CHAPTER 245

DEPARTMENT OF HUMAN SERVICES

245.037 LEASES FOR REGIONAL TREATMENT CENTER AND STATE NURSING HOME PROPERTY.

Notwithstanding any law to the contrary, money collected as rent under section 16B.24, subdivision 5, for state property at any of the regional treatment centers or state nursing home facilities administered by the commissioner of human services is dedicated to the regional treatment center or state nursing home from which it is generated. Any balance remaining at the end of the fiscal year shall not cancel and is available until expended.

History: *1Sp1993 c 1 art 7 s 1*

245.462 DEFINITIONS.

[For text of subds 1 to 3, see M.S.1992]

Subd. 4. **Case manager.** "Case manager" means an individual employed by the county or other entity authorized by the county board to provide case management services specified in section 245.4711. A case manager must have a bachelor's degree in one of the behavioral sciences or related fields from an accredited college or university and have at least 2,000 hours of supervised experience in the delivery of services to adults with mental illness, must be skilled in the process of identifying and assessing a wide range of client needs, and must be knowledgeable about local community resources and how to use those resources for the benefit of the client. The case manager shall meet in person with a mental health professional at least once each month to obtain clinical supervision of the case manager's activities. Case managers with a bachelor's degree but without 2,000 hours of supervised experience in the delivery of services to adults with mental illness must complete 40 hours of training approved by the commissioner of human services in case management skills and in the characteristics and needs of adults with serious and persistent mental illness and must receive clinical supervision regarding individual service delivery from a mental health professional at least once each week until the requirement of 2,000 hours of supervised experience is met. Clinical supervision must be documented in the client record.

Until June 30, 1996, a refugee who does not have the qualifications specified in this subdivision may provide case management services to adult refugees with serious and persistent mental illness who are members of the same ethnic group as the case manager if the person: (1) is actively pursuing credits toward the completion of a bachelor's degree in one of the behavioral sciences or a related field from an accredited college or

university; (2) completes 40 hours of training as specified in this subdivision; and (3) receives clinical supervision at least once a week until the requirements of obtaining a bachelor's degree and 2,000 hours of supervised experience are met.

[For text of subds 4a to 19, see M.S.1992]

Subd. 20. **Mental illness.** (a) "Mental illness" means an organic disorder of the brain or a clinically significant disorder of thought, mood, perception, orientation, memory, or behavior that is listed in the clinical manual of the International Classification of Diseases (ICD-9-CM), current edition, code range 290.0 to 302.99 or 306.0 to 316.0 or the corresponding code in the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM-MD), current edition, Axes I, II, or III, and that seriously limits a person's capacity to function in primary aspects of daily living such as personal relations, living arrangements, work, and recreation.

(b) An "adult with acute mental illness" means an adult who has a mental illness that is serious enough to require prompt intervention.

(c) For purposes of case management and community support services, a "person with serious and persistent mental illness" means an adult who has a mental illness and meets at least one of the following criteria:

(1) the adult has undergone two or more episodes of inpatient care for a mental illness within the preceding 24 months;

(2) the adult has experienced a continuous psychiatric hospitalization or residential treatment exceeding six months' duration within the preceding 12 months;

(3) the adult:

(i) has a diagnosis of schizophrenia, bipolar disorder, major depression, or borderline personality disorder;

(ii) indicates a significant impairment in functioning; and

(iii) has a written opinion from a mental health professional, in the last three years, stating that the adult is reasonably likely to have future episodes requiring inpatient or residential treatment, of a frequency described in clause (1) or (2), unless ongoing case management or community support services are provided;

(4) the adult has, in the last three years, been committed by a court as a mentally ill person under chapter 253B, or the adult's commitment has been stayed or continued; or

(5) the adult (i) was eligible under clauses (1) to (4), but the specified time period has expired or the adult was eligible as a child under section 245.4871, subdivision 6; and (ii) has a written opinion from a mental health professional, in the last three years, stating that the adult is reasonably likely to have future episodes requiring inpatient or residential treatment, of a frequency described in clause (1) or (2), unless ongoing case management or community support services are provided.

[For text of subds 21 to 24, see M.S.1992]

History: *1Sp1993 c 1 art 7 s 2,3*

245.464 COORDINATION OF MENTAL HEALTH SYSTEM.

Subdivision 1. **Coordination.** The commissioner shall supervise the development and coordination of locally available adult mental health services by the county boards in a manner consistent with sections 245.461 to 245.486. The commissioner shall coordinate locally available services with those services available from the regional treatment center serving the area including state-operated services offered at sites outside of the regional treatment centers. The commissioner shall review the adult mental health component of the community social services plan developed by county boards as specified in section 245.463 and provide technical assistance to county boards in developing and maintaining locally available mental health services. The commissioner shall monitor the county board's progress in developing its full system capacity and

quality through ongoing review of the county board's adult mental health component of the community social services plan and other information as required by sections 245.461 to 245.486.

[For text of subd 2, see M.S.1992]

History: *1Sp1993 c 1 art 7 s 4*

245.466 LOCAL SERVICE DELIVERY SYSTEM.

Subdivision 1. **Development of services.** The county board in each county is responsible for using all available resources to develop and coordinate a system of locally available and affordable adult mental health services. The county board may provide some or all of the mental health services and activities specified in subdivision 2 directly through a county agency or under contracts with other individuals or agencies. A county or counties may enter into an agreement with a regional treatment center under section 246.57 or with any state facility or program as defined in section 246.50, subdivision 3, to enable the county or counties to provide the treatment services in subdivision 2. Services provided through an agreement between a county and a regional treatment center must meet the same requirements as services from other service providers. County boards shall demonstrate their continuous progress toward full implementation of sections 245.461 to 245.486 during the period July 1, 1987, to January 1, 1990. County boards must develop fully each of the treatment services and management activities prescribed by sections 245.461 to 245.486 by January 1, 1990, according to the priorities established in section 245.464 and the adult mental health component of the community social services plan approved by the commissioner under section 245.478.

[For text of subds 2 to 6, see M.S.1992]

History: *1Sp1993 c 1 art 7 s 5*

245.470 OUTPATIENT SERVICES.

Subdivision 1. **Availability of outpatient services.** (a) County boards must provide or contract for enough outpatient services within the county to meet the needs of adults with mental illness residing in the county. Services may be provided directly by the county through county-operated mental health centers or mental health clinics approved by the commissioner under section 245.69, subdivision 2; by contract with privately operated mental health centers or mental health clinics approved by the commissioner under section 245.69, subdivision 2; by contract with hospital mental health outpatient programs certified by the Joint Commission on Accreditation of Hospital Organizations; or by contract with a licensed mental health professional as defined in section 245.462, subdivision 18, clauses (1) to (4). Clients may be required to pay a fee according to section 245.481. Outpatient services include:

(1) conducting diagnostic assessments;

(2) conducting psychological testing;

(3) developing or modifying individual treatment plans;

(4) making referrals and recommending placements as appropriate;

(5) treating an adult's mental health needs through therapy;

(6) prescribing and managing medication and evaluating the effectiveness of prescribed medication; and

(7) preventing placement in settings that are more intensive, costly, or restrictive than necessary and appropriate to meet client needs.

(b) County boards may request a waiver allowing outpatient services to be provided in a nearby trade area if it is determined that the client can best be served outside the county.

[For text of subd 2, see M.S.1992]

History: *1993 c 339 s 2*

245.474 REGIONAL TREATMENT CENTER INPATIENT SERVICES.

Subdivision 1. **Availability of regional treatment center inpatient services.** By July 1, 1987, the commissioner shall make sufficient regional treatment center inpatient services available to adults with mental illness throughout the state who need this level of care. Inpatient services may be provided either on the regional treatment center campus or at any state facility or program as defined in section 246.50, subdivision 3. Services must be as close to the patient's county of residence as possible. Regional treatment centers are responsible to:

(1) provide acute care inpatient hospitalization;

(2) stabilize the medical and mental health condition of the adult requiring the admission;

(3) improve functioning to the point where discharge to community-based mental health services is possible;

(4) strengthen family and community support; and

(5) facilitate appropriate discharge and referrals for follow-up mental health care in the community.

Subd. 2. **Quality of service.** The commissioner shall biennially determine the needs of all adults with mental illness who are served by regional treatment centers or at any state facility or program as defined in section 246.50, subdivision 3, by administering a client-based evaluation system. The client-based evaluation system must include at least the following independent measurements: behavioral development assessment; habilitation program assessment; medical needs assessment; maladaptive behavioral assessment; and vocational behavior assessment. The commissioner shall propose staff ratios to the legislature for the mental health and support units in regional treatment centers as indicated by the results of the client-based evaluation system and the types of state-operated services needed. The proposed staffing ratios shall include professional, nursing, direct care, medical, clerical, and support staff based on the client-based evaluation system. The commissioner shall recompute staffing ratios and recommendations on a biennial basis.

Subd. 3. **Transition to community.** Regional treatment centers must plan for and assist clients in making a transition from regional treatment centers and other inpatient facilities or programs, as defined in section 246.50, subdivision 3, to other community-based services. In coordination with the client's case manager, if any, regional treatment centers must also arrange for appropriate follow-up care in the community during the transition period. Before a client is discharged, the regional treatment center must notify the client's case manager, so that the case manager can monitor and coordinate the transition and arrangements for the client's appropriate follow-up care in the community.

History: *1Sp1993 c 1 art 7 s 6*

245.476 SCREENING FOR INPATIENT AND RESIDENTIAL TREATMENT.

Subd. 4. [Repealed, 1993 c 337 s 20]

[For text of subd 5, see M.S.1992]

245.484 RULES.

The commissioner shall adopt emergency rules to govern implementation of case management services for eligible children in section 245.4881 and professional home-based family treatment services for medical assistance eligible children, in section 245.4884, subdivision 3, by January 1, 1992, and must adopt permanent rules by January 1, 1993.

The commissioner shall adopt permanent rules as necessary to carry out sections 245.461 to 245.486 and 245.487 to 245.4888. The commissioner shall reassign agency staff as necessary to meet this deadline.

By January 1, 1994, the commissioner shall adopt permanent rules specifying program requirements for family community support services.

History: *1Sp1993 c 1 art 7 s 7*

245.4871 DEFINITIONS.

[For text of subds 1 to 3, see M.S.1992]

Subd. 4. **Case manager.** (a) "Case manager" means an individual employed by the county or other entity authorized by the county board to provide case management services specified in subdivision 3 for the child with severe emotional disturbance and the child's family. A case manager must have experience and training in working with children.

(b) A case manager must:

(1) have at least a bachelor's degree in one of the behavioral sciences or a related field from an accredited college or university;

(2) have at least 2,000 hours of supervised experience in the delivery of mental health services to children;

(3) have experience and training in identifying and assessing a wide range of children's needs; and

(4) be knowledgeable about local community resources and how to use those resources for the benefit of children and their families.

(c) The case manager may be a member of any professional discipline that is part of the local system of care for children established by the county board.

(d) The case manager must meet in person with a mental health professional at least once each month to obtain clinical supervision.

(e) Case managers with a bachelor's degree but without 2,000 hours of supervised experience in the delivery of mental health services to children with emotional disturbance must:

(1) begin 40 hours of training approved by the commissioner of human services in case management skills and in the characteristics and needs of children with severe emotional disturbance before beginning to provide case management services; and

(2) receive clinical supervision regarding individual service delivery from a mental health professional at least once each week until the requirement of 2,000 hours of experience is met.

(f) Clinical supervision must be documented in the child's record. When the case manager is not a mental health professional, the county board must provide or contract for needed clinical supervision.

(g) The county board must ensure that the case manager has the freedom to access and coordinate the services within the local system of care that are needed by the child.

(h) Until June 30, 1996, a refugee who does not have the qualifications specified in this subdivision may provide case management services to child refugees with severe emotional disturbance of the same ethnic group as the refugee if the person:

(1) is actively pursuing credits toward the completion of a bachelor's degree in one of the behavioral sciences or related fields at an accredited college or university;

(2) completes 40 hours of training as specified in this subdivision; and

(3) receives clinical supervision at least once a week until the requirements of obtaining a bachelor's degree and 2,000 hours of supervised experience are met.

[For text of subds 5 to 9, see M.S.1992]

Subd. 9a. **Crisis assistance.** "Crisis assistance" means assistance to the child, the child's family, and all providers of services to the child to: recognize factors precipitating a mental health crisis, identify behaviors related to the crisis, and be informed of available resources to resolve the crisis. Crisis assistance requires the development of a plan which addresses prevention and intervention strategies to be used in a potential crisis. Other interventions include: (1) arranging for admission to acute care hospital inpatient treatment; (2) crisis placement; (3) community resources for follow-up; and (4) emotional support to the family during crisis. Crisis assistance does not include ser-

vices designed to secure the safety of a child who is at risk of abuse or neglect or necessary emergency services.

[For text of subds 10 to 34, see M.S.1992]

History: *1993 c 339 s 3; 1Sp1993 c 1 art 7 s 8*

245.4873 COORDINATION OF CHILDREN'S MENTAL HEALTH SYSTEM.

[For text of subd 1, see M.S.1992]

Subd. 2. **State level; coordination.** The state coordinating council consists of the commissioners or designees of commissioners of the departments of human services, health, education, and corrections, and a representative of the Minnesota district judges association juvenile committee, in conjunction with the commissioner of commerce or a designee of the commissioner, and the director or designee of the director of the office of strategic and long-range planning. The members of the council shall annually alternate chairing the council beginning with the commissioner of human services and proceeding in the order as listed in this subdivision. The council shall meet at least quarterly to:

(1) educate each agency about the policies, procedures, funding, and services for children with emotional disturbances of all agencies represented;

(2) develop mechanisms for interagency coordination on behalf of children with emotional disturbances;

(3) identify barriers including policies and procedures within all agencies represented that interfere with delivery of mental health services for children;

(4) recommend policy and procedural changes needed to improve development and delivery of mental health services for children in the agency or agencies they represent;

(5) identify mechanisms for better use of federal and state funding in the delivery of mental health services for children; and

(6) perform the duties required under sections 245.494 to 245.496.

[For text of subds 3 to 6, see M.S.1992]

History: *1Sp1993 c 1 art 7 s 9*

245.488 OUTPATIENT SERVICES.

Subdivision 1. **Availability of outpatient services.** (a) County boards must provide or contract for enough outpatient services within the county to meet the needs of each child with emotional disturbance residing in the county and the child's family. Services may be provided directly by the county through county-operated mental health centers or mental health clinics approved by the commissioner under section 245.69, subdivision 2; by contract with privately operated mental health centers or mental health clinics approved by the commissioner under section 245.69, subdivision 2; by contract with hospital mental health outpatient programs certified by the Joint Commission on Accreditation of Hospital Organizations; or by contract with a licensed mental health professional as defined in section 245.4871, subdivision 27, clauses (1) to (4). A child or a child's parent may be required to pay a fee based in accordance with section 245.481. Outpatient services include:

(1) conducting diagnostic assessments;

(2) conducting psychological testing;

(3) developing or modifying individual treatment plans;

(4) making referrals and recommending placements as appropriate;

(5) treating the child's mental health needs through therapy; and

(6) prescribing and managing medication and evaluating the effectiveness of prescribed medication.

(b) County boards may request a waiver allowing outpatient services to be provided in a nearby trade area if it is determined that the child requires necessary and appropriate services that are only available outside the county.

(c) Outpatient services offered by the county board to prevent placement must be at the level of treatment appropriate to the child's diagnostic assessment.

[For text of subd 2, see M.S.1992]

History: *1993 c 339 s 4*

245.4882 RESIDENTIAL TREATMENT SERVICES.

[For text of subds 1 to 4, see M.S.1992]

Subd. 5. **Specialized residential treatment services.** The commissioner of human services shall continue efforts to further interagency collaboration to develop a comprehensive system of services, including family community support and specialized residential treatment services for children. The services shall be designed for children with emotional disturbance who exhibit violent or destructive behavior and for whom local treatment services are not feasible due to the small number of children statewide who need the services and the specialized nature of the services required. The services shall be located in community settings. If no appropriate services are available in Minnesota or within the geographical area in which the residents of the county normally do business, the commissioner is responsible, effective July 1, 1995, for 50 percent of the nonfederal costs of out-of-state treatment of children for whom no appropriate resources are available in Minnesota. Counties are eligible to receive enhanced state funding under this section only if they have established juvenile screening teams under section 260.151, subdivision 3, and if the out-of-state treatment has been approved by the commissioner. By January 1, 1995, the commissioners of human services and corrections shall jointly develop a plan, including a financing strategy, for increasing the in-state availability of treatment within a secure setting. By July 1, 1994, the commissioner of human services shall also:

(1) conduct a study and develop a plan to meet the needs of children with both a developmental disability and severe emotional disturbance; and

(2) study the feasibility of expanding medical assistance coverage to include specialized residential treatment for the children described in this subdivision.

History: *1Sp1993 c 1 art 7 s 10*

245.4885 SCREENING FOR INPATIENT AND RESIDENTIAL TREATMENT.

[For text of subds 1 to 3, see M.S.1992]

Subd. 4. [Repealed, 1993 c 337 s 20]

[For text of subd 5, see M.S.1992]

CHILDREN'S MENTAL HEALTH INTEGRATED FUND

245.491 CITATION; DECLARATION OF PURPOSE.

Subdivision 1. **Citation.** Sections 245.491 to 245.496 may be cited as "the children's mental health integrated fund."

Subd. 2. **Purpose.** The legislature finds that children with emotional or behavioral disturbances or who are at risk of suffering such disturbances often require services from multiple service systems including mental health, social services, education, corrections, juvenile court, health, and jobs and training. In order to better meet the needs of these children, it is the intent of the legislature to establish an integrated children's mental health service system that:

(1) allows local service decision makers to draw funding from a single local source

so that funds follow clients and eliminates the need to match clients, funds, services, and provider eligibilities;

(2) creates a local pool of state, local, and private funds to procure a greater medical assistance federal financial participation;

(3) improves the efficiency of use of existing resources;

(4) minimizes or eliminates the incentives for cost and risk shifting; and

(5) increases the incentives for earlier identification and intervention.

The children's mental health integrated fund established under sections 245.491 to 245.496 must be used to develop and support this integrated mental health service system. In developing this integrated service system, it is not the intent of the legislature to limit any rights available to children and their families through existing federal and state laws.

History: *1Sp1993 c 1 art 7 s 11*

245.492 DEFINITIONS.

Subdivision 1. **Definitions.** The definitions in this section apply to sections 245.491 to 245.496.

Subd. 2. **Base level funding.** "Base level funding" means funding received from state, federal, or local sources and expended across the local system of care in fiscal year 1993 for children's mental health services or for special education services for children with emotional or behavioral disturbances.

In subsequent years, base level funding may be adjusted to reflect decreases in the numbers of children in the target population.

Subd. 3. **Children with emotional or behavioral disturbances.** "Children with emotional or behavioral disturbances" includes children with emotional disturbances as defined in section 245.4871, subdivision 15, and children with emotional or behavioral disorders as defined in Minnesota Rules, part 3525.1329, subpart 1.

Subd. 4. **Family.** "Family" has the definition provided in section 245.4871, subdivision 16.

Subd. 5. **Family community support services.** "Family community support services" has the definition provided in section 245.4871, subdivision 17.

Subd. 6. **Initial target population.** "Initial target population" means a population of children that the local children's mental health collaborative agrees to serve in the start-up phase and who meet the criteria for the target population. The initial target population may be less than the target population.

Subd. 7. **Integrated fund.** "Integrated fund" is a pool of both public and private local, state, and federal resources, consolidated at the local level, to accomplish locally agreed upon service goals for the target population. The fund is used to help the local children's mental health collaborative to serve the mental health needs of children in the target population by allowing the local children's mental health collaboratives to develop and implement an integrated service system.

Subd. 8. **Integrated fund task force.** "The integrated fund task force" means the statewide task force established in Laws 1991, chapter 292, article 6, section 57.

Subd. 9. **Integrated service system.** "Integrated service system" means a coordinated set of procedures established by the local children's mental health collaborative for coordinating services and actions across categorical systems and agencies that results in:

(1) integrated funding;

(2) improved outreach, early identification, and intervention across systems;

(3) strong collaboration between parents and professionals in identifying children in the target population facilitating access to the integrated system, and coordinating care and services for these children;

(4) a coordinated assessment process across systems that determines which children need multiagency care coordination and wraparound services;

(5) multiagency plan of care; and

(6) wraparound services.

Services provided by the integrated service system must meet the requirements set out in sections 245.487 to 245.4887. Children served by the integrated service system must be economically and culturally representative of children in the service delivery area.

Subd. 10. **Interagency early intervention committee.** "Interagency early intervention committee" refers to the committee established under section 120.17, subdivision 12.

Subd. 11. **Local children's advisory council.** "Local children's advisory council" refers to the council established under section 245.4875, subdivision 5.

Subd. 12. **Local children's mental health collaborative.** "Local children's mental health collaborative" or "collaborative" means an entity formed by the agreement of representatives of the local system of care including mental health services, social services, correctional services, education services, health services, and vocational services for the purpose of developing and governing an integrated service system. A local coordinating council, a community transition interagency committee as defined in section 120.17, subdivision 16, or an interagency early intervention committee may serve as a local children's mental health collaborative if its representatives are capable of carrying out the duties of the local children's mental health collaborative set out in sections 245.491 to 245.496. Where a local coordinating council is not the local children's mental health collaborative, the local children's mental health collaborative must work closely with the local coordinating council in designing the integrated service system.

Subd. 13. **Local coordinating council.** "Local coordinating council" refers to the council established under section 245.4875, subdivision 6.

Subd. 14. **Local system of care.** "Local system of care" has the definition provided in section 245.4871, subdivision 24.

Subd. 15. **Mental health services.** "Mental health services" has the definition provided in section 245.4871, subdivision 28.

Subd. 16. **Multiagency plan of care.** "Multiagency plan of care" means a written plan of intervention and integrated services developed by a multiagency team in conjunction with the child and family based on their unique strengths and needs as determined by a multiagency assessment. The plan must outline measurable client outcomes and specific services needed to attain these outcomes, the agencies responsible for providing the specified services, funding responsibilities, timelines, the judicial or administrative procedures needed to implement the plan of care, the agencies responsible for initiating these procedures and designate one person with lead responsibility for overseeing implementation of the plan.

Subd. 17. **Respite care.** "Respite care" is planned routine care to support the continued residence of a child with emotional or behavioral disturbance with the child's family or long-term primary caretaker.

Subd. 18. **Service delivery area.** "Service delivery area" means the geographic area to be served by the local children's mental health collaborative and must include at a minimum a part of a county and school district or a special education cooperative.

Subd. 19. **Start-up funds.** "Start-up funds" means the funds available to assist a local children's mental health collaborative in planning and implementing the integrated service system for children in the target population, in setting up a local integrated fund, and in developing procedures for enhancing federal financial participation.

Subd. 20. **State coordinating council.** "State coordinating council" means the council established under section 245.4873, subdivision 2.

Subd. 21. **Target population.** "Target population" means children up to age 18 with an emotional or behavioral disturbance or who are at risk of suffering an emotional or behavioral disturbance as evidenced by a behavior or condition that affects the child's ability to function in a primary aspect of daily living including personal relations, living arrangements, work, school, and recreation, and a child who can benefit from:

(1) multiagency service coordination and wraparound services; or

(2) informal coordination of traditional mental health services provided on a temporary basis.

Children between the ages of 18 and 21 who meet these criteria may be included in the target population at the option of the local children's mental health collaborative.

Subd. 22. **Therapeutic support of foster care.** "Therapeutic support of foster care" has the definition provided in section 245.4871, subdivision 34.

Subd. 23. **Wraparound services.** "Wraparound services" are alternative, flexible, coordinated, and highly individualized services that are based on a multiagency plan of care. These services are designed to build on the strengths and respond to the needs identified in the child's multiagency assessment and to improve the child's ability to function in the home, school, and community. Wraparound services may include, but are not limited to, residential services, respite services, services that assist the child or family in enrolling in or participating in recreational activities, assistance in purchasing otherwise unavailable items or services important to maintain a specific child in the family, and services that assist the child to participate in more traditional services and programs.

History: *1Sp1993 c 1 art 7 s 12*

245.493 LOCAL LEVEL COORDINATION.

Subdivision 1. **Requirements to qualify as a local children's mental health collaborative.** In order to qualify as a local children's mental health collaborative and be eligible to receive start-up funds, the representatives of the local system of care, or at a minimum one county, one school district or special education cooperative, and one mental health entity must agree to the following:

(1) to establish a local children's mental health collaborative and develop an integrated service system; and

(2) to commit resources to providing services through the local children's mental health collaborative.

Subd. 2. **General duties of the local children's mental health collaboratives.** Each local children's mental health collaborative must:

(1) identify a service delivery area and an initial target population within that service delivery area. The initial target population must be economically and culturally representative of children in the service delivery area to be served by the local children's mental health collaborative. The size of the initial target population must also be economically viable for the service delivery area;

(2) seek to maximize federal revenues available to serve children in the target population by designating local expenditures for mental health services that can be matched with federal dollars;

(3) in consultation with the local children's advisory council and the local coordinating council, if it is not the local children's mental health collaborative, design, develop, and ensure implementation of an integrated service system and develop interagency agreements necessary to implement the system;

(4) expand membership to include representatives of other services in the local system of care including prepaid health plans under contract with the commissioner of human services to serve the mental health needs of children and families;

(5) create or designate a management structure for fiscal and clinical responsibility and outcome evaluation;

(6) spend funds generated by the local children's mental health collaborative as required in sections 245.491 to 245.496; and

(7) explore methods and recommend changes needed at the state level to reduce duplication and promote coordination of services including the use of uniform forms for reporting, billing, and planning of services.

History: *1Sp1993 c 1 art 7 s 13*

245.4931 INTEGRATED LOCAL SERVICE SYSTEM.

The integrated service system established by the local children's mental health collaborative must:

(1) include a process for communicating to agencies in the local system of care eligibility criteria for services received through the local children's mental health collaborative and a process for determining eligibility. The process shall place strong emphasis on outreach to families, respecting the family role in identifying children in need, and valuing families as partners;

(2) include measurable outcomes, timelines for evaluating progress, and mechanisms for quality assurance and appeals;

(3) involve the family, and where appropriate the individual child, in developing multiagency service plans to the extent required in sections 120.17, subdivision 3a; 245.4871, subdivision 21; 245.4881, subdivision 4; 253B.03, subdivision 7; 257.071, subdivision 1; and 260.191, subdivision 1e;

(4) meet all standards and provide all mental health services as required in sections 245.487 to 245.4888, and ensure that the services provided are culturally appropriate;

(5) spend funds generated by the local children's mental health collaborative as required in sections 245.491 to 245.496;

(6) encourage public-private partnerships to increase efficiency, reduce redundancy, and promote quality of care; and

(7) ensure that, if the county participant of the local children's mental health collaborative is also a provider of child welfare targeted case management as authorized by the 1993 legislature, then federal reimbursement received by the county for child welfare targeted case management provided to children served by the local children's mental health collaborative must be directed to the integrated fund.

History: *1Sp1993 c 1 art 7 s 14*

245.4932 REVENUE ENHANCEMENT; AUTHORITY AND RESPONSIBILITIES.

Subdivision 1. **Provider responsibilities.** The children's mental health collaborative shall have the following authority and responsibilities regarding federal revenue enhancement:

(1) the collaborative shall designate a lead county or other qualified entity as the fiscal agency for reporting, claiming, and receiving payments;

(2) the collaborative or lead county may enter into subcontracts with other counties, school districts, special education cooperatives, municipalities, and other public and nonprofit entities for purposes of identifying and claiming eligible expenditures to enhance federal reimbursement;

(3) the collaborative must continue the base level of expenditures for services for children with emotional or behavioral disturbances and their families from any state, county, federal, or other public or private funding source which, in the absence of the new federal reimbursement earned under sections 245.491 to 245.496, would have been available for those services. The base year for purposes of this subdivision shall be the accounting period closest to state fiscal year 1993;

(4) the collaborative or lead county must develop and maintain an accounting and financial management system adequate to support all claims for federal reimbursement, including a clear audit trail and any provisions specified in the contract;

(5) the collaborative shall pay the nonfederal share of the medical assistance costs for services designated by the collaborative;

(6) the lead county or other qualified entity may not use federal funds or local funds designated as matching for other federal funds to provide the nonfederal share of medical assistance.

Subd. 2. **Commissioner's responsibilities.** (1) Notwithstanding sections 256B.19,

subdivision 1, and 256B.0625, the commissioner shall be required to amend the state medical assistance plan to include as covered services eligible for medical assistance reimbursement, those services eligible for reimbursement under federal law or waiver, which a collaborative elects to provide and for which the collaborative elects to pay the nonfederal share of the medical assistance costs.

(2) The commissioner may suspend, reduce, or terminate the federal reimbursement to a provider that does not meet the requirements of sections 245.493 to 245.496.

(3) The commissioner shall recover from the collaborative any federal fiscal disallowances or sanctions for audit exceptions directly attributable to the collaborative's actions or the proportional share if federal fiscal disallowances or sanctions are based on a statewide random sample.

Subd. 3. **Payments.** Notwithstanding section 256.025, subdivision 2, payments under sections 245.493 to 245.496 to providers for wraparound service expenditures and expenditures for other services for which the collaborative elects to pay the nonfederal share of medical assistance shall only be made of federal earnings from services provided under sections 245.493 to 245.496.

Subd. 4. **Centralized disbursement of medical assistance payments.** Notwithstanding section 256B.041, and except for family community support services and therapeutic support of foster care, county payments for the cost of wraparound services and other services for which the collaborative elects to pay the nonfederal share, for reimbursement under medical assistance, shall not be made to the state treasurer. For purposes of wraparound services under sections 245.493 to 245.496, the centralized disbursement of payments to providers under section 256B.041 consists only of federal earnings from services provided under sections 245.493 to 245.496.

History: *1Sp1993 c 1 art 7 s 15*

245.494 STATE LEVEL COORDINATION.

Subdivision 1. **State coordinating council.** The state coordinating council, in consultation with the integrated fund task force, shall:

(1) assist local children's mental health collaboratives in meeting the requirements of sections 245.491 to 245.496, by seeking consultation and technical assistance from national experts and coordinating presentations and assistance from these experts to local children's mental health collaboratives;

(2) assist local children's mental health collaboratives in identifying an economically viable initial target population;

(3) develop methods to reduce duplication and promote coordinated services including uniform forms for reporting, billing, and planning of services;

(4) by September 1, 1994, develop a model multiagency plan of care that can be used by local children's mental health collaboratives in place of an individual education plan, individual family community support plan, individual family support plan, and an individual treatment plan;

(5) assist in the implementation and operation of local children's mental health collaboratives by facilitating the integration of funds, coordination of services, and measurement of results, and by providing other assistance as needed;

(6) by July 1, 1993, develop a procedure for awarding start-up funds. Development of this procedure shall be exempt from chapter 14;

(7) develop procedures and provide technical assistance to allow local children's mental health collaboratives to integrate resources for children's mental health services with other resources available to serve children in the target population in order to maximize federal participation and improve efficiency of funding;

(8) ensure that local children's mental health collaboratives and the services received through these collaboratives meet the requirements set out in sections 245.491 to 245.496;

(9) identify base level funding from state and federal sources across systems;

(10) explore ways to access additional federal funds and enhance revenues available to address the needs of the target population;

(11) develop a mechanism for identifying the state share of funding for services to children in the target population and for making these funds available on a per capita basis for services provided through the local children's mental health collaborative to children in the target population. Each year beginning January 1, 1994, forecast the growth in the state share and increase funding for local children's mental health collaboratives accordingly;

(12) identify barriers to integrated service systems that arise from data practices and make recommendations including legislative changes needed in the data practices act to address these barriers; and

(13) annually review the expenditures of local children's mental health collaboratives to ensure that funding for services provided to the target population continues from sources other than the federal funds earned under sections 245.491 to 245.496 and that federal funds earned are spent consistent with sections 245.491 to 245.496.

Subd. 2. **State coordinating council report.** Each year, beginning February 1, 1995, the state coordinating council must submit a report to the legislature on the status of the local children's mental health collaboratives. The report must include the number of local children's mental health collaboratives, the amount and type of resources committed to local children's mental health collaboratives, the additional federal revenue received as a result of local children's mental health collaboratives, the services provided, the number of children served, outcome indicators, the identification of barriers to additional collaboratives and funding integration, and recommendations for further improving service coordination and funding integration.

Subd. 3. **Duties of the commissioner of human services.** The commissioner of human services, in consultation with the integrated fund task force, shall:

(1) beginning January 1, 1994, in areas where a local children's mental health collaborative has been established, based on an independent actuarial analysis, separate all medical assistance, general assistance medical care, and MinnesotaCare resources devoted to mental health services for children and their families including inpatient, outpatient, medication management, services under the rehabilitation option, and related physician services from the total health capitation from prepaid plans, including plans established under section 256B.69, for the target population as identified in section 245.492, subdivision 21, and develop guidelines for managing these mental health benefits that will require all contractors to:

(i) provide mental health services eligible for medical assistance reimbursement;

(ii) meet performance standards established by the commissioner of human services including providing services consistent with the requirements and standards set out in sections 245.487 to 245.4888 and 245.491 to 245.496;

(iii) provide the commissioner of human services with data consistent with that collected under sections 245.487 to 245.4888; and

(iv) in service delivery areas where there is a local children's mental health collaborative for the target population defined by local children's mental health collaborative:

(A) participate in the local children's mental health collaborative;

(B) commit resources to the integrated fund that are actuarially equivalent to resources received for the target population being served by local children's mental health collaboratives; and

(C) meet the requirements and the performance standards developed for local children's mental health collaboratives;

(2) ensure that any prepaid health plan that is operating within the jurisdiction of a local children's mental health collaborative and that is able to meet all the requirements under section 245.494, subdivision 3, paragraph (1), items (i) to (iv), shall have 60 days from the date of receipt of written notice of the establishment of the collabora-

tive to decide whether it will participate in the local children's mental health collaborative; the prepaid health plan shall notify the collaborative and the commissioner of its decision to participate;

(3) develop a mechanism for integrating medical assistance resources for mental health service with resources for general assistance medical care, MinnesotaCare, and any other state and local resources available for services for children and develop a procedure for making these resources available for use by a local children's mental health collaborative;

(4) gather data needed to manage mental health care including evaluation data and data necessary to establish a separate capitation rate for children's mental health services if that option is selected;

(5) by January 1, 1994, develop a model contract for providers of mental health managed care that meets the requirements set out in sections 245.491 to 245.496 and 256B.69, and utilize this contract for all subsequent awards, and before January 1, 1995, the commissioner of human services shall not enter into or extend any contract for any prepaid plan that would impede the implementation of sections 245.491 to 245.496;

(6) develop revenue enhancement or rebate mechanisms and procedures to certify expenditures made through local children's mental health collaboratives for services including administration and outreach that may be eligible for federal financial participation under medical assistance, including expenses for administration, and other federal programs;

(7) ensure that new contracts and extensions or modifications to existing contracts under section 256B.69 do not impede implementation of sections 245.491 to 245.496;

(8) provide technical assistance to help local children's mental health collaboratives certify local expenditures for federal financial participation, using due diligence in order to meet implementation timelines for sections 245.491 to 245.496 and recommend necessary legislation to enhance federal revenue, provide clinical and management flexibility, and otherwise meet the goals of local children's mental health collaboratives and request necessary state plan amendments to maximize the availability of medical assistance for activities undertaken by the local children's mental health collaborative;

(9) take all steps necessary to secure medical assistance reimbursement under the rehabilitation option for family community support services and therapeutic support of foster care, and for residential treatment and wraparound services when these services are provided through a local children's mental health collaborative;

(10) provide a mechanism to identify separately the reimbursement to a county for child welfare targeted case management provided to children served by the local collaborative for purposes of subsequent transfer by the county to the integrated fund; and

(11) where interested and qualified contractors are available, finalize contracts within 180 days of receipt of written notification of the establishment of a local children's mental health collaborative.

Subd. 4. **Rulemaking.** The commissioners of human services, health, and corrections, and the state board of education shall adopt or amend rules as necessary to implement sections 245.491 to 245.496.

Subd. 5. **Rule modification.** By January 15, 1994, the commissioner shall report to the legislature the extent to which claims for federal reimbursement for case management as set out in Minnesota Rules, parts 9520.0900 to 9520.0926 and 9505.0322, as they pertain to mental health case management are consistent with the number of children eligible to receive this service. The report shall also identify how the commissioner intends to increase the numbers of eligible children receiving this service, including recommendations for modifying rules or statutes to improve access to this service and to reduce barriers to its provision.

In developing these recommendations, the commissioner shall:

(1) review experience and consider alternatives to the reporting and claiming

requirements, such as the rate of reimbursement, the claiming unit of time, and documenting and reporting procedures set out in Minnesota Rules, parts 9520.0900 to 9520.0926 and 9505.0322, as they pertain to mental health case management;

(2) consider experience gained from implementation of child welfare targeted case management;

(3) determine how to adjust the reimbursement rate to reflect reductions in caseload size;

(4) determine how to ensure that provision of targeted child welfare case management does not preclude an eligible child's right, or limit access, to case management services for children with severe emotional disturbance as set out in Minnesota Rules, parts 9520.0900 to 9520.0926 and 9505.0322, as they pertain to mental health case management;

(5) determine how to include cost and time data collection for contracted providers for rate setting, claims, and reimbursement purposes;

(6) evaluate the need for cost control measures where there is no county share; and

(7) determine how multiagency teams may share the reimbursement.

The commissioner shall conduct a study of the cost of county staff providing case management services under Minnesota Rules, parts 9520.0900 to 9520.0926 and 9505.0322, as they pertain to mental health case management. If the average cost of providing case management services to children with severe emotional disturbance is determined by the commissioner to be greater than the average cost of providing child welfare targeted case management, the commissioner shall ensure that a higher reimbursement rate is provided for case management services under Minnesota Rules, parts 9520.0900 to 9520.0926 and 9505.0322, to children with severe emotional disturbance. The total medical assistance funds expended for this service in the biennium ending in state fiscal year 1995 shall not exceed the amount projected in the state Medicaid forecast for case management for children with serious emotional disturbances.

History: *1Sp1993 c 1 art 7 s 16*

245.495 ADDITIONAL FEDERAL REVENUES.

(a) Each local children's mental health collaborative shall report expenditures eligible for federal reimbursement in a manner prescribed by the commissioner of human services under section 256.01, subdivision 2, clause (17). The commissioner of human services shall pay all funds earned by each local children's mental health collaborative to the collaborative. Each local children's mental health collaborative must use these funds to expand the initial target population or to develop or provide mental health services through the local integrated service system to children in the target population. Funds may not be used to supplant funding for services to children in the target population.

For purposes of this section, "mental health services" are community-based, nonresidential services, which may include respite care, that are identified in the child's multiagency plan of care.

(b) The commissioner may set aside a portion of the federal funds earned under this section to repay the special revenue maximization account under section 256.01, subdivision 2, clause (15). The set-aside must not exceed five percent of the federal reimbursement earned by collaboratives and repayment is limited to:

(1) the costs of developing and implementing sections 245.491 to 245.496, including the costs of technical assistance from the departments of human services, education, health, and corrections to implement the children's mental health integrated fund;

(2) programming the information systems; and

(3) any lost federal revenue for the central office claim directly caused by the implementation of these sections.

(c) Any unexpended funds from the set-aside described in paragraph (b) shall be distributed to counties according to section 245.496, subdivision 2.

History: *1Sp1993 c 1 art 7 s 17*

245.496 IMPLEMENTATION.

Subdivision 1. **Applications for start-up funds for local children's mental health collaboratives.** By July 1, 1993, the commissioner of human services shall publish the procedures for awarding start-up funds. Applications for local children's mental health collaboratives shall be obtained through the commissioner of human services and submitted to the state coordinating council. The application must state the amount of start-up funds requested by the local children's mental health collaborative and how the local children's mental health collaborative intends on using these funds.

Subd. 2. **Distribution of start-up funds.** By October 1, 1993, the state coordinating council must ensure distribution of start-up funds to local children's mental health collaboratives that meet the requirements established in section 245.493 and whose applications have been approved by the council. The remaining appropriation for start-up funds shall be distributed by February 1, 1994. If the number of applications received exceed the number of local children's mental health collaboratives that can be funded, the funds must be geographically distributed across the state and balanced between the seven county metro area and the rest of the state. Preference must be given to collaboratives that include the juvenile court and correctional systems, multiple school districts, or other multiple government entities from the local system of care. In rural areas, preference must also be given to local children's mental health collaboratives that include multiple counties.

Subd. 3. **Submission and approval of local collaborative proposals for integrated systems.** By December 31, 1994, a local children's mental health collaborative that received start-up funds must submit to the state coordinating council its proposal for creating and funding an integrated service system for children in the target population. Within 60 days of receiving the local collaborative proposal the state coordinating council must review the proposal and notify the local children's mental health collaborative as to whether or not the proposal has been approved. If the proposal is not approved, the state coordinating council must indicate changes needed to receive approval.

History: *1Sp1993 c 1 art 7 s 18*

245.50 INTERSTATE CONTRACTS FOR MENTAL HEALTH SERVICES.

[For text of subds 1 and 2, see M.S.1992]

Subd. 3. **Exceptions.** A contract may not be entered into under this section for services to persons who:

(1) are serving a sentence after conviction of a criminal offense;

(2) are on probation or parole;

(3) are the subject of a presentence investigation; or

(4) have been committed involuntarily in Minnesota under chapter 253B for treatment of mental illness or chemical dependency, except as provided under subdivision 5.

[For text of subd 4, see M.S.1992]

Subd. 5. **Special contracts; Wisconsin.** The commissioner of the Minnesota department of human services must enter into negotiations with appropriate personnel at the Wisconsin department of health and social services and must develop an agreement that conforms to the requirements of subdivision 4, to enable the placement in Minnesota of patients who are on emergency holds or who have been involuntarily committed as mentally ill or chemically dependent in Wisconsin and to enable the temporary placement in Wisconsin of patients who are on emergency holds in Minnesota under section 253B.05, provided that the Minnesota courts retain jurisdiction over Minnesota patients, and the state of Wisconsin affords to Minnesota patients the rights under Minnesota law. The agreement must specify that responsibility for payment for the cost of care of Wisconsin residents shall remain with the state of Wisconsin and the cost of

care of Minnesota residents shall remain with the state of Minnesota. The commissioner shall be assisted by attorneys from the Minnesota attorney general's office in negotiating and finalizing this agreement. The agreement shall be completed so as to permit placement of Wisconsin residents in Minnesota facilities and Minnesota residents in Wisconsin facilities beginning July 1, 1994.

History: *1993 c 102 s 1,2*

NOTE: The amendment to subdivision 3 by Laws 1993, chapter 102, section 1, is effective July 1, 1994. See Laws 1993, chapter 102, section 3.

245.652 CHEMICAL DEPENDENCY SERVICES FOR REGIONAL TREATMENT CENTERS.

Subdivision 1. **Purpose.** The regional treatment centers shall provide services designed to end a person's reliance on chemical use or a person's chemical abuse and increase effective and chemical-free functioning. Clinically effective programs must be provided in accordance with section 246.64. Services may be offered on the regional center campus or at sites elsewhere in the catchment area served by the regional treatment center.

[For text of subds 2 and 3, see M.S.1992]

Subd. 4. **System locations.** Programs shall be located in Anoka, Brainerd, Fergus Falls, St. Peter, and Willmar and may be offered at other selected sites.

History: *1Sp1993 c 1 art 7 s 19,20*

245.711 [Repealed, 1Sp1993 c 1 art 7 s 50]

245.712 [Repealed, 1Sp1993 c 1 art 7 s 50]

245.73 GRANTS FOR RESIDENTIAL SERVICES FOR ADULTS WITH MENTAL ILLNESS.

[For text of subd 1, see M.S.1992]

Subd. 2. **Application; criteria.** County boards may submit an application and budget for use of the money in the form specified by the commissioner. The commissioner shall make grants only to counties whose applications and budgets are approved by the commissioner for residential programs for adults with mental illness to meet licensing requirements pursuant to sections 245A.01 to 245A.16. These grants shall not be used for room and board costs. For calendar year 1994 and subsequent years, the commissioner shall allocate the money appropriated under this section on a calendar year basis.

[For text of subd 2a, see M.S.1992]

Subd. 3. **Formula.** Grants made pursuant to this section shall finance 75 to 100 percent of the county's costs of expanding or providing services for adult mentally ill persons in residential facilities as provided in subdivision 2.

[For text of subd 4, see M.S.1992]

Subd. 5. **Transfer of funds.** The commissioner may transfer money from adult mental health residential program grants to community support program grants under section 256E.12 if the county requests such a transfer and if the commissioner determines the transfer will help adults with mental illness to remain and function in their own communities. The commissioner shall consider past utilization of the residential program in determining which counties to include in the transferred fund.

History: *1Sp1993 c 1 art 7 s 21-23*

245.97 OMBUDSMAN COMMITTEE.

[For text of subds 1 to 5, see M.S.1992]

Subd. 6. **Terms, compensation, removal and expiration.** The membership terms, compensation, and removal of members of the committee and the filling of membership vacancies are governed by section 15.0575. The ombudsman committee and the medical review subcommittee expire on June 30, 1994.

History: *1993 c 286 s 26*

245.98 COMPULSIVE GAMBLING TREATMENT PROGRAM.

[For text of subds 1 to 3, see M.S.1992]

Subd. 4. **Contribution by tribal gaming.** The commissioner of human services is authorized to enter into an agreement with the governing body of any Indian tribe located within the boundaries of the state of Minnesota that conducts either class II or class III gambling, as defined in section 4 of the Indian Gaming Regulatory Act, Public Law Number 100-497, and future amendments to it, for the purpose of obtaining funding for compulsive gambling programs from the Indian tribe. Prior to entering into any agreement with an Indian tribe under this section, the commissioner shall consult with and obtain the approval of the governor or governor's designated representatives authorized to negotiate a tribal-state compact regulating the conduct of class III gambling on Indian lands of a tribe requesting negotiations. Contributions collected under this subdivision are appropriated to the commissioner of human services for the compulsive gambling treatment program under this section.

History: *1993 c 146 art 3 s 7*