and six years prior to the month of discovery due to client
176.29 error or an intentional program violation determined under section 256.046.

176.30 (h) Residents of licensed residential facilities shall not have overpayments recovered
176.31 from their personal needs allowance.

(i) Overpayments by another maintenance benefit program shall not be recovered from the general assistance or Minnesota supplemental aid grant.

EFFECTIVE DATE. This section is effective the day following final enactment.

Sec. 11. Minnesota Statutes 2016, section 626.5572, subdivision 21, is amended to read:

Subd. 21. **Vulnerable adult.** (a) "Vulnerable adult" means any person 18 years of age or older who:

(1) is a resident or inpatient of a facility;

(2) receives services required to be licensed under chapter 245A, except that a person receiving outpatient services for treatment of chemical dependency or mental illness, or one who is served in the Minnesota sex offender program on a court-hold order for commitment, or is committed as a sexual psychopathic personality or as a sexually dangerous person under chapter 253B, is not considered a vulnerable adult unless the person meets the requirements of clause (4);

(3) receives services from a home care provider required to be licensed under ~~sections 144A.43 to 144A.482~~ section 144A.471; or from a person or organization that offers, provides, or arranges for personal care assistance services under the medical assistance program as authorized under section 256B.0625, subdivision 19a, 256B.0651, 256B.0653, 256B.0654, 256B.0659, or 256B.85; or

(4) regardless of residence or whether any type of service is received, possesses a physical or mental infirmity or other physical, mental, or emotional dysfunction:

(i) that impairs the individual's ability to provide adequately for the individual's own care without assistance, including the provision of food, shelter, clothing, health care, or supervision; and

(ii) because of the dysfunction or infirmity and the need for care or services, the individual has an impaired ability to protect the individual's self from maltreatment.

(b) For purposes of this subdivision, "care or services" means care or services for the health, safety, welfare, or maintenance of an individual.

EFFECTIVE DATE. This section is effective the day following final enactment.

Sec. 12. **REVISOR'S INSTRUCTION.**

In each section of Minnesota Statutes referred to in column A, the revisor of statutes shall delete the reference in column B and insert the reference in column C. The revisor

178.1 shall make changes necessary to correct the punctuation, grammar, or structure of the
 178.2 remaining text and preserve its meaning.

178.3	<u>Column A</u>	<u>Column B</u>	<u>Column C</u>
178.4	<u>144.651, subd. 20, 29</u>	<u>Older Americans Act, section</u>	<u>Older Americans Act of 1965,</u>
178.5		<u>307(a)(12)</u>	<u>as amended, United States</u>
178.6			<u>Code, title 42, section</u>
178.7			<u>3027(a)(12) (2016)</u>
178.8	<u>256.01, subd. 2, 24</u>	<u>United States Code, title 42,</u>	<u>Older Americans Act of 1965,</u>
178.9		<u>section 3001, the Older</u>	<u>as amended, United States</u>
178.10		<u>Americans Act Amendments</u>	<u>Code, title 42, sections 3001</u>
178.11		<u>of 2006</u>	<u>- 3058ff (2016)</u>
178.12	<u>256.974</u>	<u>Older Americans Act, as</u>	<u>Older Americans Act of 1965,</u>
178.13		<u>amended, United States Code,</u>	<u>as amended, United States</u>
178.14		<u>title 42, section 3027(a)(9) and</u>	<u>Code, title 42, sections</u>
178.15		<u>3058g(a)</u>	<u>3027(a)(9) and 3058g(a)</u>
178.16			<u>(2016)</u>
178.17	<u>256.974</u>	<u>Code of Federal Regulations,</u>	<u>Code of Federal Regulations,</u>
178.18		<u>title 45, parts 1321 and 1327</u>	<u>title 45, parts 1321 (2015) and</u>
178.19			<u>1324 (Federal Register,</u>
178.20			<u>volume 81, page 35644</u>
178.21			<u>(2016))</u>
178.22	<u>256.9744, subd. 1</u>	<u>Older Americans Act, as</u>	<u>Older Americans Act of 1965,</u>
178.23		<u>amended, United States Code,</u>	<u>as amended, United States</u>
178.24		<u>title 42, section 3058g(d)</u>	<u>Code, title 42, section</u>
178.25			<u>3058g(d) (2016)</u>
178.26	<u>256.975, subd. 2</u>	<u>Older Americans Act of 1965,</u>	<u>Older Americans Act of 1965,</u>
178.27		<u>as amended</u>	<u>as amended, United States</u>
178.28			<u>Code, title 42, sections 3001</u>
178.29			<u>- 3058ff (2016)</u>
178.30	<u>256.975, subd. 7</u>	<u>United States Code, title 42,</u>	<u>Older Americans Act of 1965,</u>
178.31		<u>section 3001, the Older</u>	<u>as amended, United States</u>
178.32		<u>Americans Act Amendments</u>	<u>Code, title 42, sections 3001</u>
178.33		<u>of 2006</u>	<u>- 3058ff (2016)</u>
178.34	<u>256.977, subd. 3</u>	<u>Older Americans Act</u>	<u>Older Americans Act of 1965,</u>
178.35			<u>as amended, United States</u>
178.36			<u>Code, title 42, sections 3001</u>
178.37			<u>- 3058ff (2016)</u>
178.38	<u>256B.0917, subd. 1c</u>	<u>title III of the Older Americans</u>	<u>Older Americans Act of 1965,</u>
178.39		<u>Act</u>	<u>as amended, United States</u>
178.40			<u>Code, title 42, sections 3021</u>
178.41			<u>- 3030s-2 (2016)</u>

178.42 **EFFECTIVE DATE.** This section is effective the day following final enactment.

178.43 Sec. 13. **REPEALER.**

178.44 (a) Minnesota Statutes 2016, section 119B.125, subdivision 8, is repealed.

- 179.1
- (b) Minnesota Rules, parts 9555.7100; 9555.7200; 9555.7300; and 9555.7600, are
- 179.2
- repealed.
- 179.3
- EFFECTIVE DATE.** This section is effective the day following final enactment.

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119B.125 PROVIDER REQUIREMENTS.

Subd. 8. **Overpayment claim for failure to comply with access to records requirement.** (a) In establishing an overpayment claim under subdivision 6 for failure to provide access to attendance records, the county or commissioner is limited to the six years prior to the date the county or the commissioner requested the attendance records.

(b) When the commissioner or county establishes an overpayment claim against a current or former provider, the commissioner or county must provide notice of the claim to the provider. A notice of overpayment claim must specify the reason for the overpayment, the authority for making the overpayment claim, the time period in which the overpayment occurred, the amount of the overpayment, and the provider's right to appeal.

(c) The commissioner or county may seek to recover overpayments paid to a current or former provider. When a provider has been convicted of fraud under section 256.98, theft under section 609.52, or a federal crime relating to theft of state funds or fraudulent billing for a program administered by the commissioner or a county, recovery may be sought regardless of the amount of overpayment.

245.469 EMERGENCY SERVICES.

Subdivision 1. **Availability of emergency services.** By July 1, 1988, county boards must provide or contract for enough emergency services within the county to meet the needs of adults in the county who are experiencing an emotional crisis or mental illness. Clients may be required to pay a fee according to section 245.481. Emergency services must include assessment, crisis intervention, and appropriate case disposition. Emergency services must:

- (1) promote the safety and emotional stability of adults with mental illness or emotional crises;
- (2) minimize further deterioration of adults with mental illness or emotional crises;
- (3) help adults with mental illness or emotional crises to obtain ongoing care and treatment; and
- (4) prevent placement in settings that are more intensive, costly, or restrictive than necessary and appropriate to meet client needs.

Subd. 2. **Specific requirements.** (a) The county board shall require that all service providers of emergency services to adults with mental illness provide immediate direct access to a mental health professional during regular business hours. For evenings, weekends, and holidays, the service may be by direct toll-free telephone access to a mental health professional, a mental health practitioner, or until January 1, 1991, a designated person with training in human services who receives clinical supervision from a mental health professional.

(b) The commissioner may waive the requirement in paragraph (a) that the evening, weekend, and holiday service be provided by a mental health professional or mental health practitioner after January 1, 1991, if the county documents that:

- (1) mental health professionals or mental health practitioners are unavailable to provide this service;
- (2) services are provided by a designated person with training in human services who receives clinical supervision from a mental health professional; and
- (3) the service provider is not also the provider of fire and public safety emergency services.

(c) The commissioner may waive the requirement in paragraph (b), clause (3), that the evening, weekend, and holiday service not be provided by the provider of fire and public safety emergency services if:

- (1) every person who will be providing the first telephone contact has received at least eight hours of training on emergency mental health services reviewed by the state advisory council on mental health and then approved by the commissioner;
- (2) every person who will be providing the first telephone contact will annually receive at least four hours of continued training on emergency mental health services reviewed by the state advisory council on mental health and then approved by the commissioner;

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(3) the local social service agency has provided public education about available emergency mental health services and can assure potential users of emergency services that their calls will be handled appropriately;

(4) the local social service agency agrees to provide the commissioner with accurate data on the number of emergency mental health service calls received;

(5) the local social service agency agrees to monitor the frequency and quality of emergency services; and

(6) the local social service agency describes how it will comply with paragraph (d).

(d) Whenever emergency service during nonbusiness hours is provided by anyone other than a mental health professional, a mental health professional must be available on call for an emergency assessment and crisis intervention services, and must be available for at least telephone consultation within 30 minutes.

Subd. 3. **Mental health crisis services.** The commissioner of human services shall increase access to mental health crisis services for children and adults. In order to increase access, the commissioner must:

(1) develop a central phone number where calls can be routed to the appropriate crisis services;

(2) provide telephone consultation 24 hours a day to mobile crisis teams who are serving people with traumatic brain injury or intellectual disabilities who are experiencing a mental health crisis;

(3) expand crisis services across the state, including rural areas of the state and examining access per population;

(4) establish and implement state standards for crisis services; and

(5) provide grants to adult mental health initiatives, counties, tribes, or community mental health providers to establish new mental health crisis residential service capacity.

Priority will be given to regions that do not have a mental health crisis residential services program, do not have an inpatient psychiatric unit within the region, do not have an inpatient psychiatric unit within 90 miles, or have a demonstrated need based on the number of crisis residential or intensive residential treatment beds available to meet the needs of the residents in the region. At least 50 percent of the funds must be distributed to programs in rural Minnesota. Grant funds may be used for start-up costs, including but not limited to renovations, furnishings, and staff training. Grant applications shall provide details on how the intended service will address identified needs and shall demonstrate collaboration with crisis teams, other mental health providers, hospitals, and police.

245.4879 EMERGENCY SERVICES.

Subdivision 1. **Availability of emergency services.** County boards must provide or contract for enough mental health emergency services within the county to meet the needs of children, and children's families when clinically appropriate, in the county who are experiencing an emotional crisis or emotional disturbance. The county board shall ensure that parents, providers, and county residents are informed about when and how to access emergency mental health services for children. A child or the child's parent may be required to pay a fee according to section 245.481. Emergency service providers shall not delay the timely provision of emergency service because of delays in determining this fee or because of the unwillingness or inability of the parent to pay the fee. Emergency services must include assessment, crisis intervention, and appropriate case disposition. Emergency services must:

(1) promote the safety and emotional stability of children with emotional disturbances or emotional crises;

(2) minimize further deterioration of the child with emotional disturbance or emotional crisis;

(3) help each child with an emotional disturbance or emotional crisis to obtain ongoing care and treatment; and

(4) prevent placement in settings that are more intensive, costly, or restrictive than necessary and appropriate to meet the child's needs.

Subd. 2. **Specific requirements.** (a) The county board shall require that all service providers of emergency services to the child with an emotional disturbance provide immediate direct access

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to a mental health professional during regular business hours. For evenings, weekends, and holidays, the service may be by direct toll-free telephone access to a mental health professional, a mental health practitioner, or until January 1, 1991, a designated person with training in human services who receives clinical supervision from a mental health professional.

(b) The commissioner may waive the requirement in paragraph (a) that the evening, weekend, and holiday service be provided by a mental health professional or mental health practitioner after January 1, 1991, if the county documents that:

(1) mental health professionals or mental health practitioners are unavailable to provide this service;

(2) services are provided by a designated person with training in human services who receives clinical supervision from a mental health professional; and

(3) the service provider is not also the provider of fire and public safety emergency services.

(c) The commissioner may waive the requirement in paragraph (b), clause (3), that the evening, weekend, and holiday service not be provided by the provider of fire and public safety emergency services if:

(1) every person who will be providing the first telephone contact has received at least eight hours of training on emergency mental health services reviewed by the state advisory council on mental health and then approved by the commissioner;

(2) every person who will be providing the first telephone contact will annually receive at least four hours of continued training on emergency mental health services reviewed by the state advisory council on mental health and then approved by the commissioner;

(3) the local social service agency has provided public education about available emergency mental health services and can assure potential users of emergency services that their calls will be handled appropriately;

(4) the local social service agency agrees to provide the commissioner with accurate data on the number of emergency mental health service calls received;

(5) the local social service agency agrees to monitor the frequency and quality of emergency services; and

(6) the local social service agency describes how it will comply with paragraph (d).

(d) When emergency service during nonbusiness hours is provided by anyone other than a mental health professional, a mental health professional must be available on call for an emergency assessment and crisis intervention services, and must be available for at least telephone consultation within 30 minutes.

256B.0624 ADULT CRISIS RESPONSE SERVICES COVERED.

Subd. 4a. **Alternative provider standards.** If a county demonstrates that, due to geographic or other barriers, it is not feasible to provide mobile crisis intervention services according to the standards in subdivision 4, paragraph (b), clause (9), the commissioner may approve a crisis response provider based on an alternative plan proposed by a county or group of counties. The alternative plan must:

(1) result in increased access and a reduction in disparities in the availability of crisis services;

(2) provide mobile services outside of the usual nine-to-five office hours and on weekends and holidays; and

(3) comply with standards for emergency mental health services in section 245.469.

Subd. 5. **Mobile crisis intervention staff qualifications.** For provision of adult mental health mobile crisis intervention services, a mobile crisis intervention team is comprised of at least two mental health professionals as defined in section 245.462, subdivision 18, clauses (1) to (6), or a combination of at least one mental health professional and one mental health practitioner as defined in section 245.462, subdivision 17, with the required mental health crisis training and under the clinical supervision of a mental health professional on the team. The team must have at least two people with at least one member providing on-site crisis intervention services when needed. Team members must be experienced in mental health assessment, crisis intervention techniques, treatment engagement strategies, working with families, and clinical decision-making under emergency

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conditions and have knowledge of local services and resources. The team must recommend and coordinate the team's services with appropriate local resources such as the county social services agency, mental health services, and local law enforcement when necessary.

Subd. 6. Crisis assessment and mobile intervention treatment planning. (a) Prior to initiating mobile crisis intervention services, a screening of the potential crisis situation must be conducted. The screening may use the resources of crisis assistance and emergency services as defined in sections 245.462, subdivision 6, and 245.469, subdivisions 1 and 2. The screening must gather information, determine whether a crisis situation exists, identify parties involved, and determine an appropriate response.

(b) If a crisis exists, a crisis assessment must be completed. A crisis assessment evaluates any immediate needs for which emergency services are needed and, as time permits, the recipient's current life situation, sources of stress, mental health problems and symptoms, strengths, cultural considerations, support network, vulnerabilities, current functioning, and the recipient's preferences as communicated directly by the recipient, or as communicated in a health care directive as described in chapters 145C and 253B, the treatment plan described under paragraph (d), a crisis prevention plan, or a wellness recovery action plan.

(c) If the crisis assessment determines mobile crisis intervention services are needed, the intervention services must be provided promptly. As opportunity presents during the intervention, at least two members of the mobile crisis intervention team must confer directly or by telephone about the assessment, treatment plan, and actions taken and needed. At least one of the team members must be on site providing crisis intervention services. If providing on-site crisis intervention services, a mental health practitioner must seek clinical supervision as required in subdivision 9.

(d) The mobile crisis intervention team must develop an initial, brief crisis treatment plan as soon as appropriate but no later than 24 hours after the initial face-to-face intervention. The plan must address the needs and problems noted in the crisis assessment and include measurable short-term goals, cultural considerations, and frequency and type of services to be provided to achieve the goals and reduce or eliminate the crisis. The treatment plan must be updated as needed to reflect current goals and services.

(e) The team must document which short-term goals have been met and when no further crisis intervention services are required.

(f) If the recipient's crisis is stabilized, but the recipient needs a referral to other services, the team must provide referrals to these services. If the recipient has a case manager, planning for other services must be coordinated with the case manager. If the recipient is unable to follow up on the referral, the team must link the recipient to the service and follow up to ensure the recipient is receiving the service.

(g) If the recipient's crisis is stabilized and the recipient does not have an advance directive, the case manager or crisis team shall offer to work with the recipient to develop one.

Subd. 7. Crisis stabilization services. (a) Crisis stabilization services must be provided by qualified staff of a crisis stabilization services provider entity and must meet the following standards:

(1) a crisis stabilization treatment plan must be developed which meets the criteria in subdivision 11;

(2) staff must be qualified as defined in subdivision 8; and

(3) services must be delivered according to the treatment plan and include face-to-face contact with the recipient by qualified staff for further assessment, help with referrals, updating of the crisis stabilization treatment plan, supportive counseling, skills training, and collaboration with other service providers in the community.

(b) If crisis stabilization services are provided in a supervised, licensed residential setting, the recipient must be contacted face-to-face daily by a qualified mental health practitioner or mental health professional. The program must have 24-hour-a-day residential staffing which may include staff who do not meet the qualifications in subdivision 8. The residential staff must have 24-hour-a-day immediate direct or telephone access to a qualified mental health professional or practitioner.

(c) If crisis stabilization services are provided in a supervised, licensed residential setting that serves no more than four adult residents, and one or more individuals are present at the setting to receive residential crisis stabilization services, the residential staff must include, for at least eight

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hours per day, at least one individual who meets the qualifications in subdivision 8, paragraph (a), clause (1) or (2).

(d) If crisis stabilization services are provided in a supervised, licensed residential setting that serves more than four adult residents, and one or more are recipients of crisis stabilization services, the residential staff must include, for 24 hours a day, at least one individual who meets the qualifications in subdivision 8. During the first 48 hours that a recipient is in the residential program, the residential program must have at least two staff working 24 hours a day. Staffing levels may be adjusted thereafter according to the needs of the recipient as specified in the crisis stabilization treatment plan.

Subd. 8. **Adult crisis stabilization staff qualifications.** (a) Adult mental health crisis stabilization services must be provided by qualified individual staff of a qualified provider entity. Individual provider staff must have the following qualifications:

(1) be a mental health professional as defined in section 245.462, subdivision 18, clauses (1) to (6);

(2) be a mental health practitioner as defined in section 245.462, subdivision 17. The mental health practitioner must work under the clinical supervision of a mental health professional;

(3) be a certified peer specialist under section 256B.0615. The certified peer specialist must work under the clinical supervision of a mental health professional; or

(4) be a mental health rehabilitation worker who meets the criteria in section 256B.0623, subdivision 5, clause (4); works under the direction of a mental health practitioner as defined in section 245.462, subdivision 17, or under direction of a mental health professional; and works under the clinical supervision of a mental health professional.

(b) Mental health practitioners and mental health rehabilitation workers must have completed at least 30 hours of training in crisis intervention and stabilization during the past two years.

Subd. 9. **Supervision.** Mental health practitioners may provide crisis assessment and mobile crisis intervention services if the following clinical supervision requirements are met:

(1) the mental health provider entity must accept full responsibility for the services provided;

(2) the mental health professional of the provider entity, who is an employee or under contract with the provider entity, must be immediately available by phone or in person for clinical supervision;

(3) the mental health professional is consulted, in person or by phone, during the first three hours when a mental health practitioner provides on-site service;

(4) the mental health professional must:

(i) review and approve of the tentative crisis assessment and crisis treatment plan;

(ii) document the consultation; and

(iii) sign the crisis assessment and treatment plan within the next business day;

(5) if the mobile crisis intervention services continue into a second calendar day, a mental health professional must contact the recipient face-to-face on the second day to provide services and update the crisis treatment plan; and

(6) the on-site observation must be documented in the recipient's record and signed by the mental health professional.

Subd. 10. **Recipient file.** Providers of mobile crisis intervention or crisis stabilization services must maintain a file for each recipient containing the following information:

(1) individual crisis treatment plans signed by the recipient, mental health professional, and mental health practitioner who developed the crisis treatment plan, or if the recipient refused to sign the plan, the date and reason stated by the recipient as to why the recipient would not sign the plan;

(2) signed release forms;

(3) recipient health information and current medications;

(4) emergency contacts for the recipient;

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(5) case records which document the date of service, place of service delivery, signature of the person providing the service, and the nature, extent, and units of service. Direct or telephone contact with the recipient's family or others should be documented;

(6) required clinical supervision by mental health professionals;

(7) summary of the recipient's case reviews by staff;

(8) any written information by the recipient that the recipient wants in the file; and

(9) an advance directive, if there is one available.

Documentation in the file must comply with all requirements of the commissioner.

Subd. 11. **Treatment plan.** The individual crisis stabilization treatment plan must include, at a minimum:

(1) a list of problems identified in the assessment;

(2) a list of the recipient's strengths and resources;

(3) concrete, measurable short-term goals and tasks to be achieved, including time frames for achievement;

(4) specific objectives directed toward the achievement of each one of the goals;

(5) documentation of the participants involved in the service planning. The recipient, if possible, must be a participant. The recipient or the recipient's legal guardian must sign the service plan or documentation must be provided why this was not possible. A copy of the plan must be given to the recipient and the recipient's legal guardian. The plan should include services arranged, including specific providers where applicable;

(6) planned frequency and type of services initiated;

(7) a crisis response action plan if a crisis should occur;

(8) clear progress notes on outcome of goals;

(9) a written plan must be completed within 24 hours of beginning services with the recipient; and

(10) a treatment plan must be developed by a mental health professional or mental health practitioner under the clinical supervision of a mental health professional. The mental health professional must approve and sign all treatment plans.

256B.0944 CHILDREN'S MENTAL HEALTH CRISIS RESPONSE SERVICES.

Subdivision 1. **Definitions.** For purposes of this section, the following terms have the meanings given them.

(a) "Mental health crisis" means a child's behavioral, emotional, or psychiatric situation that, but for the provision of crisis response services to the child, would likely result in significantly reduced levels of functioning in primary activities of daily living, an emergency situation, or the child's placement in a more restrictive setting, including, but not limited to, inpatient hospitalization.

(b) "Mental health emergency" means a child's behavioral, emotional, or psychiatric situation that causes an immediate need for mental health services and is consistent with section 62Q.55. A physician, mental health professional, or crisis mental health practitioner determines a mental health crisis or emergency for medical assistance reimbursement with input from the client and the client's family, if possible.

(c) "Mental health crisis assessment" means an immediate face-to-face assessment by a physician, mental health professional, or mental health practitioner under the clinical supervision of a mental health professional, following a screening that suggests the child may be experiencing a mental health crisis or mental health emergency situation.

(d) "Mental health mobile crisis intervention services" means face-to-face, short-term intensive mental health services initiated during a mental health crisis or mental health emergency. Mental health mobile crisis services must help the recipient cope with immediate stressors, identify and utilize available resources and strengths, and begin to return to the recipient's baseline level of

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functioning. Mental health mobile services must be provided on site by a mobile crisis intervention team outside of an emergency room, urgent care, or an inpatient hospital setting.

(e) "Mental health crisis stabilization services" means individualized mental health services provided to a recipient following crisis intervention services that are designed to restore the recipient to the recipient's prior functional level. The individual treatment plan recommending mental health crisis stabilization must be completed by the intervention team or by staff after an inpatient or urgent care visit. Mental health crisis stabilization services may be provided in the recipient's home, the home of a family member or friend of the recipient, schools, another community setting, or a short-term supervised, licensed residential program if the service is not included in the facility's cost pool or per diem. Mental health crisis stabilization is not reimbursable when provided as part of a partial hospitalization or day treatment program.

Subd. 2. **Medical assistance coverage.** Medical assistance covers medically necessary children's mental health crisis response services, subject to federal approval, if provided to an eligible recipient under subdivision 3, by a qualified provider entity under subdivision 4 or a qualified individual provider working within the provider's scope of practice, and identified in the recipient's individual crisis treatment plan under subdivision 8.

Subd. 3. **Eligibility.** An eligible recipient is an individual who:

- (1) is eligible for medical assistance;
- (2) is under age 18 or between the ages of 18 and 21;
- (3) is screened as possibly experiencing a mental health crisis or mental health emergency where a mental health crisis assessment is needed;
- (4) is assessed as experiencing a mental health crisis or mental health emergency, and mental health mobile crisis intervention or mental health crisis stabilization services are determined to be medically necessary; and
- (5) meets the criteria for emotional disturbance or mental illness.

Subd. 4. **Provider entity standards.** (a) A crisis intervention and crisis stabilization provider entity must meet the administrative and clinical standards specified in section 256B.0943, subdivisions 5 and 6, meet the standards listed in paragraph (b), and be:

- (1) an Indian health service facility or facility owned and operated by a tribe or a tribal organization operating under Public Law 93-638 as a 638 facility;
- (2) a county board-operated entity; or
- (3) a provider entity that is under contract with the county board in the county where the potential crisis or emergency is occurring.

(b) The children's mental health crisis response services provider entity must:

- (1) ensure that mental health crisis assessment and mobile crisis intervention services are available 24 hours a day, seven days a week;
- (2) directly provide the services or, if services are subcontracted, the provider entity must maintain clinical responsibility for services and billing;
- (3) ensure that crisis intervention services are provided in a manner consistent with sections 245.487 to 245.4889; and
- (4) develop and maintain written policies and procedures regarding service provision that include safety of staff and recipients in high-risk situations.

Subd. 4a. **Alternative provider standards.** If a provider entity demonstrates that, due to geographic or other barriers, it is not feasible to provide mobile crisis intervention services 24 hours a day, seven days a week, according to the standards in subdivision 4, paragraph (b), clause (1), the commissioner may approve a crisis response provider based on an alternative plan proposed by a provider entity. The alternative plan must:

- (1) result in increased access and a reduction in disparities in the availability of crisis services; and
- (2) provide mobile services outside of the usual nine-to-five office hours and on weekends and holidays.

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Subd. 5. **Mobile crisis intervention staff qualifications.** (a) To provide children's mental health mobile crisis intervention services, a mobile crisis intervention team must include:

(1) at least two mental health professionals as defined in section 256B.0943, subdivision 1, paragraph (o); or

(2) a combination of at least one mental health professional and one mental health practitioner as defined in section 245.4871, subdivision 26, with the required mental health crisis training and under the clinical supervision of a mental health professional on the team.

(b) The team must have at least two people with at least one member providing on-site crisis intervention services when needed. Team members must be experienced in mental health assessment, crisis intervention techniques, and clinical decision making under emergency conditions and have knowledge of local services and resources. The team must recommend and coordinate the team's services with appropriate local resources, including the county social services agency, mental health service providers, and local law enforcement, if necessary.

Subd. 6. **Initial screening and crisis assessment planning.** (a) Before initiating mobile crisis intervention services, a screening of the potential crisis situation must be conducted. The screening may use the resources of crisis assistance and emergency services as defined in sections 245.4871, subdivision 14, and 245.4879, subdivisions 1 and 2. The screening must gather information, determine whether a crisis situation exists, identify the parties involved, and determine an appropriate response.

(b) If a crisis exists, a crisis assessment must be completed. A crisis assessment must evaluate any immediate needs for which emergency services are needed and, as time permits, the recipient's current life situation, sources of stress, mental health problems and symptoms, strengths, cultural considerations, support network, vulnerabilities, and current functioning.

(c) If the crisis assessment determines mobile crisis intervention services are needed, the intervention services must be provided promptly. As the opportunity presents itself during the intervention, at least two members of the mobile crisis intervention team must confer directly or by telephone about the assessment, treatment plan, and actions taken and needed. At least one of the team members must be on site providing crisis intervention services. If providing on-site crisis intervention services, a mental health practitioner must seek clinical supervision as required under subdivision 9.

(d) The mobile crisis intervention team must develop an initial, brief crisis treatment plan as soon as appropriate but no later than 24 hours after the initial face-to-face intervention. The plan must address the needs and problems noted in the crisis assessment and include measurable short-term goals, cultural considerations, and frequency and type of services to be provided to achieve the goals and reduce or eliminate the crisis. The crisis treatment plan must be updated as needed to reflect current goals and services. The team must involve the client and the client's family in developing and implementing the plan.

(e) The team must document in progress notes which short-term goals have been met and when no further crisis intervention services are required.

(f) If the client's crisis is stabilized, but the client needs a referral for mental health crisis stabilization services or to other services, the team must provide a referral to these services. If the recipient has a case manager, planning for other services must be coordinated with the case manager.

Subd. 7. **Crisis stabilization services.** Crisis stabilization services must be provided by a mental health professional or a mental health practitioner who works under the clinical supervision of a mental health professional and for a crisis stabilization services provider entity and must meet the following standards:

(1) a crisis stabilization treatment plan must be developed which meets the criteria in subdivision 8;

(2) services must be delivered according to the treatment plan and include face-to-face contact with the recipient by qualified staff for further assessment, help with referrals, updating the crisis stabilization treatment plan, supportive counseling, skills training, and collaboration with other service providers in the community; and

(3) mental health practitioners must have completed at least 30 hours of training in crisis intervention and stabilization during the past two years.

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Subd. 8. **Treatment plan.** (a) The individual crisis stabilization treatment plan must include, at a minimum:

- (1) a list of problems identified in the assessment;
 - (2) a list of the recipient's strengths and resources;
 - (3) concrete, measurable short-term goals and tasks to be achieved, including time frames for achievement of the goals;
 - (4) specific objectives directed toward the achievement of each goal;
 - (5) documentation of the participants involved in the service planning;
 - (6) planned frequency and type of services initiated;
 - (7) a crisis response action plan if a crisis should occur; and
 - (8) clear progress notes on the outcome of goals.
- (b) The client, if clinically appropriate, must be a participant in the development of the crisis stabilization treatment plan. The client or the client's legal guardian must sign the service plan or documentation must be provided why this was not possible. A copy of the plan must be given to the client and the client's legal guardian. The plan should include services arranged, including specific providers where applicable.

(c) A treatment plan must be developed by a mental health professional or mental health practitioner under the clinical supervision of a mental health professional. A written plan must be completed within 24 hours of beginning services with the client.

Subd. 9. **Supervision.** (a) A mental health practitioner may provide crisis assessment and mobile crisis intervention services if the following clinical supervision requirements are met:

- (1) the mental health provider entity must accept full responsibility for the services provided;
- (2) the mental health professional of the provider entity, who is an employee or under contract with the provider entity, must be immediately available by telephone or in person for clinical supervision;
- (3) the mental health professional is consulted, in person or by telephone, during the first three hours when a mental health practitioner provides on-site service; and
- (4) the mental health professional must review and approve the tentative crisis assessment and crisis treatment plan, document the consultation, and sign the crisis assessment and treatment plan within the next business day.

(b) If the mobile crisis intervention services continue into a second calendar day, a mental health professional must contact the client face-to-face on the second day to provide services and update the crisis treatment plan. The on-site observation must be documented in the client's record and signed by the mental health professional.

Subd. 10. **Client record.** The provider must maintain a file for each client that complies with the requirements under section 256B.0943, subdivision 11, and contains the following information:

- (1) individual crisis treatment plans signed by the recipient, mental health professional, and mental health practitioner who developed the crisis treatment plan, or if the recipient refused to sign the plan, the date and reason stated by the recipient for not signing the plan;
- (2) signed release of information forms;
- (3) recipient health information and current medications;
- (4) emergency contacts for the recipient;
- (5) case records that document the date of service, place of service delivery, signature of the person providing the service, and the nature, extent, and units of service. Direct or telephone contact with the recipient's family or others should be documented;
- (6) required clinical supervision by mental health professionals;
- (7) summary of the recipient's case reviews by staff; and
- (8) any written information by the recipient that the recipient wants in the file.

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Subd. 11. **Excluded services.** The following services are excluded from reimbursement under this section:

- (1) room and board services;
- (2) services delivered to a recipient while admitted to an inpatient hospital;
- (3) transportation services under children's mental health crisis response service;
- (4) services provided and billed by a provider who is not enrolled under medical assistance to provide children's mental health crisis response services;
- (5) crisis response services provided by a residential treatment center to clients in their facility;
- (6) services performed by volunteers;
- (7) direct billing of time spent "on call" when not delivering services to a recipient;
- (8) provider service time included in case management reimbursement;
- (9) outreach services to potential recipients; and
- (10) a mental health service that is not medically necessary.

9555.6255 RESIDENT'S RIGHTS.

Subpart 1. **Information about rights.** The operator shall ensure that a resident and a resident's legal representative are given, at admission:

- A. an explanation and copy of the resident's rights specified in subparts 2 to 7;
- B. a written summary of the Vulnerable Adults Act prepared by the department; and
- C. the name, address, and telephone number of the local agency to which a resident or a resident's legal representative may submit an oral or written complaint.

Subp. 2. **Right to use telephone.** A resident has the right to daily, private access to and use of a non-coin operated telephone for local calls and long distance calls made collect or paid for by the resident.

Subp. 3. **Right to receive and send mail.** A resident has the right to receive and send uncensored, unopened mail.

Subp. 4. **Right to privacy.** A resident has the right to personal privacy and privacy for visits from others, and the respect of individuality and cultural identity. Privacy must be respected by operators, caregivers, household members, and volunteers by knocking on the door of a resident's bedroom and seeking consent before entering, except in an emergency, and during toileting, bathing, and other activities of personal hygiene, except as needed for resident safety or assistance as noted in the resident's individual record.

Subp. 5. **Right to use personal property.** A resident has the right to keep and use personal clothing and possessions as space permits, unless to do so would infringe on the health, safety, or rights of other residents or household members.

Subp. 6. **Right to associate.** A resident has the right to meet with or refuse to meet with visitors and participate in activities of commercial, religious, political, and community groups without interference if the activities do not infringe on the rights of other residents or household members.

Subp. 7. **Married residents.** Married residents have the right to privacy for visits by their spouses, and, if both spouses are residents of the adult foster home, they have the right to share a bedroom and bed.

9555.7100 SCOPE.

Parts 9555.7100 to 9555.7600 govern the investigation and reporting of maltreatment of vulnerable adults and some aspects of the emergency and continuing protective social services required to be furnished by local social services agencies under Minnesota Statutes, section 626.557.

9555.7200 DEFINITIONS.

Subpart 1. **Scope.** As used in parts 9555.7100 to 9555.7600, the following terms have the meanings given them.

Subp. 2. **Abuse.** "Abuse" means:

- A. any act which constitutes a violation of Minnesota Statutes, section 609.322 related to prostitution;
- B. any act which constitutes a violation of Minnesota Statutes, sections 609.342 to 609.345 related to criminal sexual conduct; or
- C. the intentional and nontherapeutic infliction of physical pain or injury, or any persistent course of conduct intended to produce mental or emotional distress.

Subp. 3. **Caretaker.** "Caretaker" means an individual or facility which has responsibility for the care of a vulnerable adult as a result of family relationship, or which has assumed responsibility for all or a portion of the care of the vulnerable adult voluntarily, by contract, or by agreement. A person who has assumed only financial responsibility for an adult is not a caretaker.

Subp. 4. **County of financial responsibility.** "County of financial responsibility" means the county designated as the county of financial responsibility.

Subp. 5. **Facility.** "Facility" means a hospital or other entity required to be licensed pursuant to Minnesota Statutes, sections 144.50 to 144.58; a nursing home required to be licensed pursuant

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to Minnesota Statutes, section 144A.02; an agency, residential or nonresidential program required to be licensed pursuant to Minnesota Statutes, chapter 245A; a mental health program receiving funds pursuant to Minnesota Statutes, section 245.61; and any entity required to be certified for participation in titles XVIII or XIX of the Social Security Act, United States Code, title 42, section 1395 et seq.

Subp. 6. **False.** "False" means disproved to the satisfaction of the investigating agency.

Subp. 7. **Host county.** "Host county" means the county in which a facility is located.

Subp. 8. **Impairment of mental or physical function or emotional status.** "Impairment of mental or physical function or emotional status" means a condition which includes being substantially unable to carry out one or more of the essential major activities of daily living, such as caring for oneself, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning, or working; being unable to protect oneself from hazardous or abusive situations without assistance; a substantial disorder of thought or mood which significantly impairs judgment, behavior, capacity to recognize reality or ability to cope with the ordinary demands of life; substantial difficulty in engaging in the rational decision-making process, and inability to weigh the possible benefits and risks of seeking assistance; a condition in which an individual is so fearful, so ashamed, so confused, or so anxious about the consequences of reporting that that individual would be unable or unlikely to make a responsible decision regarding whether or not to report abuse or neglect.

Subp. 9. **Licensing agency.** "Licensing agency" means:

A. the commissioner of health, for a facility which is required to be licensed or certified by the Department of Health;

B. the commissioner of human services for programs required by Minnesota Statutes, chapter 245A, to be licensed;

C. any licensing board which regulates persons pursuant to Minnesota Statutes, section 214.01; and

D. the Minnesota Department of Health if the human services occupation of the alleged perpetrator is credentialed pursuant to Minnesota Statutes, section 149A.20 or 214.13.

Subp. 10. **Local social services agency.** "Local social services agency" means the local agency under the authority of the human services board or board of county commissioners which is responsible for social services.

Subp. 11. **Neglect.** "Neglect" means failure by a caretaker to supply or to ensure the supply of necessary food, clothing, shelter, health care, or supervision for a vulnerable adult.

Subp. 12. **Report.** "Report" means any verbal or written report of abuse or neglect of a vulnerable adult received by the local social services agency, police department, county sheriff, or licensing agency.

Subp. 13. **State agency.** "State agency" means the Minnesota Department of Human Services.

Subp. 14. **Substantiated.** "Substantiated" means proved to the satisfaction of the investigating agency.

Subp. 15. **Vulnerable adult.** "Vulnerable adult" means any person 18 years of age or older:

A. who is a resident or patient of a facility;

B. who receives services at or from a program required to be licensed pursuant to Minnesota Statutes, chapter 245A; or

C. who, regardless of residence, is unable or unlikely to report abuse or neglect without assistance because of impairment of mental or physical function or emotional status.

Subp. 16. **Inconclusive.** "Inconclusive" means a report which cannot be substantiated or disproved to the satisfaction of the investigating agency.

9555.7300 COMPLAINT INVESTIGATION BY LOCAL SOCIAL SERVICES AGENCIES.

Subpart 1. **Duty to accept and investigate complaints.** The local social services agency shall accept and investigate all complaints alleging that a vulnerable adult has been abused or neglected in that agency's county. The local social services agency shall notify each relevant licensing agency

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and the local police departments or county sheriffs and shall cooperate in coordinating its investigation with the investigations of the licensing agencies, police departments, and sheriffs. The local social services agency shall immediately send a report of its findings to all other agencies notified concerning the complaint in question.

Subp. 2. **Time limits to initiate investigations.** The local social services agency shall begin to investigate all complaints within the following time limits:

A. The local social services agency shall conduct an immediate on-site investigation for complaints alleging or from which it can be inferred that a vulnerable adult is in need of immediate care or protection because the adult is life-threatened or likely to experience physical injury due to abuse or abandonment.

B. The local social services agency shall begin its investigation within 24 hours for complaints alleging, or when there is substantial evidence, that a vulnerable adult is not in need of immediate care or protection but is allegedly abused.

C. The local social services agency shall begin its investigation within 72 hours for complaints alleging, or when there is substantial evidence, that a vulnerable adult is not in need of immediate care or protection but is allegedly neglected.

Subp. 3. **Investigations related to a facility.** When an investigation involves an alleged incident or situation related to a facility, the local social services agency shall make an on-site visit to the facility to assess the validity of the complaint. This investigation shall include the following activities when necessary to make an accurate assessment, but activities specified in items A, C, and E need not occur on the site of the facility:

- A. discussion with the reporter;
- B. discussion with the facility administrator or responsible designee;
- C. discussion with the physician or other professionals, or any corroborating contacts as necessary;
- D. contact with the alleged victim;
- E. discussion with the alleged perpetrator;
- F. examination of the physical conditions or the psychological climate of the facility; and
- G. inspection of the alleged victim's record.

The local social services agency shall also determine whether the reported abuse or neglect places other vulnerable adults in jeopardy of being abused or neglected.

The local social services agency shall immediately send a report of its findings to all other agencies notified concerning the complaint in question.

Subp. 4. **Investigations not related to a facility.** When an investigation involves an alleged incident or situation which is not related to a facility, the local social services agency shall assess the validity of the complaint. This investigation shall include the following activities where necessary to make an accurate assessment:

- A. discussion with the alleged victim;
- B. discussion with the reporter or any corroborating contacts, as necessary;
- C. discussion with the alleged perpetrator;
- D. discussion with the physician or other professionals; and
- E. examination of the physical conditions or the psychological climate of the residence.

The local social services agency shall also determine whether the reported abuse or neglect places other vulnerable adults in jeopardy of being abused or neglected.

Subp. 5. **Investigations by agencies which are not in the county of financial responsibility.** When a complaint involves a vulnerable adult who is receiving services from a facility located in a county other than the adult's county of financial responsibility, the local social services agency of the host county shall:

- A. investigate the complaint in accordance with subpart 3 and determine whether the complaint is substantiated, inconclusive, or false;

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B. notify each relevant licensing agency, the police or sheriff, and the county of financial responsibility;

C. consult with the county of financial responsibility, unless the host county must take immediate emergency measures and representatives of the county of financial responsibility are not available;

D. take whatever measures are necessary to correct the situation or to remove the adult from the facility and notify the county of financial responsibility of the actions taken to correct the situation or of the removal of the adult from the facility; and

E. complete and transmit all required written forms and findings to appropriate agencies.

The local social services agency of the county of financial responsibility shall then resume responsibility for ensuring ongoing planning and services for the vulnerable adult.

Subp. 6. **Use of outside experts.** When it is investigating alleged abuse or neglect of a vulnerable adult, the local social services agency shall consult persons with appropriate expertise if the local agency believes that it lacks the expertise necessary for making judgments pertaining to the allegations. This consultation may include matters of physical health, mental health, specialized treatment such as behavior modification, geriatrics, or other matters.

Subp. 7. **Investigations after initial complaint assessment.** If upon the initial assessment required by subparts 1 to 6 there appears to be substance to a complaint, the local social services agency shall attempt to determine the following:

A. the risk posed if the vulnerable adult remains in the present circumstances;

B. the current physical and emotional condition of the vulnerable adult, including the history or pattern of abuse or neglect or related prior injuries;

C. the name, address, age, sex, and relationship of the alleged perpetrator to the vulnerable adult; and

D. in a complaint of neglect, the relationship of the caretaker to the vulnerable adult, including the agreed-upon roles and responsibilities of the caretaker and the vulnerable adult.

9555.7600 ACTIONS ON BEHALF OF A VULNERABLE ADULT WHO REFUSES SERVICES.

If a vulnerable adult who is the victim of abuse or neglect by a caretaker refuses an offer of services from a local social services agency and in the judgment of that agency the vulnerable adult's safety or welfare is in jeopardy, the agency shall seek the authority to intervene on behalf of that adult. If the agency believes it to be in the adult's best interest, it shall seek or help the family or victim seek any of the following:

A. a restraining order or a court order for removal of the perpetrator from the residence of the vulnerable adult pursuant to Minnesota Statutes, section 518B.01;

B. guardianship or conservatorship pursuant to Minnesota Statutes, sections 525.539 to 525.6198, or guardianship or conservatorship pursuant to Minnesota Statutes, chapter 252A;

C. a hold order or commitment pursuant to the Minnesota Hospitalization and Commitment Act, Minnesota Statutes, chapter 253A; or

D. a referral to the prosecuting attorney for possible criminal prosecution of the perpetrator under Minnesota Statutes, chapter 609.