CHAPTER 245

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245.001 MS 2006 [Renumbered 15.001]

245.01 MS 1949 [Repealed, 1953 c 593 s 6]

245.02 MS 1949 [Repealed, 1953 c 593 s 6]

245.021 DEFINITIONS.

(a) For the purposes of this chapter, the definitions in this section have the meanings given them.

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

(c) "Executive board" has the meaning given in section 246C.015.

History: *2024 c 79 art 8 s 1*

245.03 DEPARTMENT OF HUMAN SERVICES ESTABLISHED; COMMISSIONER.

Subdivision 1. **Establishment.** There is created a Department of Human Services. A commissioner of human services shall be appointed by the governor under the provisions of section 15.06. The commissioner shall be selected on the basis of ability and experience in welfare and without regard to political affiliations. The commissioner may appoint up to two deputy commissioners.

Subd. 2. **Mission; efficiency.** It is part of the department's mission that within the department's resources the commissioner shall endeavor to:

(1) prevent the waste or unnecessary spending of public money;

(2) use innovative fiscal and human resource practices to manage the state's resources and operate the department as efficiently as possible, including the authority to consolidate different nonentitlement grant programs, having similar functions or serving similar populations, as may be determined by the commissioner, while protecting the original purposes of the programs. Nonentitlement grant funds consolidated by the commissioner shall be reflected in the department's biennial budget. With approval of the commissioner, vendors who are eligible for funding from any of the commissioner's granting authority under section 256.01, subdivision 2, paragraph (a), clause (6), may submit a single application for a grant agreement including multiple awards;

(3) coordinate the department's activities wherever appropriate with the activities of other governmental agencies;

(4) use technology where appropriate to increase agency productivity, improve customer service, increase public access to information about government, and increase public participation in the business of government;

(5) utilize constructive and cooperative labor-management practices to the extent otherwise required by chapters 43A and 179A;

(6) report to the legislature on the performance of agency operations and the accomplishment of agency goals in the agency's biennial budget according to section 16A.10, subdivision 1; and

(7) recommend to the legislature appropriate changes in law necessary to carry out the mission and improve the performance of the department.

History: *1953 c 593 s 1; 1965 c 45 s 17; 1969 c 1129 art 8 s 6; 1977 c 305 s 30; 1984 c 654 art 5 s 58; 1995 c 248 art 11 s 18; 1997 c 203 art 9 s 2; 1998 c 366 s 64; 2013 c 108 art 6 s 1; 2015 c 78 art 4 s 61*

245.031 [Obsolete]

245.0311 MS 2012 [Repealed, 2014 c 262 art 3 s 18]

245.0312 MS 2012 [Repealed, 2014 c 262 art 3 s 18]

245.0313 AID TO PERSONS WITH DISABILITIES.

Notwithstanding any provision of law to the contrary, the cost of care not met by federal funds for any developmentally disabled patient eligible for the medical assistance program or the Supplemental Security Income for the aged, blind and disabled program in institutions under the control of the commissioner of

human services shall be paid by the state and county in the same proportion as provided in section 256B.19 for division of costs.

History: *1969 c 1136 s 23 subd 2; 1971 c 961 s 20; 1973 c 717 s 10; 1981 c 360 art 2 s 13; 1984 c 654 art 5 s 58; 2005 c 56 s 1*

245.032 [Obsolete]

245.033 MS 1971 [Repealed, 1973 c 717 s 33]

245.035 INTERVIEW EXPENSES.

Job applicants for professional, administrative, or highly technical positions recruited by the commissioner of human services may be reimbursed for necessary travel expenses to and from interviews arranged by the commissioner of human services.

History: *1976 c 163 s 42; 1984 c 654 art 5 s 58*

245.036 [Renumbered 246C.16, subdivision 1]

245.037 [Renumbered 246C.16, subd 2]

245.04 MS 1980 [Repealed, 1981 c 253 s 48]

245.041 [Renumbered 246C.15]

245.05 MS 1980 [Repealed, 1981 c 253 s 48]

245.06 MS 1980 [Repealed, 1981 c 253 s 48]

245.07 MS 1980 [Repealed, 1981 c 253 s 48]

245.071 MS 1967 [Repealed, 1969 c 334 s 2]

245.072 MS 2012 [Repealed, 2014 c 262 art 4 s 9]

245.073 TECHNICAL TRAINING; COMMUNITY-BASED PROGRAMS.

(a) In conjunction with the discharge of persons from regional treatment centers and their admission to state-operated and privately operated community-based programs, the commissioner may provide technical training assistance to the community-based programs. The commissioner may apply for and accept money from any source including reimbursement charges from the community-based programs for reasonable costs of training. Money received must be deposited in the general fund and is appropriated annually to the commissioner of human services for training under this section.

(b) The commissioner must coordinate with the executive board to provide technical training assistance to community-based programs under this section and section 246C.11, subdivision 5.

History: *1989 c 282 art 6 s 2; 2024 c 79 art 10 s 2*

245.08 [Obsolete]

245.09 [Unnecessary]

245.095 LIMITS ON RECEIVING PUBLIC FUNDS.

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

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

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

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

(1) prohibit any associated entities or associated individuals from enrolling, becoming licensed, receiving grant funds, or registering in any other program administered by the commissioner; and

(2) disenroll, revoke or suspend a license of, disqualify, or debar any associated entities or associated individuals in any other program administered by the commissioner.

(c) If a provider, vendor, or individual enrolled, licensed, or otherwise receiving funds under any contract or registered in any program administered by a Minnesota state or federal agency is excluded from that program, the commissioner of human services may:

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

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

(d) The duration of a prohibition, disenrollment, revocation, suspension, disqualification, or debarment under paragraph (a) must last for the longest applicable sanction or disqualifying period in effect for the provider, vendor, or individual permitted by state or federal law. The duration of a prohibition, disenrollment, revocation, suspension, disqualification, or debarment under paragraphs (b) and (c) may last until up to the longest applicable sanction or disqualifying period in effect for the provider, vendor, individual, associated entity, or associated individual as permitted by state or federal law.

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

(b) "Associated entity" means a provider or vendor owned or controlled by an excluded individual.

(c) "Associated individual" means an individual or entity that has a relationship with the business or its owners or controlling individuals, such that the individual or entity would have knowledge of the financial practices of the program in question.

(d) "Convicted" means a judgment of conviction has been entered by a federal, state, or local court, regardless of whether an appeal from the judgment is pending, and includes a stay of adjudication, a court-ordered diversion program, or a plea of guilty or nolo contendere.

(e) "Credible allegation of fraud" means an allegation that has been verified by the commissioner from any source, including but not limited to:

(1) fraud hotline complaints;

(2) claims data mining;

(3) patterns identified through provider audits, civil false claims cases, and law enforcement investigations;

(4) court filings and other legal documents, including but not limited to police reports, complaints, indictments, informations, affidavits, declarations, and search warrants; and

(5) information from the inspector general appointed under chapter 15E, including information listed on the inspector general's exclusion list under section 15E.25, subdivision 1, clause (11).

Allegations are credible when they have an indicium of reliability and the state agency has reviewed all allegations, facts, and evidence carefully and acts judiciously on a case-by-case basis.

(f) "Excluded" means removed under other authorities from a program administered by a Minnesota state or federal agency. Excluded includes but is not limited to:

(1) a final determination to stop payments;

(2) a conclusive background study disqualification, except for a disqualification issued under section 245C.15, subdivision 4c, that has not been set aside or had a variance granted under section 245C.30; and

(3) a final agency decision regarding a denial of a license application.

(g) "Fraud" has the meaning given in section 256B.02, subdivision 20.

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

(i) "Provider" means any entity, individual, owner, controlling individual, license holder, director, or managerial official of an entity receiving payment from a program administered by a Minnesota state or federal agency.

Subd. 3. **Notice.** Within five days of taking an action under subdivision (1), paragraph (a), (b), or (c), against a provider, vendor, individual, associated individual, or associated entity, the commissioner must send notice of the action to the provider, vendor, individual, associated individual, or associated entity. The notice must state:

(1) the basis for the action;

(2) the effective date of the action;

(3) the right to appeal the action; and

(4) the requirements and procedures for reinstatement.

Subd. 4. **Appeal.** Upon receipt of a notice under subdivision 3, a provider, vendor, individual, associated individual, or associated entity may request a contested case hearing, as defined in section 14.02, subdivision 3, by filing with the commissioner a written request of appeal. The scope of any contested case hearing is solely limited to action taken under this section. The commissioner must receive the appeal request no later than 30 days after the date the notice was mailed to the provider, vendor, individual, associated individual, or associated entity. The appeal request must specify:

(1) each disputed item and the reason for the dispute;

(2) the authority in statute or rule upon which the provider, vendor, individual, associated individual, or associated entity relies for each disputed item;

(3) the name and address of the person or entity with whom contacts may be made regarding the appeal; and

(4) any other information required by the commissioner.

Subd. 5. **Withholding of payments.** (a) Except as otherwise provided by state or federal law, the commissioner may withhold payments to a provider, vendor, individual, associated individual, or associated entity in any program administered by the commissioner if the commissioner determines:

(1) there is a credible allegation of fraud for which an investigation is pending for a program administered by a Minnesota state or federal agency;

(2) the individual, the entity, or an associated individual or entity was convicted of a crime, in state or federal court, for an offense that involves fraud or theft against a program administered by the commissioner or another state or federal agency;

(3) the provider is operating after a state or federal agency orders the suspension, revocation, or decertification of the provider's license or certification, or if the provider is subject to a temporary immediate suspension, regardless of whether the action is under appeal; or

(4) the provider, vendor, individual, associated individual, or associated entity, including those receiving funds under any contract or registered program, has a background study disqualification under section 245C.15, subdivisions 1 to 4b, that has not been set aside and for which no variance has been issued.

(b) The commissioner must send notice of the withholding of payments within five days of taking such action. The notice must:

(1) state that payments are being withheld according to this subdivision;

(2) set forth the general allegations related to the withholding action, except the notice need not disclose specific information concerning an ongoing investigation;

(3) state that the withholding is for a temporary period and cite the circumstances under which the withholding will be terminated; and

(4) inform the provider, vendor, individual, associated individual, or associated entity of the right to submit written evidence to contest the withholding action for consideration by the commissioner.

(c) If the commissioner withholds payments under this subdivision, the provider, vendor, individual, associated individual, or associated entity has a right to request administrative reconsideration. A request for administrative reconsideration must be made in writing, state with specificity the reasons the payment withholding decision is in error, and include documents to support the request. Within 60 days from receipt of the request, the commissioner shall judiciously review allegations, facts, evidence available to the commissioner, and information submitted by the provider, vendor, individual, associated individual, or associated entity to determine whether the payment withholding should remain in place.

(d) The commissioner shall stop withholding payments if the commissioner determines there is insufficient evidence of fraud by the provider, vendor, individual, associated individual, or associated entity or when

legal proceedings relating to the alleged fraud are completed, unless the commissioner has sent notice under subdivision 3 to the provider, vendor, individual, associated individual, or associated entity.

(e) The withholding of payments under this section is a temporary action and is not subject to appeal under section 256.045 or chapter 14.

(f) Section 15.013 does not apply to the commissioner taking action under this section.

Subd. 6. **Data practices.** The commissioner may exchange information, including claims data, with state or federal agencies, professional boards, departments, or programs for the purpose of investigating or prosecuting a criminal, civil, or administrative proceeding related to suspected fraud or exclusion from any program administered by a state or federal agency.

Subd. 7. **Exemption.** Nothing in this section modifies, supersedes, limits, or expands the commissioner's authority to impose sanctions under section 256B.064.

History: *2015 c 78 art 4 s 5; 1Sp2019 c 9 art 2 s 13; 2023 c 70 art 8 s 2; 1Sp2025 c 3 art 17 s 3; 2026 c 92 art 2 s 12; 2026 c 121 art 3 s 2; art 4 s 1,2*

245.096 CHANGES TO GRANT PROGRAMS.

Prior to implementing any changes to a grant funding formula disbursed through allocations administered by the commissioner, the commissioner must provide a report on the nature of the changes, the effect the changes will have, whether any funding will change, and other relevant information, to the chairs and ranking minority members of the legislative committees with jurisdiction over human services. The report must be provided prior to the start of a regular session, and the proposed changes cannot be implemented until after the adjournment of that regular session.

History: *2022 c 99 art 1 s 5; 2026 c 121 art 11 s 2*

245.0962 [Renumbered 142A.47]

245.10 [Unnecessary]

245.11 [Unnecessary]

245.12 [Unnecessary]

245.21 [Renumbered 256.451]

245.22 [Renumbered 256.452]

245.23 [Renumbered 256.453]

245.24 [Renumbered 256.454]

245.25 [Renumbered 256.455]

245.26 [Renumbered 256.456]

245.27 [Renumbered 256.457]

245.28 [Renumbered 256.458]

245.29 [Renumbered 256.459]

245.30 [Renumbered 256.461]

245.31 [Renumbered 256.462]

245.32 [Renumbered 256.463]

245.33 [Renumbered 256.464]

245.34 [Renumbered 256.465]

245.35 [Renumbered 256.466]

245.36 [Renumbered 256.467]

245.37 [Renumbered 256.468]

245.38 [Renumbered 256.469]

245.39 [Renumbered 256.471]

245.40 [Renumbered 256.472]

245.41 [Renumbered 256.473]

245.42 [Renumbered 256.474]

245.43 [Renumbered 256.475]

245.46 MS 1971 [Repealed, 1973 c 650 art 21 s 33]

ADULT MENTAL HEALTH ACT

245.461 POLICY AND CITATION.

Subdivision 1. **Citation.** Sections 245.461 to 245.486 may be cited as the "Minnesota Comprehensive Adult Mental Health Act."

Subd. 2. **Mission statement.** The commissioner shall create and ensure a unified, accountable, comprehensive adult mental health service system that:

(1) recognizes the right of adults with mental illness to control their own lives as fully as possible;

(2) promotes the independence and safety of adults with mental illness;

(3) reduces chronicity of mental illness;

(4) eliminates abuse of adults with mental illness;

(5) provides services designed to:

(i) increase the level of functioning of adults with mental illness or restore them to a previously held higher level of functioning;

(ii) stabilize adults with mental illness;

(iii) prevent the development and deepening of mental illness;

(iv) support and assist adults in resolving mental health problems that impede their functioning;

(v) promote higher and more satisfying levels of emotional functioning; and

(vi) promote sound mental health; and

(6) provides a quality of service that is effective, efficient, appropriate, and consistent with contemporary professional standards in the field of mental health.

Subd. 3. MS 2012 [Repealed, 2013 c 107 art 4 s 22]

Subd. 4. **Housing mission statement.** The commissioner shall ensure that the housing services provided as part of a comprehensive mental health service system:

(1) allow all persons with mental illness to live in stable, affordable housing, in settings that maximize community integration and opportunities for acceptance;

(2) allow persons with mental illness to actively participate in the selection of their housing from those living environments available to the general public; and

(3) provide necessary support regardless of where persons with mental illness choose to live.

Subd. 5. **Funding from the federal government and other sources.** The commissioner shall seek and apply for federal and other nonstate, nonlocal government funding for the mental health services specified in sections 245.461 to 245.486, in order to maximize nonstate, nonlocal dollars for these services.

Subd. 6. **Diagnostic codes list.** By July 1, 2013, the commissioner of human services shall develop a list of diagnostic codes to define the range of child and adult mental illnesses for the statewide mental health system. The commissioner may use the International Classification of Diseases (ICD); the American Psychiatric Association's Diagnostic and Statistical Manual (DSM); or a combination of both to develop the list. The commissioner shall establish an advisory committee, comprising mental health professional associations, counties, Tribes, managed care organizations, state agencies, and consumer organizations that shall advise the commissioner regarding development of the diagnostic codes list. The commissioner shall annually notify providers of changes to the list.

History: *1987 c 403 art 2 s 16; 1989 c 282 art 4 s 1; 1991 c 292 art 6 s 1,2; 2012 c 216 art 12 s 1*

245.462 DEFINITIONS.

Subdivision 1. **Definitions.** The definitions in this section apply to sections 245.461 to 245.4863.

Subd. 2. **Acute care hospital inpatient treatment.** "Acute care hospital inpatient treatment" means short-term medical, nursing, and psychosocial services provided in an acute care hospital licensed under chapter 144.

Subd. 2a. **Case management contact.** "Case management contact" means interactive communication conducted in person, by interactive video that meets the requirements of section 256B.0625, subdivision 20b, or by telephone with the client; client's parent; legal guardian, guardian ad litem, or attorney for clients that are children or youth under 19 years of age; or client's attorney for clients that are adults 19 years of age or older.

Subd. 3. **Case management services.** "Case management services" means activities that are coordinated with the community support services program as defined in subdivision 6 and are designed to help adults with serious and persistent mental illness in gaining access to needed medical, social, educational, vocational,

and other necessary services as they relate to the client's mental health needs. Case management services include developing a functional assessment, an individual community support plan, referring and assisting the person to obtain needed mental health and other services, ensuring coordination of services, and monitoring the delivery of services.

Subd. 4. **Case management service provider.** (a) "Case management service provider" means a case manager or case manager associate employed by the county or other entity authorized by the county board to provide case management services specified in section 245.4711.

(b) A case manager must:

(1) be skilled in the process of identifying and assessing a wide range of client needs;

(2) be knowledgeable about local community resources and how to use those resources for the benefit of the client;

(3) be a mental health practitioner as defined in section 245I.04, subdivision 4, or have a bachelor's degree in one of the behavioral sciences or related fields including, but not limited to, social work, psychology, or nursing from an accredited college or university. A case manager who is not a mental health practitioner or who does not have a bachelor's degree in one of the behavioral sciences or related fields must meet the requirements of paragraph (c); and

(4) meet the supervision and continuing education requirements described in paragraphs (d), (e), and (f), as applicable.

(c) Case managers without a bachelor's degree or with a bachelor's degree that is not in one of the behavioral sciences or related fields must meet one of the requirements in clauses (1) to (5):

(1) have four years of experience as a case manager associate as defined in this section;

(2) be a registered nurse without a bachelor's degree and have a combination of specialized training in psychiatry and work experience consisting of community interaction and involvement or community discharge planning in a mental health setting totaling three years;

(3) be a person who qualified as a case manager under the 1998 Department of Human Service waiver provision and meet the continuing education and mentoring requirements in this section;

(4) prior to direct service delivery, complete at least 80 hours of specific training on the characteristics and needs of adults with serious and persistent mental illness that is consistent with national practice standards; or

(5) prior to direct service delivery, demonstrate competency in practice and knowledge of the characteristics and needs of adults with serious and persistent mental illness, consistent with national practice standards.

(d) A case manager with at least 2,000 hours of supervised experience in the delivery of services to adults with mental illness must receive regular ongoing supervision and clinical supervision totaling 38 hours per year of which at least one hour per month must be clinical supervision regarding individual service delivery with a case management supervisor. The remaining 26 hours of supervision may be provided by a case manager with two years of experience. Group supervision may not constitute more than one-half of the required supervision hours. Clinical supervision must be documented in the client record.

(e) A case manager without 2,000 hours of supervised experience in the delivery of services to adults with mental illness must:

(1) receive clinical supervision regarding individual service delivery from a mental health professional at least one hour per week until the requirement of 2,000 hours of experience is met; and

(2) complete 40 hours of training approved by the commissioner in case management skills and the characteristics and needs of adults with serious and persistent mental illness.

(f) A case manager who is not licensed, registered, or certified by a health-related licensing board must receive 30 hours of continuing education and training in mental illness and mental health services every two years.

(g) A case manager associate (CMA) must:

(1) work under the direction of a case manager or case management supervisor;

(2) be at least 21 years of age;

(3) have at least a high school diploma or its equivalent; and

(4) meet one of the following criteria:

(i) have an associate of arts degree in one of the behavioral sciences or human services;

(ii) be a certified peer specialist under section 256B.0615;

(iii) be a registered nurse without a bachelor's degree;

(iv) within the previous ten years, have three years of life experience with serious and persistent mental illness as defined in subdivision 20; as a child had a serious mental illness as defined in section 245.4871, subdivision 6; or have three years life experience as a primary caregiver to an adult with serious and persistent mental illness within the previous ten years;

(v) have 6,000 hours work experience as a nondegreed state hospital technician; or

(vi) have at least 6,000 hours of supervised experience in the delivery of services to persons with mental illness.

Individuals meeting one of the criteria in items (i) to (v) may qualify as a case manager after four years of supervised work experience as a case manager associate. Individuals meeting the criteria in item (vi) may qualify as a case manager after three years of supervised experience as a case manager associate.

(h) A case management associate must meet the following supervision, mentoring, and continuing education requirements:

(1) have 40 hours of preservice training described under paragraph (e), clause (2);

(2) receive annual continuing education in mental illness and mental health services according to the following schedule, based on years of service as a case management associate:

(i) at least 40 hours in the first year;

(ii) at least 30 hours in the second year;

(iii) at least 20 hours in the third year; and

(iv) at least 20 hours in the fourth year; and

(3) receive at least four hours of supervision per month from a case management supervisor.

(i) A case management supervisor must meet the criteria for mental health professionals, as specified in subdivision 18.

(j) An immigrant who does not have the qualifications specified in this subdivision may provide case management services to adult immigrants with serious and persistent mental illness who are members of the same ethnic group as the case manager if the person:

(1) is currently enrolled in and is actively pursuing credits toward the completion of a bachelor's degree in one of the behavioral sciences or a related field including, but not limited to, social work, psychology, or nursing 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 this subdivision are met.

Subd. 4a. MS 2022 [Repealed, 2021 c 30 art 17 s 113]

Subd. 5. **Commissioner.** "Commissioner" means the commissioner of human services.

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 treatment 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,

(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. A program that meets the accreditation standards for Clubhouse International model programs meets the requirements of this subdivision.

Subd. 7. **County board.** "County board" means the county board of commissioners or board established pursuant to the Joint Powers Act, section 471.59, or the Human Services Act, sections 402.01 to 402.10.

Subd. 8. **Day treatment services.** "Day treatment," "day treatment services," or "day treatment program" means the treatment services described by section 256B.0671, subdivision 3.

Subd. 9. **Diagnostic assessment.** "Diagnostic assessment" has the meaning given in section 245I.10, subdivisions 4 to 6.

Subd. 10. **Education and prevention services.** "Education and prevention services" means services designed to educate the general public or special high-risk target populations about mental illness, to increase the understanding and acceptance of problems associated with mental illness, to increase people's awareness of the availability of resources and services, and to improve people's skills in dealing with high-risk situations known to affect people's mental health and functioning. The services include the distribution of information to individuals and agencies identified by the county board and the local mental health advisory council, on predictors and symptoms of mental disorders, where mental health services are available in the county, and how to access the services.

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.

Subd. 11a. **Functional assessment.** "Functional assessment" means an assessment by the case manager of the adult's:

(1) mental health symptoms as presented in the adult's diagnostic assessment;

(2) mental health needs as presented in the adult's diagnostic assessment;

(3) use of drugs and alcohol;

(4) vocational and educational functioning;

(5) social functioning, including the use of leisure time;

(6) interpersonal functioning, including relationships with the adult's family;

(7) self-care and independent living capacity;

(8) medical and dental health;

(9) financial assistance needs;

(10) housing and transportation needs; and

(11) other needs and problems.

Subd. 12. **Individual community support plan.** "Individual community support plan" means a written plan developed by a case manager on the basis of a diagnostic assessment and functional assessment. The plan identifies specific services needed by an adult with serious and persistent mental illness to develop independence or improved functioning in daily living, health and medication management, social functioning, interpersonal relationships, financial management, housing, transportation, and employment.

Subd. 13. **Individual placement agreement.** "Individual placement agreement" means a written agreement or supplement to a service contract entered into between the county board and a service provider on behalf of an individual adult to provide residential treatment services.

Subd. 14. **Individual treatment plan.** "Individual treatment plan" means the formulation of planned services that are responsive to the needs and goals of a client. An individual treatment plan must be completed according to section 245I.10, subdivisions 7 and 8.

Subd. 14c. **Mental health crisis services.** "Mental health crisis services" means crisis assessment, crisis intervention, and crisis stabilization services.

Subd. 15. MS 1990 [Repealed, 1991 c 94 s 25]

Subd. 16. **Mental health funds.** "Mental health funds" are funds expended under sections 245.73 and 256K.10, federal mental health block grant funds, and funds expended under section 256D.06 to facilities licensed under section 245I.23 or Minnesota Rules, parts 9520.0500 to 9520.0670.

Subd. 17. **Mental health practitioner.** "Mental health practitioner" means a staff person who is qualified according to section 245I.04, subdivision 4.

Subd. 18. **Mental health professional.** "Mental health professional" means a staff person who is qualified according to section 245I.04, subdivision 2.

Subd. 19. **Mental health services.** "Mental health services" means at least all of the treatment services and case management activities that are provided to adults with mental illness and are described in sections 245.461 to 245.486.

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 detailed in a diagnostic codes list published by the commissioner, 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 has been treated by a crisis team two or more times within the preceding 24 months;

(4) the adult:

(i) has a diagnosis of schizophrenia, bipolar disorder, major depression, schizoaffective disorder, 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;

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

(6) the adult (i) was eligible under clauses (1) to (5), 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; or

(7) the adult was eligible as a child under section 245.4871, subdivision 6, and is age 21 or younger.

Subd. 21. **Outpatient services.** "Outpatient services" means mental health services, excluding day treatment and community support services programs, provided by or under the treatment supervision of a mental health professional to adults with mental illness who live outside a hospital. Outpatient services include clinical activities such as individual, group, and family therapy; individual treatment planning; diagnostic assessments; medication management; and psychological testing.

Subd. 22. **Regional treatment center inpatient services.** "Regional treatment center inpatient services" means the 24-hour-a-day comprehensive medical, nursing, or psychosocial services required to be provided pursuant to section 246C.12.

Subd. 23. **Residential treatment.** "Residential treatment" means a 24-hour-a-day program under the treatment supervision of a mental health professional, in a community residential setting other than an acute care hospital or regional treatment center inpatient unit, that must be licensed as a residential treatment program for adults with mental illness under chapter 245I, Minnesota Rules, parts 9520.0500 to 9520.0670, or other rules adopted by the commissioner.

Subd. 24. **Service provider.** "Service provider" means either a county board or an entity under contract with the county board that provides adult mental health services funded by sections 245.461 to 245.486. A contracting entity may be an individual, organization, or agency, including a regional treatment center.

Subd. 25. MS 1988 [Repealed, 1989 c 282 art 4 s 64]

Subd. 26. **Significant impairment in functioning.** "Significant impairment in functioning" means a condition, including significant suicidal ideation or thoughts of harming self or others, which harmfully affects, recurrently or consistently, a person's activities of daily living in employment, housing, family and social relationships, or education.

Subd. 27. **Treatment supervision.** "Treatment supervision" means the treatment supervision described by section 245I.06.

History: *1987 c 403 art 2 s 17; 1988 c 689 art 2 s 64-73; 1989 c 282 art 4 s 2; 1990 c 426 art 2 s 6; 1990 c 568 art 5 s 34; 1991 c 292 art 6 s 3,4; 1992 c 526 s 1; 1Sp1993 c 1 art 7 s 2,3; 1996 c 451 art 5 s 4; 1997 c 7 art 1 s 94; 1998 c 407 art 4 s 2,3; 1999 c 86 art 1 s 55; 1999 c 172 s 15; 1999 c 245 art 5 s 2,3; 2000 c 474 s 3; 1Sp2001 c 9 art 9 s 5-8; 2002 c 221 s 15; 2002 c 375 art 2 s 5; 2002 c 379 art 1 s 113; 2004 c 288 art 3 s 7; 2005 c 147 art 1 s 65; 2007 c 147 art 8 s 3; 2009 c 79 art 7 s 1; 2011 c 86 s 1; 2012 c 216 art 12 s 2; 2013 c 108 art 4 s 1; 2015 c 78 art 2 s 2; 2016 c 158 art 1 s 214; 2016 c 163 art 2 s 1; 2017 c 79 s 1; 1Sp2017 c 6 art 8 s 1; 2018 c 128 s 1,2; 2018 c 182 art 1 s 43; 2021 c 30 art 17 s 10-20; 1Sp2021 c 7 art 11 s 1; 2022 c 98 art 4 s 3,26; 2023 c 50 art 1 s 1,2; 2023 c 70 art 9 s 1; 2024 c 79 art 8 s 3,4; art 10 s 2; 2024 c 80 art 8 s 68; 2024 c 127 art 61 s 1; 2025 c 38 art 4 s 6; art 8 s 9; 2026 c 121 art 3 s 3*

245.463 PLANNING FOR A MENTAL HEALTH SYSTEM.

Subdivision 1. MS 2012 [Repealed, 2013 c 107 art 4 s 22]

Subd. 2. **Technical assistance.** The commissioner shall provide ongoing technical assistance to county boards to improve system capacity and quality. The commissioner and county boards shall exchange information as needed about the numbers of adults with mental illness residing in the county and extent of existing treatment components locally available to serve the needs of those persons. County boards shall cooperate with the commissioner in obtaining necessary planning information upon request.

Subd. 3. MS 2012 [Repealed, 2013 c 107 art 4 s 22]

Subd. 4. MS 2012 [Repealed, 2013 c 107 art 4 s 22]

History: *1987 c 403 art 2 s 18; 1989 c 282 art 4 s 3,4; art 6 s 3; 1991 c 94 s 24; 1Sp2003 c 14 art 11 s 11; 2005 c 98 art 3 s 1*

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 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.

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 are developed for adults with mental illness within available resources based on the following ranked priorities:

(1) the provision of locally available emergency services;

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

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

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

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

Subd. 3. **Public-private partnerships.** The commissioner may establish a mechanism by which counties, the Department of Human Services, Direct Care and Treatment, hospitals, health plans, consumers, providers, and others may enter into agreements that allow for capacity building and oversight of any agreed-upon entity that is developed through these partnerships. The purpose of these partnerships is the development and provision of mental health services which would be more effective, efficient, and accessible than services that might be provided separately by each partner.

History: *1987 c 403 art 2 s 19; 1989 c 282 art 4 s 5; 1991 c 94 s 24; 1Sp1993 c 1 art 7 s 4; 2004 c 288 art 3 s 8; 2005 c 98 art 3 s 2; 2024 c 79 art 8 s 5; 2024 c 125 art 5 s 43; 2024 c 127 art 50 s 43*

245.465 DUTIES OF COUNTY BOARD.

Subdivision 1. **Use of mental health funds.** The county board in each county shall use its share of mental health funds allocated by the commissioner according to the mental health plan approved by the commissioner. The county board must:

(1) develop and coordinate a system of affordable and locally available adult mental health services in accordance with sections 245.461 to 245.486;

(2) with the involvement of the local adult mental health advisory council or the adult mental health subcommittee of an existing advisory council, develop a biennial adult mental health plan which considers the assessment of unmet needs in the county as reported by the local adult mental health advisory council under section 245.466, subdivision 5, clause (3). The county shall provide, upon request of the local adult mental health advisory council, readily available data to assist in the determination of unmet needs;

(3) provide for case management services to adults with serious and persistent mental illness in accordance with sections 245.462, subdivisions 3 and 4; 245.4711; and 245.486;

(4) provide for screening of adults specified in section 245.476 upon admission to a residential treatment facility or acute care hospital inpatient, or informal admission to a regional treatment center;

(5) prudently administer grants and purchase-of-service contracts that the county board determines are necessary to fulfill its responsibilities under sections 245.461 to 245.486; and

(6) assure that mental health professionals, mental health practitioners, and case managers employed by or under contract with the county to provide mental health services have experience and training in working with adults with mental illness.

Subd. 2. MS 2004 [Repealed, 2006 c 282 art 16 s 17]

Subd. 3. **Responsibility not duplicated.** For individuals who have health care coverage, the county board is not responsible for providing mental health services which are within the limits of the individual's health care coverage.

History: *1987 c 403 art 2 s 20; 1988 c 689 art 2 s 74; 1989 c 282 art 4 s 6; 1991 c 94 s 1; 1991 c 292 art 4 s 4; 1Sp2003 c 14 art 11 s 11; 2005 c 98 art 3 s 3; 2007 c 147 art 8 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, under the control of the Direct Care and Treatment executive board 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.

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 services in accordance with section 245.469;

(3) outpatient services in accordance with section 245.470;

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

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

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

(7) regional treatment center inpatient services in accordance with section 246C.12;

(8) screening in accordance with section 245.476; and

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

Subd. 3. **Local contracts.** Effective January 1, 1988, the county board shall review all proposed county agreements, grants, or other contracts related to mental health services for funding from any local, state, or federal governmental sources. Contracts with service providers must:

(1) name the commissioner as a third-party beneficiary;

(2) identify monitoring and evaluation procedures not in violation of the Minnesota Government Data Practices Act, chapter 13, which are necessary to ensure effective delivery of quality services;

(3) include a provision that makes payments conditional on compliance by the contractor and all subcontractors with sections 245.461 to 245.486 and all other applicable laws, rules, and standards; and

(4) require financial controls and auditing procedures.

Subd. 3a. **Transition plan related to termination of contract.** Counties must prepare a transition plan that provides for continuity of care in the event of contract termination with a community mental health center under section 245.62, or a community support services program under section 245.462, subdivision 6. The county shall provide at least 90 days' notice of the termination to the contracted agency and the commissioner of human services. The transition plan must provide information to clients on how to access medical records and how to transfer to other providers.

Subd. 4. **Joint county mental health agreements.** In order to provide efficiently the services required by sections 245.461 to 245.486, counties are encouraged to join with one or more county boards to establish a multicounty local mental health authority pursuant to the Joint Powers Act, section 471.59, the Human Services Act, sections 402.01 to 402.10, community mental health center provisions, section 245.62, or enter into multicounty mental health agreements. Participating county boards shall establish acceptable ways of apportioning the cost of the services.

Subd. 5. **Local advisory council.** The county board, individually or in conjunction with other county boards, shall establish a local adult mental health advisory council or mental health subcommittee of an existing advisory council. The council's members must reflect a broad range of community interests. They must include at least one consumer, one family member of an adult with mental illness, one mental health professional, and one community support services program representative. The local adult mental health advisory council or mental health subcommittee of an existing advisory council shall meet at least quarterly to review, evaluate, and make recommendations regarding the local mental health system. Annually, the local adult mental health advisory council or mental health subcommittee of an existing advisory council shall:

(1) arrange for input from the regional treatment center's mental illness program unit regarding coordination of care between the regional treatment center and community-based services;

(2) identify for the county board the individuals, providers, agencies, and associations as specified in section 245.462, subdivision 10;

(3) provide to the county board a report of unmet mental health needs of adults residing in the county to be included in the county's mental health plan, and participate in developing the mental health plan; and

(4) coordinate its review, evaluation, and recommendations regarding the local mental health system with the state advisory council on mental health.

The county board shall consider the advice of its local mental health advisory council or mental health subcommittee of an existing advisory council in carrying out its authorities and responsibilities.

Subd. 6. **Other local authority.** The county board may establish procedures and policies that are not contrary to those of the commissioner or sections 245.461 to 245.486 regarding local adult mental health services and facilities. The county board shall perform other acts necessary to carry out sections 245.461 to 245.486.

Subd. 7. **IMD downsizing flexibility.** If a county presents a budget-neutral plan for a net reduction in the number of institution for mental disease (IMD) beds funded by housing support under chapter 256I, the commissioner may transfer the net savings from housing support to medical assistance and mental health grants to provide appropriate services in non-IMD settings. For the purposes of this subdivision, "a budget neutral plan" means a plan that does not increase the state share of costs.

History: *1987 c 403 art 2 s 21; 1988 c 689 art 2 s 75-77; 1989 c 282 art 4 s 7-10; 1991 c 94 s 2,24; 1Sp1993 c 1 art 7 s 5; 1997 c 107 s 2; 1999 c 86 art 1 s 56; 1Sp2003 c 14 art 11 s 11; 2005 c 10 art 1 s 42; 2005 c 98 art 3 s 4,5; 2014 c 312 art 29 s 1; 2015 c 21 art 1 s 38; 2016 c 158 art 1 s 83; art 2 s 44; 1Sp2017 c 6 art 2 s 39; 2024 c 79 art 8 s 6; art 10 s 2*

245.4661 ADULT MENTAL HEALTH INITIATIVE SERVICES.

Subdivision 1. **Adult mental health initiative services.** Each county board, county boards acting jointly, or Tribal government must provide or contract for sufficient infrastructure for the delivery of mental health services under the Minnesota Comprehensive Adult Mental Health Act, sections 245.461 to 245.486.

Subd. 1a. **Direct payment.** For purposes of this section, "direct payment" means a funding mechanism used by the commissioner to distribute state appropriations to a county or Tribe for the purpose of carrying out duties, services, or activities authorized under this section. A direct payment is not a grant under section 16B.97 and is not subject to statewide grant-making policies and laws, including but not limited to sections 16A.15 and 16C.05, except as specifically required by the commissioner. A direct payment must be used for the purposes and allowable activities established by the commissioner and is subject to financial oversight, reporting, and monitoring requirements under subdivision 12.

Subd. 2. **Program design and implementation.** Adult mental health initiatives shall be responsible for designing, planning, improving, and maintaining a mental health service delivery system for adults with serious and persistent mental illness that would:

(1) provide an expanded array of services from which clients can choose services appropriate to their needs;

(2) be based on purchasing strategies that improve access and coordinate services without cost shifting;

(3) prioritize evidence-based services and implement services that are promising practices or theory-based practices so that the service can be evaluated according to subdivision 5a;

(4) incorporate existing state facilities and resources into the community mental health infrastructure through creative partnerships with local vendors; and

(5) utilize adult mental health initiative funding only after all other eligible funding sources have been applied. Appropriations and all funds that are attributable to the operation of state-operated services under the control of the Direct Care and Treatment executive board are excluded unless appropriated specifically by the legislature for a purpose consistent with this section.

Subd. 3. **Adult mental health initiative evaluation.** Evaluation of each adult mental health initiative will be based on outcome evaluation criteria determined by the commissioners of human services and management and budget after consultation with stakeholders.

Subd. 3a. **Authority and rulemaking.** (a) The commissioner may distribute money under this section through direct payments to counties or Tribes when the commissioner determines that a direct payment is the most effective and efficient method to support the delivery of adult mental health services, Tribal government activities, or county responsibilities under this section. The commissioner shall establish eligibility criteria, allowable uses, documentation standards, and reporting requirements for recipients of direct payments. The commissioner is authorized to engage in rulemaking to fulfill the requirements of this subdivision.

(b) By January 1, 2027, the commissioner must submit a report to the chairs and ranking minority members of the legislative committees with jurisdiction over human services finance and policy that includes, at a minimum, the commissioner's plan for determining direct payment eligibility criteria, allowable uses of direct payments, documentation standards, and reporting requirements for recipients of direct payments.

Subd. 4. **Notice of adult mental health initiative discontinuation.** Each adult mental health initiative may be discontinued for any reason by the managing entity or the commissioner of human services, after 90 days' written notice to the other party.

Subd. 5. **Planning for adult mental health initiatives.** Each local plan for adult mental health initiative services must be developed under the direction of the county board, or multiple county boards acting jointly, as the local mental health authority. The planning process for each adult mental health initiative shall include, but not be limited to, mental health consumers, families, advocates, local mental health advisory councils, local and state providers, representatives of state and local public employee bargaining units, and the department of human services. As part of the planning process, the county board or boards shall designate a managing entity responsible for receipt of funds and management of adult mental health initiatives.

Subd. 5a. **Evaluations.** The commissioner of management and budget, in consultation with the commissioner of human services and within available appropriations, shall create and maintain an inventory of adult mental health initiative services administered by the county boards, identifying evidence-based services and services that are theory-based or promising practices. The commissioner of management and budget, in consultation with the commissioner of human services, shall select adult mental health initiative services that are promising practices or theory-based activities for which the commissioner of management and budget shall conduct evaluations using experimental or quasi-experimental design. The commissioner of human services, in consultation with the commissioner of management and budget, shall encourage county boards to administer adult mental health initiative services to support experimental or quasi-experimental evaluation and shall require county boards to collect and report information that is needed to complete the inventory and evaluation for any adult mental health initiative service that is selected for an evaluation. The

commissioner of management and budget, under section 15.08, may obtain additional relevant data to support the inventory and the experimental or quasi-experimental evaluation studies.

Subd. 6. **Duties of commissioner.** (a) For purposes of adult mental health initiatives, the commissioner shall facilitate integration of funds or other resources as needed and requested by each adult mental health initiative. These resources may include:

(1) community support services funds administered under Minnesota Rules, parts 9535.1700 to 9535.1760;

(2) other mental health special project funds;

(3) medical assistance, MinnesotaCare, and housing support under chapter 256I if requested by the adult mental health initiative's managing entity and if the commissioner determines this would be consistent with the state's overall health care reform efforts; and

(4) regional treatment center resources, with consent from the Direct Care and Treatment executive board.

(b) The commissioner shall review overall status of the initiatives at least every two years and recommend any legislative changes needed by January 15 of each odd-numbered year.

(c) The commissioner may waive administrative rule requirements that are incompatible with the implementation of the adult mental health initiative.

(d) The commissioner may exempt the participating counties from fiscal sanctions for noncompliance with requirements in laws and rules that are incompatible with the implementation of the adult mental health initiative.

(e) The commissioner may award grants to an entity designated by a county board or group of county boards to pay for start-up and implementation costs of the adult mental health initiative.

Subd. 7. **Duties of adult mental health initiative board.** The adult mental health initiative board, or other entity which is approved to administer an adult mental health initiative, shall:

(1) administer the initiative in a manner that is consistent with the objectives described in subdivision 2 and the planning process described in subdivision 5;

(2) assure that no one is denied services that they would otherwise be eligible for; and

(3) provide the commissioner of human services with timely and pertinent information through the submission of data and participation in an evaluation of the adult mental health initiatives, to be designed cooperatively by the commissioner and the initiatives. For services provided to American Indians in Tribal Nations or urban Indian communities, oral reports using a system designed in partnership between the commissioner and the reporting community satisfy the requirements of this clause.

Subd. 8. MS 2020 [Repealed, 2022 c 99 art 1 s 49]

Subd. 9. **Programs and eligible services.** (a) The following three distinct programs may receive direct payments under this section:

(1) mental health crisis services;

(2) housing with supports for adults with serious mental illness; and

(3) projects for assistance in transitioning from homelessness (PATH program).

(b) The following services are eligible for funding as direct payments under this section as the payor of last resort:

(1) community education and prevention;

(2) client outreach;

(3) early identification and intervention;

(4) adult outpatient diagnostic assessment and psychological testing;

(5) peer support services;

(6) community support program services (CSP);

(7) adult residential crisis stabilization;

(8) supported employment;

(9) assertive community treatment (ACT);

(10) housing subsidies;

(11) basic living, social skills, and community intervention;

(12) emergency response services;

(13) adult outpatient psychotherapy;

(14) adult outpatient medication management;

(15) adult mobile crisis services, including the purchase and renovation of vehicles by mobile crisis teams in order to provide protected transport under section 256B.0625, subdivision 17, paragraph (l), clause (6);

(16) adult day treatment;

(17) partial hospitalization;

(18) adult residential treatment;

(19) adult mental health targeted case management; and

(20) transportation.

Subd. 10. **Commissioner duty to report on use of funds biennially.** (a) By November 1, 2016, and biennially thereafter, the commissioner shall provide sufficient information to the members of the legislative committees having jurisdiction over mental health funding and policy issues to evaluate the use of funds appropriated under this section. The commissioner shall provide, at a minimum, the following information:

(1) the amount of funding to adult mental health initiatives, what programs and services were funded in the previous two years, gaps in services that each initiative brought to the attention of the commissioner, and outcome data for the programs and services that were funded; and

(2) the amount of funding for other targeted services and the location of services.

(b) This subdivision expires January 1, 2032.

Subd. 11. **Adult mental health initiative funding.** When implementing the funding formula to distribute adult mental health initiative funds, the commissioner shall ensure that no adult mental health initiative region receives less than the amount the region received in fiscal year 2022 in combined adult mental health initiative funding.

Subd. 12. **Oversight of direct payments.** (a) The commissioner shall develop and maintain monitoring, financial review, and accountability procedures for all direct payments issued under this section.

(b) Recipients of direct payments must comply with all documentation, reporting, and expenditure requirements established by the commissioner.

(c) The commissioner may require corrective action, suspend payments, or recover money if a recipient fails to comply with requirements established under this subdivision.

(d) The commissioner shall develop a direct payment acknowledgment process to ensure that recipients understand the terms, conditions, and oversight requirements associated with direct payments.

(e) The commissioner is authorized to engage in rulemaking to fulfill the requirements of this subdivision.

(f) By January 1, 2027, the commissioner must submit a report to the chairs and ranking minority members of the legislative committees with jurisdiction over human services finance and policy that, at a minimum, describes the commissioner's development of the monitoring, financial review, and accountability procedures as required under this section.

History: *1999 c 245 art 5 s 21; 2005 c 98 art 3 s 6; 1Sp2005 c 4 art 2 s 2; art 5 s 4,5; 2013 c 107 art 4 s 1,2; 2013 c 108 art 4 s 2,3; 2015 c 71 art 2 s 8-11; 2016 c 158 art 1 s 84; art 2 s 45; 1Sp2017 c 6 art 2 s 39; 2021 c 30 art 17 s 21; 2022 c 98 art 14 s 10; 2022 c 99 art 1 s 6; 2023 c 25 s 116,117; 2023 c 70 art 17 s 3; 2024 c 79 art 8 s 7,8; 2025 c 38 art 4 s 7; 1Sp2025 c 3 art 15 s 1-3; 2026 c 121 art 6 s 1-5*

245.4662 MENTAL HEALTH INNOVATION GRANT PROGRAM.

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

(b) "Community partnership" means a project involving the collaboration of two or more eligible applicants.

(c) "Eligible applicant" means an eligible county, Indian Tribe, mental health service provider, hospital, or community partnership. Eligible applicant does not include a state-operated direct care and treatment facility or program under chapters 246 and 246C.

(d) "Intensive residential treatment services" has the meaning given in section 256B.0632.

(e) "Metropolitan area" means the seven-county metropolitan area, as defined in section 473.121, subdivision 2.

Subd. 2. **Grants authorized.** The commissioner of human services shall, in consultation with stakeholders, award grants to eligible applicants to plan, establish, or operate programs to improve accessibility and quality of community-based, outpatient mental health services and reduce the number of clients admitted to regional treatment centers and community behavioral health hospitals. The commissioner shall award half of all grant funds to eligible applicants in the metropolitan area and half of all grant funds to eligible applicants outside the metropolitan area. An applicant may apply for and the commissioner may award grants for two-year

periods. The commissioner may reallocate underspending among grantees within the same grant period. The mental health innovation account is established under section 246.18 for ongoing funding.

Subd. 3. **Allocation of grants.** (a) An application must be on a form and contain information as specified by the commissioner but at a minimum must contain:

(1) a description of the purpose or project for which grant funds will be used;

(2) a description of the specific problem the grant funds will address;

(3) a letter of support from the local mental health authority;

(4) a description of achievable objectives, a work plan, and a timeline for implementation and completion of processes or projects enabled by the grant; and

(5) a process for documenting and evaluating results of the grant.

(b) The commissioner shall review each application to determine whether the application is complete and whether the applicant and the project are eligible for a grant. In evaluating applications according to paragraph (c), the commissioner shall establish criteria including, but not limited to: the eligibility of the project; the applicant's thoroughness and clarity in describing the problem grant funds are intended to address; a description of the applicant's proposed project; a description of the population demographics and service area of the proposed project; the manner in which the applicant will demonstrate the effectiveness of any projects undertaken; the proposed project's longevity and demonstrated financial sustainability after the initial grant period; and evidence of efficiencies and effectiveness gained through collaborative efforts. The commissioner may also consider other relevant factors. In evaluating applications, the commissioner may request additional information regarding a proposed project, including information on project cost. An applicant's failure to provide the information requested disqualifies an applicant. The commissioner shall determine the number of grants awarded.

(c) Eligible applicants may receive grants under this section for purposes including, but not limited to, the following:

(1) intensive residential treatment services providing time-limited mental health services in a residential setting;

(2) the creation of stand-alone urgent care centers for mental health and psychiatric consultation services, crisis residential services, or collaboration between crisis teams and critical access hospitals;

(3) establishing new community mental health services or expanding the capacity of existing services, including supportive housing; and

(4) other innovative projects that improve options for mental health services in community settings and reduce the number of clients who remain in regional treatment centers and community behavioral health hospitals beyond when discharge is determined to be clinically appropriate.

Subd. 4. MS 2020 [Repealed, 2022 c 55 art 1 s 187]

History: *1Sp2017 c 6 art 8 s 2; 2021 c 30 art 17 s 22; 2024 c 79 art 10 s 2; 2025 c 38 art 7 s 2*

245.4663 MENTAL HEALTH PROVIDER SUPERVISION GRANT PROGRAM.

Subdivision 1. **Grant program established.** The commissioner shall award grants to licensed or certified mental health providers that meet the criteria in subdivision 2 to fund supervision of or preceptorships for

students, interns, and clinical trainees who are working toward becoming mental health professionals; to subsidize the costs of licensing applications and examination fees for clinical trainees; and to fund training for workers to become supervisors. For purposes of this section, an intern may include an individual who is working toward an undergraduate degree in the behavioral sciences or related field at an accredited educational institution.

Subd. 2. **Eligible providers.** In order to be eligible for a grant under this section, a mental health provider must:

(1) provide at least 25 percent of the provider's yearly patient encounters to state public program enrollees or patients receiving sliding fee schedule discounts through a formal sliding fee schedule meeting the standards established by the United States Department of Health and Human Services under Code of Federal Regulations, title 42, section 51c.303;

(2) primarily serve underrepresented communities as defined in section 148E.010, subdivision 20; or

(3) provide services to people in a city or township that is not within the seven-county metropolitan area as defined in section 473.121, subdivision 2, and is not the city of Duluth, Mankato, Moorhead, Rochester, or St. Cloud.

Subd. 3. **Application; grant award.** A mental health provider seeking a grant under this section must apply to the commissioner at a time and in a manner specified by the commissioner. The commissioner shall review each application to determine if the application is complete, the mental health provider is eligible for a grant, and the proposed project is an allowable use of grant funds. The commissioner must determine the grant amount awarded to applicants that the commissioner determines will receive a grant.

Subd. 4. **Allowable uses of grant funds.** A mental health provider must use grant funds received under this section for one or more of the following:

(1) to pay for direct supervision hours or preceptorships for students, interns, and clinical trainees, in an amount up to $7,500 per student, intern, or clinical trainee;

(2) to establish a program to provide supervision to multiple students, interns, or clinical trainees;

(3) to pay licensing application and examination fees for clinical trainees; or

(4) to provide a weekend training program for workers to become supervisors.

Subd. 5. **Program oversight.** During the grant period, the commissioner may require grant recipients to provide the commissioner with information necessary to evaluate the program.

History: *2022 c 99 art 1 s 7; 2023 c 70 art 5 s 12; art 9 s 2; 2024 c 127 art 61 s 2*

245.467 QUALITY OF SERVICES.

Subdivision 1. **Criteria.** Mental health services required by this chapter must be:

(1) based, when feasible, on research findings;

(2) based on individual clinical needs, cultural and ethnic needs, and other special needs of individuals being served;

(3) provided in the most appropriate, least restrictive setting available to the county board;

(4) accessible to all age groups;

(5) delivered in a manner that provides accountability;

(6) provided by qualified individuals as required in this chapter;

(7) coordinated with mental health services offered by other providers; and

(8) provided under conditions which protect the rights and dignity of the individuals being served.

Subd. 2. **Diagnostic assessment.** A provider of services governed by this section must complete a diagnostic assessment of a client according to the standards of section 245I.10.

Subd. 3. **Individual treatment plans.** A provider of services governed by this section must complete an individual treatment plan for a client according to the standards of section 245I.10, subdivisions 7 and 8.

Subd. 4. **Referral for case management.** Each provider of emergency services, day treatment services, outpatient treatment, community support services, residential treatment, acute care hospital inpatient treatment, or regional treatment center inpatient treatment must inform each of its clients with serious and persistent mental illness of the availability and potential benefits to the client of case management. If the client consents, the provider must refer the client by notifying the county employee designated by the county board to coordinate case management activities of the client's name and address and by informing the client of whom to contact to request case management. The provider must document compliance with this subdivision in the client's record.

Subd. 5. **Information for billing.** Each provider of outpatient treatment, community support services, day treatment services, emergency services, residential treatment, or acute care hospital inpatient treatment must include the name and home address of each client for whom services are included on a bill submitted to a county, if the client has consented to the release of that information and if the county requests the information. Each provider shall attempt to obtain each client's consent and must explain to the client that the information can only be released with the client's consent and may be used only for purposes of payment and maintaining provider accountability. The provider shall document the attempt in the client's record.

Subd. 6. **Restricted access to data.** The county board shall establish procedures to ensure that the names and addresses of persons receiving mental health services are disclosed only to:

(1) county employees who are specifically responsible for determining county of financial responsibility or making payments to providers;

(2) staff who provide treatment services or case management and their clinical supervisors; and

(3) personnel of the welfare system or health care providers who have access to the data under section 13.46, subdivision 7.

Release of mental health data on individuals submitted under subdivisions 4 and 5, to persons other than those specified in this subdivision, or use of this data for purposes other than those stated in subdivisions 4 and 5, results in civil or criminal liability under the standards in section 13.08 or 13.09.

History: *1987 c 403 art 2 s 22; 1988 c 689 art 2 s 78-80; 1989 c 282 art 4 s 11-13; 1990 c 568 art 5 s 1,2; 2011 c 86 s 2; 2015 c 71 art 2 s 12; 2016 c 158 art 2 s 46; 1Sp2017 c 6 art 8 s 3; 2021 c 30 art 17 s 23,24; 2022 c 98 art 4 s 4,5*

245.468 EDUCATION AND PREVENTION SERVICES.

By July 1, 1988, county boards must provide or contract for education and prevention services to adults residing in the county. Education and prevention services must be designed to:

(1) convey information regarding mental illness and treatment resources to the general public and special high-risk target groups;

(2) increase understanding and acceptance of problems associated with mental illness;

(3) improve people's skills in dealing with high-risk situations known to have an impact on adults' mental health functioning;

(4) prevent development or deepening of mental illness; and

(5) refer adults with additional mental health needs to appropriate mental health services.

History: *1987 c 403 art 2 s 23; 1989 c 282 art 4 s 14*

245.4682 MENTAL HEALTH SERVICE DELIVERY AND FINANCE REFORM.

Subdivision 1. **Policy.** The commissioner of human services shall undertake a series of reforms to address the underlying structural, financial, and organizational problems in Minnesota's mental health system with the goal of improving the availability, quality, and accountability of mental health care within the state.

Subd. 2. **General provisions.** (a) In the design and implementation of reforms to the mental health system, the commissioner shall:

(1) consult with consumers, families, counties, Tribes, advocates, providers, and other stakeholders;

(2) bring to the legislature, and the State Advisory Council on Mental Health, by January 15, 2008, recommendations for legislation to update the role of counties and to clarify the case management roles, functions, and decision-making authority of health plans and counties, and to clarify county retention of the responsibility for the delivery of social services as required under subdivision 3, paragraph (a);

(3) withhold implementation of any recommended changes in case management roles, functions, and decision-making authority until after the release of the report due January 15, 2008;

(4) ensure continuity of care for persons affected by these reforms including ensuring client choice of provider by requiring broad provider networks and developing mechanisms to facilitate a smooth transition of service responsibilities;

(5) provide accountability for the efficient and effective use of public and private resources in achieving positive outcomes for consumers;

(6) ensure client access to applicable protections and appeals; and

(7) make budget transfers necessary to implement the reallocation of services and client responsibilities between counties and health care programs that do not increase the state and county costs and efficiently allocate state funds.

(b) When making transfers under paragraph (a) necessary to implement movement of responsibility for clients and services between counties and health care programs, the commissioner, in consultation with counties, shall ensure that any transfer of state grants to health care programs, including the value of case management transfer grants under section 256B.0625, subdivision 20, does not exceed the value of the

services being transferred for the latest 12-month period for which data is available. The commissioner may make quarterly adjustments based on the availability of additional data during the first four quarters after the transfers first occur. If case management transfer grants under section 256B.0625, subdivision 20, are repealed and the value, based on the last year prior to repeal, exceeds the value of the services being transferred, the difference becomes an ongoing part of each county's adult mental health grants under sections 245.4661 and 256K.10.

(c) This appropriation is not authorized to be expended after December 31, 2010, unless approved by the legislature.

Subd. 3. **Projects for coordination of care.** (a) Consistent with section 256B.69 and chapter 256L, the commissioner is authorized to solicit, approve, and implement up to three projects to demonstrate the integration of physical and mental health services within prepaid health plans and their coordination with social services. The commissioner shall require that each project be based on locally defined partnerships that include at least one health maintenance organization, community integrated service network, or accountable provider network authorized and operating under chapter 62D, 62N, or 62T, or county-based purchasing entity under section 256B.692 that is eligible to contract with the commissioner as a prepaid health plan, and the county or counties within the service area. Counties shall retain responsibility and authority for social services in these locally defined partnerships.

(b) The commissioner, in consultation with consumers, families, and their representatives, shall:

(1) determine criteria for approving the projects and use those criteria to solicit proposals for preferred integrated networks. The commissioner must develop criteria to evaluate the partnership proposed by the county and prepaid health plan to coordinate access and delivery of services. The proposal must at a minimum address how the partnership will coordinate the provision of:

(i) client outreach and identification of health and social service needs paired with expedited access to appropriate resources;

(ii) activities to maintain continuity of health care coverage;

(iii) children's residential mental health treatment and treatment foster care;

(iv) court-ordered assessments and treatments;

(v) prepetition screening and commitments under chapter 253B;

(vi) assessment and treatment of children identified through mental health screening of child welfare and juvenile corrections cases;

(vii) home and community-based waiver services;

(viii) assistance with finding and maintaining employment;

(ix) housing; and

(x) transportation;

(2) determine specifications for contracts with prepaid health plans to improve the plan's ability to serve persons with mental health conditions, including specifications addressing:

(i) early identification and intervention of physical and behavioral health problems;

(ii) communication between the enrollee and the health plan;

(iii) facilitation of enrollment for persons who are also eligible for a Medicare special needs plan offered by the health plan;

(iv) risk screening procedures;

(v) health care coordination;

(vi) member services and access to applicable protections and appeal processes;

(vii) specialty provider networks;

(viii) transportation services;

(ix) treatment planning; and

(x) administrative simplification for providers;

(3) begin implementation of the projects no earlier than January 1, 2009, with not more than 40 percent of the statewide population included during calendar year 2009 and additional counties included in subsequent years;

(4) waive any administrative rule not consistent with the implementation of the projects;

(5) allow potential bidders at least 90 days to respond to the request for proposals; and

(6) conduct an independent evaluation to determine if mental health outcomes have improved in that county or counties according to measurable standards designed in consultation with the advisory body established under this subdivision and reviewed by the State Advisory Council on Mental Health.

(c) Notwithstanding any statute or administrative rule to the contrary, the commissioner may enroll all persons eligible for medical assistance with serious mental illness in the prepaid plan of their choice within the project service area unless:

(1) the individual is eligible for home and community-based services for persons with developmental disabilities and related conditions under section 256B.092; or

(2) the individual has a basis for exclusion from the prepaid plan under section 256B.69, subdivision 4, other than disability, or mental illness.

(d) The commissioner shall involve organizations representing persons with mental illness and their families in the development and distribution of information used to educate potential enrollees regarding their options for health care and mental health service delivery under this subdivision.

(e) If the person described in paragraph (c) does not elect to remain in fee-for-service medical assistance, or declines to choose a plan, the commissioner may preferentially assign that person to the prepaid plan participating in the preferred integrated network. The commissioner shall implement the enrollment changes within a project's service area on the timeline specified in that project's approved application.

(f) A person enrolled in a prepaid health plan under paragraphs (c) and (d) may disenroll from the plan at any time.

(g) The commissioner, in consultation with consumers, families, and their representatives, shall evaluate the projects begun in 2009, and shall refine the design of the service integration projects before expanding

the projects. The commissioner shall report to the chairs of the legislative committees with jurisdiction over mental health services by March 1, 2008, on plans for evaluation of preferred integrated networks established under this subdivision.

(h) The commissioner shall apply for any federal waivers necessary to implement these changes.

(i) Payment for Medicaid service providers under this subdivision for the months of May and June will be made no earlier than July 1 of the same calendar year.

History: *2007 c 147 art 8 s 5; 2013 c 108 art 4 s 4; 2016 c 158 art 2 s 47; 2024 c 80 art 8 s 68; 2025 c 38 art 8 s 10*

245.469 EMERGENCY SERVICES.

Subdivision 1. **Availability of emergency services.** (a) County boards must provide or contract for enough emergency services within the county to meet the needs of adults, children, and families in the county who are experiencing an emotional crisis or mental illness. Clients must not be charged for services provided and emergency service providers must not delay or deny the timely provision of emergency services to a client due to payor source for the services provided. Emergency service providers must meet the qualifications under section 256B.0624, subdivision 4. Emergency services must include assessment, crisis intervention, and appropriate case disposition. Emergency services must:

(1) promote the safety and emotional stability of each client;

(2) minimize further deterioration of each client;

(3) help each client to obtain ongoing care and treatment;

(4) prevent placement in settings that are more intensive, costly, or restrictive than necessary and appropriate to meet client needs; and

(5) provide support, psychoeducation, and referrals to each client's family members, service providers, and other third parties on behalf of the client in need of emergency services.

(b) If a county provides engagement services under section 253B.041, the county's emergency service providers must refer clients to engagement services when the client meets the criteria for engagement services.

Subd. 2. **Specific requirements.** (a) The county board shall require that all service providers of emergency services to adults or children 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, clinical trainee, or mental health practitioner.

(b) The commissioner may waive the requirement in paragraph (a) that the evening, weekend, and holiday service be provided by a mental health professional, clinical trainee, or mental health practitioner if the county documents that:

(1) mental health professionals, clinical trainees, 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 treatment 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 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 approved by the commissioner;

(3) the local social service agency has provided public education about available emergency mental health services and can assure potential users of emergency services that their calls will be handled appropriately;

(4) the local social service agency agrees to provide the commissioner with accurate data on the number of emergency mental health service calls received;

(5) the local social service agency agrees to monitor the frequency and quality of emergency services; and

(6) the local social service agency describes how it will comply with paragraph (d).

(d) Whenever emergency service during nonbusiness hours is provided by anyone other than a mental health professional, a mental health professional must be available on call for an emergency assessment and crisis intervention services, and must be available for at least telephone consultation within 30 minutes.

Subd. 3. **Mental health crisis services.** The commissioner of human services shall increase access to mental health crisis services for children and adults. In order to increase access, the commissioner must:

(1) promote the 988 Lifeline;

(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 and requirements for crisis services as outlined in section 256B.0624; 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.

History: *1987 c 403 art 2 s 24; 1988 c 689 art 2 s 81; 1989 c 282 art 4 s 15; 1990 c 568 art 5 s 3; 1991 c 312 s 1; 2015 c 71 art 2 s 42; 2021 c 30 art 16 s 1,2; 2023 c 70 art 17 s 4; 2025 c 38 art 4 s 8; 2026 c 95 art 5 s 1*

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 clinics meeting the standards of chapter 245I; by contract with privately operated mental health clinics meeting the standards of chapter 245I; by contract with hospital mental health outpatient programs certified by the Joint Commission on Accreditation of Hospital Organizations; or by contract with a mental health professional. 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.

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

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

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

(3) develop individual treatment plans;

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

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

History: *1987 c 403 art 2 s 25; 1989 c 282 art 4 s 16; 1990 c 568 art 2 s 38; 1991 c 255 s 19; 1993 c 339 s 2; 2009 c 79 art 7 s 2; 2021 c 30 art 17 s 25*

245.4705 EMPLOYMENT SUPPORT SERVICES AND PROGRAMS.

The commissioner of human services shall cooperate with the commissioner of employment and economic development in the operation of a statewide system, as provided in section 268A.14, to reimburse providers for employment support services for persons with mental illness.

History: *1999 c 223 art 2 s 36; 2004 c 206 s 52*

245.471 MS 1988 [Repealed, 1989 c 282 art 4 s 64]

245.4711 CASE MANAGEMENT SERVICES.

Subdivision 1. **Availability of case management services.** (a) By January 1, 1989, the county board shall provide case management services for all adults with serious and persistent mental illness who are residents of the county and who request or consent to the services and to each adult for whom the court appoints a case manager. Staffing ratios must be sufficient to serve the needs of the clients. The case manager must meet the requirements in section 245.462, subdivision 4.

(b) Case management services provided to adults with serious and persistent mental illness eligible for medical assistance must be billed to the medical assistance program under sections 256B.02, subdivision 8, and 256B.0625.

(c) Case management services are eligible for reimbursement under the medical assistance program. Costs associated with mentoring, supervision, and continuing education may be included in the reimbursement rate methodology used for case management services under the medical assistance program.

Subd. 2. **Notification and determination of case management eligibility.** (a) The county board shall notify the adult of the adult's potential eligibility for case management services within five working days after receiving a request from an individual or a referral from a provider under section 245.467, subdivision 4. The county board shall send a written notice to the adult and the adult's representative, if any, that identifies the designated case management providers.

(b) The county board must determine whether an adult who requests or is referred for case management services meets the criteria of section 245.462, subdivision 20, paragraph (c). If a diagnostic assessment is needed to make the determination, the county board shall offer to assist the adult in obtaining a diagnostic assessment. The county board shall notify, in writing, the adult and the adult's representative, if any, of the eligibility determination. If the adult is determined to be eligible for case management services, the county board shall refer the adult to the case management provider for case management services. If the adult is determined not to be eligible or refuses case management services, the local agency shall offer to refer the adult to a mental health provider or other appropriate service provider and to assist the adult in making an appointment with the provider of the adult's choice.

Subd. 3. **Duties of case manager.** Upon a determination of eligibility for case management services, and if the adult consents to the services, the case manager shall complete a written functional assessment according to section 245.462, subdivision 11a. The case manager shall develop an individual community support plan for the adult according to subdivision 4, paragraph (a), review the adult's progress, and monitor the provision of services. If services are to be provided in a host county that is not the county of financial responsibility, the case manager shall consult with the host county and obtain a letter demonstrating the concurrence of the host county regarding the provision of services.

Subd. 4. **Individual community support plan.** (a) The case manager must develop an individual community support plan for each adult that incorporates the client's individual treatment plan. The individual

treatment plan may not be a substitute for the development of an individual community support plan. The individual community support plan must be developed within 30 days of client intake and reviewed at least every 180 days after it is developed, unless the case manager receives a written request from the client or the client's family for a review of the plan every 90 days after it is developed. The case manager is responsible for developing the individual community support plan based on a diagnostic assessment and a functional assessment and for implementing and monitoring the delivery of services according to the individual community support plan. To the extent possible, the adult with serious and persistent mental illness, the person's family, advocates, service providers, and significant others must be involved in all phases of development and implementation of the individual community support plan.

(b) The client's individual community support plan must state:

(1) the goals of each service;

(2) the activities for accomplishing each goal;

(3) a schedule for each activity; and

(4) the frequency of face-to-face contacts by the case manager, as appropriate to client need and the implementation of the individual community support plan.

Subd. 5. **Coordination between case manager and community support services.** (a) The county board must establish procedures that ensure ongoing contact and coordination between the case manager and the community support services program as well as other mental health services.

(b) The case manager must have at least one case management contact in every calendar month with a documented core service component, as defined by the commissioner, to claim reimbursement for adult mental health targeted case management. Adult mental health case managers must not conduct the case management contact by telephone with the adult client or the adult client's legal representative for more than two consecutive calendar months.

Subd. 6. MS 1989 Supp [Repealed, 1990 c 568 art 5 s 35]

Subd. 7. MS 1989 Supp [Repealed, 1990 c 568 art 5 s 35]

Subd. 8. MS 1989 Supp [Repealed, 1990 c 568 art 5 s 35]

Subd. 9. MS 1996 [Repealed, 1997 c 93 s 4]

History: *1989 c 282 art 4 s 17; 1990 c 568 art 5 s 4-6; 1991 c 292 art 6 s 5; 1997 c 93 s 1; 1999 c 245 art 5 s 4; 2022 c 98 art 17 s 26; 2023 c 50 art 1 s 3,4; 2026 c 121 art 3 s 4*

COMMUNITY SUPPORT AND DAY TREATMENT SERVICES

245.4712 COMMUNITY SUPPORT AND DAY TREATMENT SERVICES.

Subdivision 1. **Availability of community support services.** (a) County boards must provide or contract for sufficient community support services within the county to meet the needs of adults with serious and persistent mental illness who are residents of the county. Adults may be required to pay a fee according to section 245.481. The community support services program must be designed to improve the ability of adults with serious and persistent mental illness to:

(1) find and maintain competitive employment;

(2) handle basic activities of daily living;

(3) participate in leisure time activities;

(4) set goals and plans; and

(5) obtain and maintain appropriate living arrangements.

The community support services program must also be designed to reduce the need for and use of more intensive, costly, or restrictive placements both in number of admissions and length of stay.

(b) Community support services are those services that are supportive in nature and not necessarily treatment oriented, and include:

(1) conducting outreach activities such as home visits, health and wellness checks, and problem solving;

(2) connecting people to resources to meet their basic needs;

(3) finding, securing, and supporting people in their housing;

(4) attaining and maintaining health insurance benefits;

(5) assisting with job applications, finding and maintaining employment, and securing a stable financial situation;

(6) fostering social support, including support groups, mentoring, peer support, and other efforts to prevent isolation and promote recovery; and

(7) educating about mental illness, treatment, and recovery.

(c) Community support services shall use all available funding streams. The county shall maintain the level of expenditures for this program, as required under section 245.4835. County boards must continue to provide funds for those services not covered by other funding streams and to maintain an infrastructure to carry out these services. The county is encouraged to fund evidence-based practices such as Individual Placement and Supported Employment and Illness Management and Recovery.

(d) The commissioner shall collect data on community support services programs, including, but not limited to, demographic information such as age, sex, race, the number of people served, and information related to housing, employment, hospitalization, symptoms, and satisfaction with services.

Subd. 2. **Day treatment services provided.** (a) Day treatment services must be developed as a part of the community support services available to adults with serious and persistent mental illness residing in the county. Adults may be required to pay a fee according to section 245.481. Day treatment services must be designed to:

(1) provide a structured environment for treatment;

(2) provide support for residing in the community;

(3) prevent placement in settings that are more intensive, costly, or restrictive than necessary and appropriate to meet client need;

(4) coordinate with or be offered in conjunction with a local education agency's special education program; and

(5) operate on a continuous basis throughout the year.

(b) An adult day treatment program must comply with medical assistance requirements in section 256B.0671, subdivision 3.

(c) County boards may request a waiver from including day treatment services if they can document that:

(1) an alternative plan of care exists through the county's community support services for clients who would otherwise need day treatment services;

(2) day treatment, if included, would be duplicative of other components of the community support services; and

(3) county demographics and geography make the provision of day treatment services cost ineffective and infeasible.

Subd. 3. **Benefits assistance.** The county board must offer to help adults with serious and persistent mental illness in applying for state and federal benefits, including Supplemental Security Income, medical assistance, Medicare, general assistance, and Minnesota supplemental aid. The help must be offered as part of the community support program available to adults with serious and persistent mental illness for whom the county is financially responsible and who may qualify for these benefits.

History: *1990 c 568 art 5 s 7; 1999 c 245 art 5 s 5; 2007 c 147 art 8 s 6; 2013 c 85 art 3 s 19; 2014 c 275 art 1 s 36; 2016 c 158 art 2 s 48; 2021 c 30 art 17 s 26*

245.472 RESIDENTIAL TREATMENT SERVICES.

Subdivision 1. **Availability of residential treatment services.** By July 1, 1988, county boards must provide or contract for enough residential treatment services to meet the needs of all adults with mental illness residing in the county and needing this level of care. Residential treatment services include both intensive and structured residential treatment with length of stay based on client residential treatment need. Services must be as close to the county as possible. Residential treatment must be designed to:

(1) prevent placement in settings that are more intensive, costly, or restrictive than necessary and appropriate to meet client needs;

(2) help clients achieve the highest level of independent living;

(3) help clients gain the necessary skills to function in a less structured setting; and

(4) stabilize crisis admissions.

Subd. 2. **Specific requirements.** Providers of residential services must be licensed under chapter 245I or applicable rules adopted by the commissioner. Residential services must be provided under treatment supervision.

Subd. 3. **Transition to community.** Residential treatment programs must plan for and assist clients in making a transition from residential treatment facilities to other community-based services. In coordination with the client's case manager, if any, residential treatment facilities must also arrange for appropriate follow-up care in the community during the transition period. Before a client is discharged, the residential treatment facility 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.

Subd. 4. **Admission, continued stay, and discharge criteria.** No later than January 1, 1992, the county board shall ensure that placement decisions for residential services are based on the clinical needs of the adult. The county board shall ensure that each entity under contract with the county to provide residential treatment services has admission, continued stay, discharge criteria and discharge planning criteria as part of the contract. Contracts shall specify specific responsibilities between the county and service providers to ensure comprehensive planning and continuity of care between needed services according to data privacy requirements. All contracts for the provision of residential services must include provisions guaranteeing clients the right to appeal under section 245.477 and to be advised of their appeal rights.

History: *1987 c 403 art 2 s 27; 1988 c 689 art 2 s 84; 1989 c 282 art 4 s 18,19; 1991 c 292 art 6 s 6,7; 2016 c 158 art 1 s 214; 2021 c 30 art 17 s 27*

245.473 ACUTE CARE HOSPITAL INPATIENT SERVICES.

Subdivision 1. **Availability of acute care inpatient services.** By July 1, 1988, county boards must make available through contract or direct provision enough acute care hospital inpatient treatment services as close to the county as possible for adults with mental illness residing in the county. Acute care hospital inpatient treatment services must be designed to:

(1) stabilize the medical and mental health condition for which admission is required;

(2) improve functioning to the point where discharge to residential treatment or community-based mental health services is possible; and

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

Subd. 2. **Specific requirements.** Providers of acute care hospital inpatient services must meet applicable standards established by the commissioners of health and human services.

Subd. 3. **Admission, continued stay, and discharge criteria.** No later than January 1, 1992, the county board shall ensure that placement decisions for acute care inpatient services are based on the clinical needs of the adult. The county board shall ensure that each entity under contract with the county to provide acute care hospital treatment services has admission, continued stay, discharge criteria and discharge planning criteria as part of the contract. Contracts shall specify specific responsibilities between the county and service providers to ensure comprehensive planning and continuity of care between needed services according to data privacy requirements. All contracts for the provision of acute care hospital inpatient treatment services must include provisions guaranteeing clients the right to appeal under section 245.477 and to be advised of their appeal rights.

Subd. 4. **Individual placement agreement.** Except for services reimbursed under chapters 256B and 256D, the county board shall enter into an individual placement agreement with a provider of acute care hospital inpatient treatment services to an adult eligible for services under this section. The agreement must specify the payment rate and the terms and conditions of county payment for the placement.

History: *1987 c 403 art 2 s 28; 1989 c 282 art 4 s 20; 1991 c 292 art 6 s 8,9*

245.474 [Renumbered 246C.12]

245.475 MS 1988 [Repealed, 1989 c 282 art 4 s 64]

245.476 SCREENING FOR INPATIENT AND RESIDENTIAL TREATMENT.

Subdivision 1. MS 1990 [Repealed, 1991 c 292 art 6 s 59]

Subd. 2. MS 1990 [Repealed, 1991 c 292 art 6 s 59]

Subd. 3. MS 1990 [Repealed, 1991 c 292 art 6 s 59]

Subd. 4. MS 1992 [Repealed, 1993 c 337 s 20]

Subd. 5. **Report on preadmission screening.** The commissioner shall review the statutory preadmission screening requirements for psychiatric hospitalization, both in the regional treatment centers and other hospitals, to determine if changes in preadmission screening are needed. The commissioner shall deliver a report of the review to the legislature by January 31, 1990.

History: *1987 c 403 art 2 s 31; 1988 c 689 art 2 s 87; 1989 c 282 art 4 s 22-24; art 6 s 4*

245.477 APPEALS.

Any adult who requests mental health services under sections 245.461 to 245.486 must be advised of services available and the right to appeal at the time of the request and each time the individual community support plan or individual treatment plan is reviewed. Any adult whose request for mental health services under sections 245.461 to 245.486 is denied, not acted upon with reasonable promptness, or whose services are suspended, reduced, or terminated by action or inaction for which the county board is responsible under sections 245.461 to 245.486 may contest that action or inaction before the state agency as specified in section 256.045. The commissioner shall monitor the nature and frequency of administrative appeals under this section.

History: *1987 c 403 art 2 s 32; 1988 c 689 art 2 s 88; 1989 c 282 art 4 s 25; 2022 c 98 art 17 s 26; 2023 c 50 art 1 s 5*

245.478 MS 2002 [Repealed, 1Sp2003 c 14 art 11 s 12]

245.479 COUNTY OF FINANCIAL RESPONSIBILITY.

For purposes of sections 245.461 to 245.486 and 245.487 to 245.4889, the county of financial responsibility is determined under section 256G.02, subdivision 4. Disputes between counties regarding financial responsibility must be resolved by the commissioner in accordance with section 256G.09.

History: *1987 c 403 art 2 s 35; 1988 c 689 art 2 s 92; 1989 c 282 art 4 s 28; 1991 c 292 art 6 s 58 subd 1; 1Sp2003 c 14 art 11 s 11; 2007 c 147 art 8 s 38*

245.48 MS 1994 [Repealed, 1995 c 264 art 3 s 51]

245.481 FEES FOR MENTAL HEALTH SERVICES.

A client or, in the case of a child, the child or the child's parent may be required to pay a fee for mental health services provided under sections 245.461 to 245.4682, 245.470 to 245.486, and 245.487 to 245.4889. The fee must be based on the person's ability to pay according to the fee schedule adopted by the county board. In adopting the fee schedule for mental health services, the county board may adopt the fee schedule provided by the commissioner or adopt a fee schedule recommended by the county board and approved by the commissioner. Agencies or individuals under contract with a county board to provide mental health services under sections 245.461 to 245.486 and 245.487 to 245.4889 must not charge clients whose mental health services are paid wholly or in part from public funds fees which exceed the county board's adopted

fee schedule. This section does not apply to regional treatment center fees, which are governed by sections 246.50 to 246.55.

History: *1989 c 282 art 4 s 30; 1991 c 292 art 6 s 58 subd 1; 1Sp2003 c 14 art 11 s 11; 2007 c 147 art 8 s 38; 2025 c 38 art 4 s 9*

245.482 REPORTING AND EVALUATION.

Subdivision 1. **Reports.** The commissioner shall specify requirements for reports, including quarterly fiscal reports, according to section 256.01, subdivision 2, paragraph (o).

Subd. 2. **Fiscal reports.** The commissioner shall develop a unified format for quarterly fiscal reports that will include information that the commissioner determines necessary to carry out sections 245.461 to 245.486 and 245.487 to 245.4889. The county board shall submit a completed fiscal report in the required format no later than 30 days after the end of each quarter.

Subd. 3. **Program reports.** The commissioner shall develop unified formats for reporting, which will include information that the commissioner determines necessary to carry out sections 245.461 to 245.486 and 245.487 to 245.4889. The county board shall submit completed program reports in the required format according to the reporting schedule developed by the commissioner.

Subd. 4. **Provider reports.** The commissioner may develop formats and procedures for direct reporting from providers to the commissioner to include information that the commissioner determines necessary to carry out sections 245.461 to 245.486 and 245.487 to 245.4889. In particular, the provider reports must include aggregate information by county of residence about mental health services paid for by funding sources other than counties.

Subd. 5. MS 2014 [Repealed, 2016 c 158 art 1 s 215]

Subd. 6. **Inaccurate or incomplete reports.** The commissioner shall promptly notify a county or provider if a required report is clearly inaccurate or incomplete. The commissioner may delay all or part of a mental health fund payment if an appropriately completed report is not received as required by this section.

Subd. 7. **Statewide evaluation.** The commissioner shall use the county and provider reports required by this section to complete the statewide report required in sections 245.461 and 245.487.

History: *1987 c 403 art 2 s 36; 1988 c 689 art 2 s 93; 1989 c 89 s 1; 1989 c 282 art 4 s 31; 1991 c 292 art 6 s 58 subd 1; 1994 c 465 art 3 s 17; 1Sp2003 c 14 art 11 s 11; 2007 c 147 art 8 s 38; 2013 c 107 art 4 s 3; 2015 c 78 art 4 s 61*

245.483 TERMINATION OR RETURN OF AN ALLOCATION.

Subdivision 1. **Funds not properly used.** If the commissioner determines that a county is not meeting the requirements of sections 245.461 to 245.486 and 245.487 to 245.4889, or that funds are not being used according to the approved mental health plan, all or part of the mental health funds may be terminated upon 30 days' notice to the county board. The commissioner may require repayment of any funds not used according to the approved mental health plan. If the commissioner receives a written appeal from the county board within the 30-day period, opportunity for a hearing under the Minnesota Administrative Procedure Act, chapter 14, must be provided before the allocation is terminated or is required to be repaid. The 30-day period begins when the county board receives the commissioner's notice by certified mail.

Subd. 2. **Use of returned funds.** The commissioner may reallocate the funds returned.

Subd. 3. **Delayed payments.** If the commissioner finds that a county board or its contractors are not in compliance with the approved mental health plan or sections 245.461 to 245.486 and 245.487 to 245.4889, the commissioner may delay payment of all or part of the quarterly mental health funds until the county board and its contractors meet the requirements. The commissioner shall not delay a payment longer than three months without first issuing a notice under subdivision 2 that all or part of the allocation will be terminated or required to be repaid. After this notice is issued, the commissioner may continue to delay the payment until completion of the hearing in subdivision 2.

Subd. 4. **State assumption of responsibility.** If the commissioner determines that services required by sections 245.461 to 245.486 and 245.487 to 245.4889 will not be provided by the county board in the manner or to the extent required by sections 245.461 to 245.486 and 245.487 to 245.4889, the commissioner shall contract directly with providers to ensure that clients receive appropriate services. In this case, the commissioner shall use the county's mental health funds to the extent necessary to carry out the county's responsibilities under sections 245.461 to 245.486 and 245.487 to 245.4889. The commissioner shall work with the county board to allow for a return of authority and responsibility to the county board as soon as compliance with sections 245.461 to 245.486 and 245.487 to 245.4889 can be assured.

History: *1987 c 403 art 2 s 37; 1989 c 282 art 4 s 32; 1991 c 94 s 24; 1991 c 292 art 6 s 58 subd 1; 1Sp2003 c 14 art 11 s 11; 2005 c 98 art 3 s 7,8,24; 2007 c 147 art 8 s 38*

245.4835 COUNTY MAINTENANCE OF EFFORT.

Subdivision 1. **Required expenditures.** (a) Counties must maintain a level of expenditures for mental health services under sections 245.461 to 245.484 and 245.487 to 245.4889 so that each year's county expenditures are at least equal to that county's average expenditures for those services for calendar years 2004 and 2005. The commissioner will adjust each county's base level for minimum expenditures in each year by the amount of any increase or decrease in that county's state grants or other noncounty revenues for mental health services under sections 245.461 to 245.484 and 245.487 to 245.4889.

(b) In order to simplify administration and improve budgeting predictability, the commissioner:

(1) shall use each county's actual prior year revenues to adjust the county's minimum required expenditures for the coming year;

(2) may use more current information regarding major changes in revenues if the change is known early enough to allow counties time to adjust their budgets;

(3) shall allocate each county's revenues proportionally across applicable expenditures; and

(4) may adjust a county's base if the county's population is substantially declining and the county's per capita mental health expenditures are substantially higher than the state average, and the commissioner has determined that mental health services in that county would not be negatively impacted.

Subd. 2. **Failure to maintain expenditures.** (a) If a county does not comply with subdivision 1, the commissioner shall require the county to develop a corrective action plan according to a format and timeline established by the commissioner. If the commissioner determines that a county has not developed an acceptable corrective action plan within the required timeline, or that the county is not in compliance with an approved corrective action plan, the protections provided to that county under section 245.485 do not apply.

(b) The commissioner shall consider the following factors to determine whether to approve a county's corrective action plan:

(1) the degree to which a county is maximizing revenues for mental health services from noncounty sources;

(2) the degree to which a county is expanding use of alternative services that meet mental health needs, but do not count as mental health services within existing reporting systems. If approved by the commissioner, the alternative services must be included in the county's base as well as subsequent years. The commissioner's approval for alternative services must be based on the following criteria:

(i) the service must be provided to children or adults with mental illness;

(ii) the services must be based on an individual treatment plan or individual community support plan as defined in the Comprehensive Mental Health Act; and

(iii) the services must be supervised by a mental health professional and provided by staff who meet the staff qualifications defined in sections 245I.22, subdivision 5, and 245I.30, subdivision 4.

(c) Additional county expenditures to make up for the prior year's underspending may be spread out over a two-year period.

[See Note.]

History: *2006 c 282 art 16 s 4; 2007 c 147 art 8 s 38; 2009 c 167 s 2,3; 2012 c 187 art 1 s 35; 2017 c 40 art 1 s 48; 2022 c 98 art 17 s 26; 2023 c 50 art 1 s 6; 2025 c 38 art 8 s 11; 2026 c 121 art 8 s 3*

NOTE: The amendment to subdivision 2 by Laws 2026, chapter 121, article 8, section 3, is effective January 1, 2028. Laws 2026, chapter 121, article 8, section 17.

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 245.4889. 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: *1987 c 403 art 2 s 38; 1989 c 282 art 4 s 33; 1991 c 292 art 6 s 10,58 subd 1; 1992 c 571 art 10 s 10; 1Sp1993 c 1 art 7 s 7; 1Sp2003 c 14 art 11 s 11; 2007 c 147 art 8 s 38*

245.485 WHERE A CLAIM MUST BE BROUGHT.

Sections 245.461 to 245.484 and 245.487 to 245.4889 do not independently establish a right of action on behalf of recipients of services or service providers against a county board or the commissioner. A claim for monetary damages must be brought under section 3.736 or 3.751.

History: *1987 c 403 art 2 s 39; 1989 c 282 art 4 s 34; 1991 c 292 art 6 s 58 subd 1; 1Sp2003 c 14 art 11 s 11; 2007 c 147 art 8 s 38*

245.486 LIMITED APPROPRIATIONS.

Nothing in sections 245.461 to 245.485 and 245.487 to 245.4889 shall be construed to require the commissioner or county boards to fund services beyond the limits of legislative appropriations.

History: *1987 c 403 art 2 s 40; 1989 c 282 art 4 s 35; 1991 c 292 art 6 s 58 subd 1; 1Sp2003 c 14 art 11 s 11; 2007 c 147 art 8 s 38*

245.4861 MS 2012 [Repealed, 2014 c 262 art 3 s 18]

245.4862 MS 2024 [Repealed, 2025 c 38 art 3 s 87]

245.4863 INTEGRATED CO-OCCURRING DISORDER TREATMENT.

(a) The commissioner shall require individuals who perform substance use disorder assessments to screen clients for co-occurring mental health disorders, and staff who perform mental health diagnostic assessments to screen for co-occurring substance use disorders. Screening tools must be approved by the commissioner. If a client screens positive for a co-occurring mental health or substance use disorder, the individual performing the screening must document what actions will be taken in response to the results and whether further assessments must be performed.

(b) Notwithstanding paragraph (a), screening is not required when:

(1) the presence of co-occurring disorders was documented for the client in the past 12 months;

(2) the client is currently receiving co-occurring disorders treatment;

(3) the client is being referred for co-occurring disorders treatment; or

(4) a mental health professional who is competent to perform diagnostic assessments of co-occurring disorders is performing a diagnostic assessment to identify whether the client may have co-occurring mental health and substance use disorders. If an individual is identified to have co-occurring mental health and substance use disorders, the assessing mental health professional must document what actions will be taken to address the client's co-occurring disorders.

(c) The commissioner shall adopt rules as necessary to implement this section. The commissioner shall ensure that the rules are effective on July 1, 2013, thereby establishing a certification process for integrated dual disorder treatment providers and a system through which individuals receive integrated dual diagnosis treatment if assessed as having both a substance use disorder and a serious mental illness.

(d) The commissioner shall apply for any federal waivers necessary to secure, to the extent allowed by law, federal financial participation for the provision of integrated dual diagnosis treatment to persons with co-occurring disorders.

History: *1Sp2011 c 9 art 8 s 9; 2016 c 106 s 1; 2021 c 30 art 17 s 28; 2022 c 98 art 4 s 51; 2025 c 38 art 8 s 12*

CHILDREN'S MENTAL HEALTH ACT

245.487 CITATION; DECLARATION OF POLICY; MISSION.

Subdivision 1. **Citation.** Sections 245.487 to 245.4889 may be cited as the "Minnesota Comprehensive Children's Mental Health Act."

Subd. 2. **Findings.** The legislature finds there is a need for further development of existing clinical services for children with mental illness and their families and the creation of new services for this population. Although the services specified in sections 245.487 to 245.4889 are mental health services, sections 245.487 to 245.4889 emphasize the need for a child-oriented and family-oriented approach of therapeutic programming and the need for continuity of care with other community agencies. At the same time, sections 245.487 to 245.4889 emphasize the importance of developing special mental health expertise in children's mental health services because of the unique needs of this population.

Nothing in sections 245.487 to 245.4889 shall be construed to abridge the authority of the court to make dispositions under chapter 260, but the mental health services due any child with serious and persistent mental illness, as defined in section 245.462, subdivision 20, or with a serious mental illness, as defined in section 245.4871, subdivision 6, shall be made a part of any disposition affecting that child.

Subd. 3. **Mission of children's mental health service system.** As part of the comprehensive children's mental health system established under sections 245.487 to 245.4889, the commissioner of human services shall create and ensure a unified, accountable, comprehensive children's mental health service system that is consistent with the provision of public social services for children and that:

(1) identifies children who are eligible for mental health services;

(2) makes preventive services available to all children;

(3) assures access to a continuum of services that:

(i) educate the community about the mental health needs of children;

(ii) address the unique physical, emotional, social, and educational needs of children;

(iii) are coordinated with the range of social and human services provided to children and their families by the Departments of Education, Human Services, Health, and Corrections;

(iv) are appropriate to the developmental needs of children; and

(v) are sensitive to cultural differences and special needs;

(4) includes early screening and prompt intervention to:

(i) identify and treat the mental health needs of children in the least restrictive setting appropriate to their needs; and

(ii) prevent further deterioration;

(5) provides mental health services to children and their families in the context in which the children live and go to school;

(6) addresses the unique problems of paying for mental health services for children, including:

(i) access to private insurance coverage; and

(ii) public funding;

(7) includes the child and the child's family in planning the child's program of mental health services, unless clinically inappropriate to the child's needs; and

(8) when necessary, assures a smooth transition from mental health services appropriate for a child to mental health services needed by a person who is at least 18 years of age.

Subd. 4. MS 2012 [Repealed, 2014 c 262 art 3 s 18]

Subd. 5. MS 2012 [Repealed, 2014 c 262 art 3 s 18]

Subd. 6. **Funding from the federal government and other sources.** The commissioner shall seek and apply for federal and other nonstate, nonlocal government funding for mental health services specified in sections 245.487 to 245.4889, in order to maximize nonstate, nonlocal dollars for these services.

Subd. 7. **Diagnostic codes list.** By July 1, 2013, the commissioner of human services shall develop a list of diagnostic codes to define the range of child and adult mental illnesses for the statewide mental health system. The commissioner may use the International Classification of Diseases (ICD); the American Psychiatric Association's Diagnostic and Statistical Manual (DSM); or a combination of both to develop the list. The commissioner shall establish an advisory committee, comprising mental health professional associations, counties, Tribes, managed care organizations, state agencies, and consumer organizations that shall advise the commissioner regarding development of the diagnostic codes list. The commissioner shall annually notify providers of changes to the list.

History: *1989 c 282 art 4 s 37; 1990 c 568 art 5 s 9,10; 1991 c 199 art 2 s 1; 1991 c 292 art 6 s 11,12,58 subd 1; 1Sp1995 c 3 art 16 s 13; 2003 c 130 s 12; 1Sp2003 c 14 art 11 s 11; 2007 c 147 art 8 s 38; 2012 c 216 art 12 s 3; 2025 c 38 art 8 s 13*

245.4871 DEFINITIONS.

Subdivision 1. **Definitions.** The definitions in this section apply to sections 245.487 to 245.4889.

Subd. 2. **Acute care hospital inpatient treatment.** "Acute care hospital inpatient treatment" means short-term medical, nursing, and psychosocial services provided in an acute care hospital licensed under chapter 144.

Subd. 3. **Case management services.** "Case management services" means activities that are coordinated with the family community support services and are designed to help the child with serious mental illness and the child's family obtain needed mental health services, social services, educational services, health services, vocational services, recreational services, and related services in the areas of volunteer services, advocacy, transportation, and legal services. Case management services include assisting in obtaining a comprehensive diagnostic assessment, developing an individual family community support plan, and assisting the child and the child's family in obtaining needed services by coordination with other agencies and assuring continuity of care. Case managers must assess and reassess the delivery, appropriateness, and effectiveness of services over time.

Subd. 4. **Case management service provider.** (a) "Case management service provider" means a case manager or case manager associate 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 serious mental illness and the child's family.

(b) A case manager must:

(1) have experience and training in working with children;

(2) be a mental health practitioner under section 245I.04, subdivision 4, or have at least a bachelor's degree in one of the behavioral sciences or a related field including, but not limited to, social work, psychology, or nursing from an accredited college or university or meet the requirements of paragraph (d);

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

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

(5) meet the supervision and continuing education requirements of paragraphs (e), (f), and (g), as applicable.

(c) A 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) A case manager who is not a mental health practitioner and does not have a bachelor's degree or who has a bachelor's degree that is not in one of the behavioral sciences or related fields must meet one of the requirements in clauses (1) to (5):

(1) have three or four years of experience as a case manager associate;

(2) be a registered nurse without a bachelor's degree who has a combination of specialized training in psychiatry and work experience consisting of community interaction and involvement or community discharge planning in a mental health setting totaling three years;

(3) be a person who qualified as a case manager under the 1998 Department of Human Services waiver provision and meets the continuing education, supervision, and mentoring requirements in this section;

(4) prior to direct service delivery, complete at least 80 hours of specific training on the characteristics and needs of children with serious mental illness that is consistent with national practices standards; or

(5) prior to direct service delivery, demonstrate competency in practice and knowledge of the characteristics and needs of children with serious mental illness, consistent with national practices standards.

(e) A case manager with at least 2,000 hours of supervised experience in the delivery of mental health services to children must receive regular ongoing supervision and clinical supervision totaling 38 hours per year, of which at least one hour per month must be clinical supervision regarding individual service delivery with a case management supervisor. The other 26 hours of supervision may be provided by a case manager with two years of experience. Group supervision may not constitute more than one-half of the required supervision hours.

(f) A case manager without 2,000 hours of supervised experience in the delivery of mental health services to children with mental illness 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 serious mental illness before beginning to provide case management services; and

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

(g) A case manager who is not licensed, registered, or certified by a health-related licensing board must receive 30 hours of continuing education and training in serious mental illness and mental health services every two years.

(h) 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.

(i) 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.

(j) A case manager associate (CMA) must:

(1) work under the direction of a case manager or case management supervisor;

(2) be at least 21 years of age;

(3) have at least a high school diploma or its equivalent; and

(4) meet one of the following criteria:

(i) have an associate of arts degree in one of the behavioral sciences or human services;

(ii) be a registered nurse without a bachelor's degree;

(iii) have three years of life experience as a primary caregiver to a child with serious mental illness as defined in subdivision 6 within the previous ten years;

(iv) have 6,000 hours work experience as a nondegreed state hospital technician; or

(v) have 6,000 hours of supervised work experience in the delivery of mental health services to children with mental illness; hours worked as a mental health behavioral aide I or II under section 245I.30, subdivision 4, may count toward the 6,000 hours of supervised work experience.

Individuals meeting one of the criteria in items (i) to (iv) may qualify as a case manager after four years of supervised work experience as a case manager associate. Individuals meeting the criteria in item (v) may qualify as a case manager after three years of supervised experience as a case manager associate.

(k) Case manager associates must meet the following supervision, mentoring, and continuing education requirements:

(1) have 40 hours of preservice training described under paragraph (f), clause (1);

(2) receive at least 40 hours of continuing education in serious mental illness and mental health service annually; and

(3) receive at least five hours of mentoring per week from a case management mentor. A "case management mentor" means a qualified, practicing case manager or case management supervisor who teaches or advises and provides intensive training and clinical supervision to one or more case manager associates. Mentoring may occur while providing direct services to consumers in the office or in the field and may be provided to individuals or groups of case manager associates. At least two mentoring hours per week must be individual and face-to-face.

(l) A case management supervisor must meet the criteria for a mental health professional as specified in subdivision 27.

(m) An immigrant who does not have the qualifications specified in this subdivision may provide case management services to child immigrants with serious mental illness of the same ethnic group as the immigrant if the person:

(1) is currently enrolled in and 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.

[See Note.]

Subd. 5. **Child.** "Child" means a person under 18 years of age, or a person 18 years of age or older and under 21 years of age receiving continuous children's mental health targeted case management services under section 245.4881.

Subd. 6. **Child with serious mental illness.** For purposes of eligibility for case management and family community support services, "child with serious mental illness" means a child who has a mental illness and who meets one of the following criteria:

(1) the child has been admitted within the last three years or is at risk of being admitted to inpatient treatment or residential treatment for a mental illness; or

(2) the child is a Minnesota resident and is receiving inpatient treatment or residential treatment for a mental illness through the interstate compact; or

(3) the child has one of the following as determined by a mental health professional:

(i) psychosis or a clinical depression; or

(ii) risk of harming self or others as a result of a mental illness; or

(iii) psychopathological symptoms as a result of being a victim of physical or sexual abuse or of psychic trauma within the past year; or

(4) the child, as a result of a mental illness, has significantly impaired home, school, or community functioning that has lasted at least one year or that, in the written opinion of a mental health professional, presents substantial risk of lasting at least one year.

Subd. 7. MS 2012 [Repealed, 2014 c 262 art 3 s 18]

Subd. 7a. **Clinical supervision.** "Clinical supervision" means the oversight responsibility for individual treatment plans and individual mental health service delivery, including oversight provided by the case manager. Clinical supervision must be provided by a mental health professional. The supervising mental health professional must cosign an individual treatment plan and the mental health professional's name must be documented in the client's record.

Subd. 8. **Commissioner.** "Commissioner" means the commissioner of human services.

Subd. 9. **County board.** "County board" means the county board of commissioners or board established under the Joint Powers Act, section 471.59, or the Human Services Act, sections 402.01 to 402.10.

Subd. 9a. **Crisis planning.** "Crisis planning" means the development of a written plan to assist a child and the child's family in preventing and addressing a potential crisis and is distinct from mobile crisis services defined in section 256B.0624. The plan must address prevention, de-escalation, and intervention strategies to be used in a crisis. The plan identifies factors that might precipitate a crisis, behaviors or symptoms related to the emergence of a crisis, and the resources available to resolve a crisis. The plan must address the following potential needs: (1) acute care; (2) crisis placement; (3) community resources for follow-up; and (4) emotional support to the family during crisis. When appropriate for the child's needs, the plan must include strategies to reduce the child's risk of suicide and self-injurious behavior. Crisis planning does not include services designed to secure the safety of a child who is at risk of abuse or neglect or necessary emergency services.

Subd. 10. **Day treatment services.** "Day treatment," "day treatment services," or "day treatment program" means a structured program of treatment and care provided to a child in:

(1) an outpatient hospital accredited by the Joint Commission on Accreditation of Health Organizations and licensed under sections 144.50 to 144.55;

(2) a community mental health center under section 245.62;

(3) an entity that is under contract with the county board to operate a program that meets the requirements of section 245.4884, subdivision 2, and Minnesota Rules, parts 9505.0170 to 9505.0475;

(4) an entity that operates a program that meets the requirements of section 245.4884, subdivision 2, and Minnesota Rules, parts 9505.0170 to 9505.0475, that is under contract with an entity that is under contract with a county board; or

(5) a program certified under section 256B.0943.

Day treatment consists of group psychotherapy and other intensive therapeutic services that are provided for a minimum two-hour time block by a multidisciplinary staff under the treatment supervision of a mental health professional. Day treatment may include education and consultation provided to families and other individuals as an extension of the treatment process. The services are aimed at stabilizing the child's mental health status, and developing and improving the child's daily independent living and socialization skills. Day treatment services are distinguished from day care by their structured therapeutic program of psychotherapy services. Day treatment services are not a part of inpatient hospital or residential treatment services.

A day treatment service must be available to a child up to 15 hours a week throughout the year and must be coordinated with, integrated with, or part of an education program offered by the child's school.

Subd. 11. MS 2012 [Repealed, 2014 c 262 art 3 s 18]

Subd. 11a. **Diagnostic assessment.** "Diagnostic assessment" has the meaning given in section 245I.10, subdivisions 4 to 6.

Subd. 12. **Mental health identification and intervention services.** "Mental health identification and intervention services" means services that are designed to identify children who are at risk of needing or who need mental health services and that arrange for intervention and treatment.

Subd. 13. **Education and prevention services.** (a) "Education and prevention services" means services designed to:

(1) educate the general public;

(2) increase the understanding and acceptance of problems associated with children's mental illnesses;

(3) improve people's skills in dealing with high-risk situations known to affect children's mental health and functioning; and

(4) refer specific children or their families with mental health needs to mental health services.

(b) The services include distribution to individuals and agencies identified by the county board and the local children's mental health advisory council of information on predictors and symptoms of mental illnesses, where mental health services are available in the county, and how to access the services.

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

Subd. 15. **Mental illness.** "Mental illness" means an organic disorder of the brain or a clinically significant disorder of thought, mood, perception, orientation, memory, or behavior that:

(1) is detailed in a diagnostic codes list published by the commissioner; and

(2) seriously limits a child's capacity to function in primary aspects of daily living such as personal relations, living arrangements, work, school, and recreation.

Mental illness is a generic term and is intended to reflect all categories of disorder described in the clinical code list published by the commissioner as "usually first evident in childhood or adolescence."

Subd. 16. **Family.** "Family" means a child and one or more of the following persons whose participation is necessary to accomplish the child's treatment goals: (1) a person related to the child by blood, marriage, or adoption; (2) a person who is the child's foster parent or significant other; (3) a person who is the child's legal representative.

Subd. 17. **Family community support services.** "Family community support services" means services provided under the treatment supervision of a mental health professional and designed to help each child with serious mental illness to function and remain with the child's family in the community. Family community support services do not include acute care hospital inpatient treatment, residential treatment services, or regional treatment center services. Family community support services include:

(1) client outreach to each child with serious mental illness and the child's family;

(2) medication monitoring where necessary;

(3) assistance in developing independent living skills;

(4) assistance in developing parenting skills necessary to address the needs of the child with serious mental illness;

(5) assistance with leisure and recreational activities;

(6) crisis planning, including crisis placement and respite care;

(7) professional home-based family treatment;

(8) foster care with therapeutic supports;

(9) day treatment;

(10) assistance in locating respite care and special needs day care; and

(11) assistance in obtaining potential financial resources, including those benefits listed in section 245.4884, subdivision 5.

Subd. 18. MS 2012 [Repealed, 2014 c 262 art 3 s 18]

Subd. 18a. **Functional assessment.** "Functional assessment" means an assessment by the case manager of the child's:

(1) mental health symptoms as presented in the child's diagnostic assessment;

(2) mental health needs as presented in the child's diagnostic assessment;

(3) use of drugs and alcohol;

(4) vocational and educational functioning;

(5) social functioning, including the use of leisure time;

(6) interpersonal functioning, including relationships with the child's family;

(7) self-care and independent living capacity;

(8) medical and dental health;

(9) financial assistance needs;

(10) housing and transportation needs; and

(11) other needs and problems.

Subd. 19. **Individual family community support plan.** "Individual family community support plan" means a written plan developed by a case manager in conjunction with the family and the child with serious mental illness on the basis of a diagnostic assessment and a functional assessment. The plan identifies specific services needed by a child and the child's family to:

(1) treat the symptoms and dysfunctions determined in the diagnostic assessment;

(2) relieve conditions leading to mental illness and improve the personal well-being of the child;

(3) improve family functioning;

(4) enhance daily living skills;

(5) improve functioning in education and recreation settings;

(6) improve interpersonal and family relationships;

(7) enhance vocational development; and

(8) assist in obtaining transportation, housing, health services, and employment.

Subd. 20. **Individual placement agreement.** "Individual placement agreement" means a written agreement or supplement to a service contract entered into between the county board and a service provider on behalf of a child to provide residential treatment services.

Subd. 21. **Individual treatment plan.** (a) "Individual treatment plan" means the formulation of planned services that are responsive to the needs and goals of a client. An individual treatment plan must be completed according to section 245I.10, subdivisions 7 and 8.

(b) A children's residential facility licensed under Minnesota Rules, chapter 2960, is exempt from the requirements of section 245I.10, subdivisions 7 and 8. Instead, the individual treatment plan must:

(1) include a written plan of intervention, treatment, and services for a child with a mental illness that the service provider develops under the clinical supervision of a mental health professional on the basis of a diagnostic assessment;

(2) be developed in conjunction with the family unless clinically inappropriate; and

(3) identify goals and objectives of treatment, treatment strategy, a schedule for accomplishing treatment goals and objectives, and the individuals responsible for providing treatment to the child with a mental illness.

Subd. 22. **Legal representative.** "Legal representative" means a guardian, conservator, or guardian ad litem of a child with a mental illness authorized by the court to make decisions about mental health services for the child.

Subd. 23. MS 1990 [Repealed, 1991 c 94 s 25]

Subd. 24. **Local system of care.** "Local system of care" means services that are locally available to the child and the child's family. The services are mental health, social services, correctional services, education services, health services, and vocational services.

Subd. 24a. **Mental health crisis services.** "Mental health crisis services" means crisis assessment, crisis intervention, and crisis stabilization services.

Subd. 25. MS 2012 [Repealed, 2014 c 262 art 3 s 18]

Subd. 26. **Mental health practitioner.** "Mental health practitioner" means a staff person who is qualified according to section 245I.04, subdivision 4.

Subd. 27. **Mental health professional.** "Mental health professional" means a staff person who is qualified according to section 245I.04, subdivision 2.

Subd. 28. **Mental health services.** "Mental health services" means at least all of the treatment services and case management activities that are provided to children with mental illnesses and are described in sections 245.487 to 245.4889.

Subd. 29. **Outpatient services.** "Outpatient services" means mental health services, excluding day treatment and community support services programs, provided by or under the treatment supervision of a mental health professional to children with mental illnesses who live outside a hospital. Outpatient services include clinical activities such as individual, group, and family therapy; individual treatment planning; diagnostic assessments; medication management; and psychological testing.

Subd. 30. **Parent.** "Parent" means the birth or adoptive mother or father of a child. This definition does not apply to a person whose parental rights have been terminated in relation to the child.

Subd. 31. **Professional home-based family treatment.** (a) "Professional home-based family treatment" means intensive mental health services provided to children because of mental illness: (1) who are at risk

of residential treatment or therapeutic foster care; (2) who are in residential treatment or therapeutic foster care; or (3) who are returning from residential treatment or therapeutic foster care.

(b) Services are provided to the child and the child's family primarily in the child's home environment. Services may also be provided in the child's school, child care setting, or other community setting appropriate to the child. Services must be provided on an individual family basis, must be child-oriented and family-oriented, and must be designed using information from diagnostic and functional assessments to meet the specific mental health needs of the child and the child's family. Services must be coordinated with other services provided to the child and the child's family.

(c) Examples of services are: (1) individual therapy; (2) family therapy; (3) client outreach; (4) assistance in developing individual living skills; (5) assistance in developing parenting skills necessary to address the needs of the child; (6) assistance with leisure and recreational services; (7) crisis planning, including crisis respite care and arranging for crisis placement; and (8) assistance in locating respite and child care. Services must be coordinated with other services provided to the child and family.

Subd. 32. **Residential treatment.** "Residential treatment" means a 24-hour-a-day program under the treatment supervision of a mental health professional, in a community residential setting other than an acute care hospital or regional treatment center inpatient unit, that must be licensed as a residential treatment program for children with mental illnesses under Minnesota Rules, parts 2960.0580 to 2960.0700, or other rules adopted by the commissioner.

Subd. 32a. MS 2020 [Repealed, 1Sp2021 c 7 art 11 s 49]

Subd. 33. **Service provider.** "Service provider" means either a county board or an entity under contract with the county board that provides children's mental health services funded under sections 245.487 to 245.4889. A contracting entity may be an individual, organization, or agency, including a regional treatment center.

Subd. 33a. **Culturally informed mental health consultant.** "Culturally informed mental health consultant" is a person who is recognized by the culture as one who has knowledge of a particular culture and its definition of health and mental health; and who is used as necessary to assist the county board and its mental health providers in assessing and providing appropriate mental health services for children from that particular cultural, linguistic, or racial heritage and their families.

Subd. 34. **Therapeutic support of foster care.** "Therapeutic support of foster care" means the mental health training and mental health support services and treatment supervision provided by a mental health professional to foster families caring for children with serious mental illnesses to provide a therapeutic family environment and support for the child's improved functioning. Therapeutic support of foster care includes services provided under section 256B.0946.

Subd. 35. **Transition services.** "Transition services" means mental health services, designed within an outcome oriented process that promotes movement from school to postschool activities, including postsecondary education, vocational training, integrated employment including supported employment, continuing and adult education, adult mental health and social services, other adult services, independent living, or community participation.

Subd. 36. **Treatment supervision.** "Treatment supervision" means the treatment supervision described by section 245I.06.

History: *1989 c 282 art 4 s 38; 1990 c 568 art 5 s 11,34; 1991 c 292 art 6 s 13-15,58 subd 1; 1992 c 526 s 2; 1992 c 571 art 10 s 11; 1993 c 339 s 3; 1Sp1993 c 1 art 7 s 8; 1995 c 207 art 8 s 2-4; 1996 c 451*

art 5 s 5; 1998 c 407 art 4 s 4; 1999 c 86 art 1 s 57; 1999 c 159 s 30; 1999 c 172 s 16; 1999 c 245 art 5 s 6,7; 2000 c 474 s 4; 2000 c 499 s 33; 1Sp2001 c 9 art 9 s 10-12; 2002 c 375 art 2 s 6; 2002 c 379 art 1 s 113; 1Sp2003 c 14 art 11 s 11; 2005 c 147 art 1 s 66; 2007 c 147 art 8 s 38; 2009 c 79 art 7 s 3; 2009 c 142 art 2 s 11; 2009 c 167 s 4; 2012 c 216 art 12 s 4; 2013 c 108 art 4 s 5; 2014 c 262 art 3 s 1,2; 2015 c 21 art 1 s 39; 2016 c 158 art 1 s 85; 2016 c 163 art 2 s 2; 2017 c 79 s 2; 1Sp2017 c 6 art 8 s 4,5; 2018 c 128 s 3,4; 1Sp2020 c 2 art 5 s 1; 2021 c 30 art 17 s 29-40; 2022 c 98 art 4 s 6; art 17 s 26; 2023 c 50 art 1 s 7,8; 2024 c 79 art 8 s 10; 2025 c 38 art 4 s 10-12; art 8 s 14-26; 1Sp2025 c 3 art 15 s 4; 2026 c 121 art 8 s 4

NOTE: The amendment to subdivision 4 by Laws 2026, chapter 121, article 8, section 4, is effective January 1, 2028. Laws 2026, chapter 121, article 8, section 17.

245.4872 MS 2012 [Repealed, 2014 c 262 art 3 s 18]

245.4873 COORDINATION OF CHILDREN'S MENTAL HEALTH SYSTEM.

Subdivision 1. **State and local coordination.** Coordination of the development and delivery of mental health services for children shall occur on the state and local levels to assure the availability of services to meet the mental health needs of children in a cost-effective manner.

Subd. 2. **State level; coordination.** The Children's Cabinet, under section 4.045, in consultation with a representative of the Minnesota District Judges Association Juvenile Committee, shall:

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

(2) develop mechanisms for interagency coordination on behalf of children with mental illnesses;

(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; and

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

Subd. 3. MS 2012 [Repealed, 2014 c 262 art 3 s 18]

Subd. 4. **Individual case coordination.** The case manager designated under section 245.4881 is responsible for ongoing coordination with any other person responsible for planning, development, and delivery of social services, education, corrections, health, or vocational services for the individual child. The individual family community support plan developed by the case manager shall reflect the coordination among the local service system providers.

Subd. 5. **Duties of the commissioner.** The commissioner shall supervise the development and coordination of locally available children's mental health services by the county boards in a manner consistent with sections 245.487 to 245.4889. The commissioner shall provide technical assistance to county boards in developing and maintaining locally available and coordinated children's 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 children's mental health proposals and other information as required by sections 245.487 to 245.4889.

Subd. 6. MS 2012 [Repealed, 2014 c 262 art 3 s 18]

History: *1989 c 282 art 4 s 40; 1990 c 568 art 5 s 12; 1991 c 94 s 24; 1991 c 292 art 6 s 16,58 subd 1; 1Sp1993 c 1 art 7 s 9; 1995 c 207 art 8 s 5; art 11 s 2; 1Sp2003 c 14 art 11 s 11; 2005 c 98 art 3 s 10; 2007 c 147 art 8 s 38; 2014 c 262 art 3 s 3; 2022 c 98 art 17 s 26; 2023 c 50 art 1 s 9; 2025 c 38 art 8 s 27*

245.4874 DUTIES OF COUNTY BOARD.

Subdivision 1. **Duties of county board.** (a) The county board must:

(1) develop a system of affordable and locally available children's mental health services according to sections 245.487 to 245.4889;

(2) consider the assessment of unmet needs in the county as reported by the local children's mental health advisory council under section 245.4875, subdivision 5, paragraph (b), clause (3). The county shall provide, upon request of the local children's mental health advisory council, readily available data to assist in the determination of unmet needs;

(3) assure that parents and providers in the county receive information about how to gain access to services provided according to sections 245.487 to 245.4889;

(4) coordinate the delivery of children's mental health services with services provided by social services, education, corrections, health, and vocational agencies to improve the availability of mental health services to children and the cost-effectiveness of their delivery;

(5) assure that mental health services delivered according to sections 245.487 to 245.4889 are delivered expeditiously and are appropriate to the child's diagnostic assessment and individual treatment plan;

(6) provide for case management services to each child with serious mental illness according to sections 245.486; 245.4871, subdivisions 3 and 4; and 245.4881, subdivisions 1, 3, and 5;

(7) provide for screening of each child under section 245.4885 upon admission to a residential treatment facility;

(8) prudently administer grants and purchase-of-service contracts that the county board determines are necessary to fulfill its responsibilities under sections 245.487 to 245.4889;

(9) assure that mental health professionals, mental health practitioners, and case managers employed by or under contract to the county to provide mental health services are qualified under section 245.4871;

(10) assure that children's mental health services are coordinated with adult mental health services specified in sections 245.461 to 245.486 so that a continuum of mental health services is available to serve persons with mental illness, regardless of the person's age;

(11) assure that culturally competent mental health consultants are used as necessary to assist the county board in assessing and providing appropriate treatment for children of cultural or racial minority heritage; and

(12) consistent with section 245.486, arrange for or provide a children's mental health screening for:

(i) a child receiving child protective services;

(ii) a child in residential treatment or therapeutic foster care;

(iii) a child for whom parental rights have been terminated;

(iv) a child found to be delinquent; or

(v) a child found to have committed a juvenile petty offense for the third or subsequent time.

A children's mental health screening is not required when a screening or diagnostic assessment has been performed within the previous 180 days, or the child is currently under the care of a mental health professional.

(b) When a child is receiving protective services or is in residential treatment or foster care, the court or county agency must notify a parent or guardian whose parental rights have not been terminated of the potential mental health screening and the option to prevent the screening by notifying the court or county agency in writing.

(c) When a child is found to be delinquent or a child is found to have committed a juvenile petty offense for the third or subsequent time, the court or county agency must obtain written informed consent from the parent or legal guardian before a screening is conducted unless the court, notwithstanding the parent's failure to consent, determines that the screening is in the child's best interest.

(d) The screening shall be conducted with a screening instrument approved by the commissioner of human services according to criteria that are updated and issued annually to ensure that approved screening instruments are valid and useful for child welfare and juvenile justice populations. Screenings shall be conducted by a mental health practitioner as defined in section 245.4871, subdivision 26, or a probation officer or local social services agency staff person who is trained in the use of the screening instrument. Training in the use of the instrument shall include:

(1) training in the administration of the instrument;

(2) the interpretation of its validity given the child's current circumstances;

(3) the state and federal data practices laws and confidentiality standards;

(4) the parental consent requirement; and

(5) providing respect for families and cultural values.

If the screen indicates a need for assessment, the child's family, or if the family lacks mental health insurance, the local social services agency, in consultation with the child's family, shall have conducted a diagnostic assessment, including a functional assessment. The administration of the screening shall safeguard the privacy of children receiving the screening and their families and shall comply with the Minnesota Government Data Practices Act, chapter 13, and the federal Health Insurance Portability and Accountability Act of 1996, Public Law 104-191. Screening results are classified as private data on individuals, as defined by section 13.02, subdivision 12. The county board or Tribal Nation may provide the commissioner with access to the screening results for the purposes of program evaluation and improvement.

(e) When the county board refers clients to providers of children's therapeutic services and supports under section 256B.0943, the county board must clearly identify the desired services components not covered under section 256B.0943 and identify the reimbursement source for those requested services, the method of payment, and the payment rate to the provider.

Subd. 2. **Responsibility not duplicated.** For individuals who have health care coverage, the county board is not responsible for providing mental health services which are within the limits of the individual's health care coverage.

History: *1989 c 282 art 4 s 41; 1990 c 568 art 5 s 13; 1991 c 94 s 6; 1991 c 292 art 6 s 17,58 subd 1; 1995 c 207 art 8 s 6; 1Sp2003 c 14 art 4 s 2; art 11 s 11; 2004 c 288 art 3 s 9; 2005 c 98 art 3 s 11; 1Sp2005 c 4 art 2 s 3; 2007 c 147 art 8 s 7,38; art 11 s 8; 2011 c 86 s 3; 2014 c 262 art 3 s 4; 2015 c 21 art 1 s 40; 2021 c 30 art 13 s 1; 2025 c 38 art 4 s 13*

245.4875 LOCAL SERVICE DELIVERY SYSTEM.

Subdivision 1. **Development of children's 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 children's mental health services. The county board may provide some or all of the children's 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 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.

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

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

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

(3) emergency services according to section 245.4879;

(4) outpatient services according to section 245.488;

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

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

(7) residential treatment services according to section 245.4882;

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

(9) screening according to section 245.4885;

(10) case management according to section 245.4881;

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

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

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

Subd. 3. MS 2012 [Repealed, 2014 c 262 art 3 s 18]

Subd. 4. **Joint county mental health agreements.** To efficiently provide the children's mental health services required by sections 245.487 to 245.4889, counties are encouraged to join with one or more county boards to establish a multicounty local children's mental health authority under the Joint Powers Act, section 471.59, the Human Services Act, sections 402.01 to 402.10, community mental health center provisions,

section 245.62, or enter into multicounty mental health agreements. Participating county boards shall establish acceptable ways of apportioning the cost of the services.

Subd. 5. **Local children's advisory council.** (a) By October 1, 1989, the county board, individually or in conjunction with other county boards, shall establish a local children's mental health advisory council or children's mental health subcommittee of the existing local mental health advisory council or shall include persons on its existing mental health advisory council who are representatives of children's mental health interests. The following individuals must serve on the local children's mental health advisory council, the children's mental health subcommittee of an existing local mental health advisory council, or be included on an existing mental health advisory council: (1) at least one person who was in a mental health program as a child or adolescent; (2) at least one parent of a child or adolescent with serious mental illness; (3) one children's mental health professional; (4) representatives of minority populations of significant size residing in the county; (5) a representative of the children's mental health local coordinating council; and (6) one family community support services program representative.

(b) The local children's mental health advisory council or children's mental health subcommittee of an existing advisory council shall seek input from parents, former consumers, providers, and others about the needs of children with mental illness in the local area and services needed by families of these children, and shall meet monthly, unless otherwise determined by the council or subcommittee, but not less than quarterly, to review, evaluate, and make recommendations regarding the local children's mental health system. Annually, the local children's mental health advisory council or children's mental health subcommittee of the existing local mental health advisory council shall:

(1) arrange for input from the local system of care providers regarding coordination of care between the services;

(2) identify for the county board the individuals, providers, agencies, and associations as specified in section 245.4877, clause (2); and

(3) provide to the county board a report of unmet mental health needs of children residing in the county.

(c) The county board shall consider the advice of its local children's mental health advisory council or children's mental health subcommittee of the existing local mental health advisory council in carrying out its authorities and responsibilities.

Subd. 6. MS 2012 [Repealed, 2014 c 262 art 3 s 18]

Subd. 7. MS 2012 [Repealed, 2014 c 262 art 3 s 18]

Subd. 8. **Transition services.** The county board may continue to provide mental health services as defined in sections 245.487 to 245.4889 to persons over 18 years of age, but under 21 years of age, if the person was receiving case management or family community support services prior to age 18, and if one of the following conditions is met:

(1) the person is receiving special education services through the local school district;

(2) it is in the best interest of the person to continue services defined in sections 245.487 to 245.4889; or

(3) the person is requesting services and the services are medically necessary.

History: *1989 c 282 art 4 s 42; 1990 c 568 art 5 s 14,34; 1991 c 94 s 7,24; 1991 c 292 art 6 s 58 subd 1; 1995 c 207 art 8 s 7,8; 1999 c 86 art 1 s 58; 1Sp2001 c 9 art 9 s 13; 2002 c 379 art 1 s 113; 1Sp2003 c*

14 art 11 s 11; 2005 c 10 art 1 s 43; 2005 c 98 art 3 s 12,13; 2007 c 147 art 8 s 38; 2013 c 108 art 4 s 6; 2025 c 38 art 8 s 28

245.4876 QUALITY OF SERVICES.

Subdivision 1. **Criteria.** Children's mental health services required by sections 245.487 to 245.4889 must be:

(1) based, when feasible, on research findings;

(2) based on individual clinical, cultural, and ethnic needs, and other special needs of the children being served;

(3) delivered in a manner that improves family functioning when clinically appropriate;

(4) provided in the most appropriate, least restrictive setting that meets the requirements in subdivision 1a, and that is available to the county board to meet the child's treatment needs;

(5) accessible to all age groups of children;

(6) appropriate to the developmental age of the child being served;

(7) delivered in a manner that provides accountability to the child for the quality of service delivered and continuity of services to the child during the years the child needs services from the local system of care;

(8) provided by qualified individuals as required in sections 245.487 to 245.4889;

(9) coordinated with children's mental health services offered by other providers;

(10) provided under conditions that protect the rights and dignity of the individuals being served; and

(11) provided in a manner and setting most likely to facilitate progress toward treatment goals.

Subd. 1a. **Appropriate setting to receive services.** A child must be provided with mental health services in the least restrictive setting that is appropriate to the needs and current condition of the individual child. For a child to receive mental health services in a residential treatment or acute care hospital inpatient setting, the family may not be required to demonstrate that services were first provided in a less restrictive setting and that the child failed to make progress toward or meet treatment goals in the less restrictive setting.

Subd. 2. **Diagnostic assessment.** A provider of services governed by this section must complete a diagnostic assessment of a client according to the standards of section 245I.10. Notwithstanding the required timelines for completing a diagnostic assessment in section 245I.10, a children's residential facility licensed under Minnesota Rules, chapter 2960, that provides mental health services to children must, within ten days of the client's admission: (1) complete the client's diagnostic assessment; or (2) review and update the client's diagnostic assessment with a summary of the child's current mental health status and service needs if a diagnostic assessment is available that was completed within 180 days preceding admission and the client's mental health status has not changed markedly since the diagnostic assessment.

Subd. 3. **Individual treatment plans.** A provider of services governed by this section must complete an individual treatment plan for a client according to the standards of section 245I.10, subdivisions 7 and 8. A children's residential facility licensed according to Minnesota Rules, chapter 2960, is exempt from the requirements in section 245I.10, subdivisions 7 and 8. Instead, the facility must involve the child and the

child's family in all phases of developing and implementing the individual treatment plan to the extent appropriate and must review the individual treatment plan every 90 days after intake.

Subd. 3a. MS 2021 Supp [Expired, 1Sp2021 c 7 art 11 s 2]

Subd. 4. **Referral for case management.** Each provider of emergency services, outpatient treatment, community support services, family community support services, day treatment services, screening under section 245.4885, professional home-based family treatment services, residential treatment facilities, acute care hospital inpatient treatment facilities, or regional treatment center services must inform each child with serious mental illness, and the child's parent or legal representative, of the availability and potential benefits to the child of case management. The information shall be provided as specified in subdivision 5. If consent is obtained according to subdivision 5, the provider must refer the child by notifying the county employee designated by the county board to coordinate case management activities of the child's name and address and by informing the child's family of whom to contact to request case management. The provider must document compliance with this subdivision in the child's record. The parent or child may directly request case management even if there has been no referral.

Subd. 5. **Consent for services or for release of information.** (a) Although sections 245.487 to 245.4889 require each county board, within the limits of available resources, to make the mental health services listed in those sections available to each child residing in the county who needs them, the county board shall not provide any services, either directly or by contract, unless consent to the services is obtained under this subdivision. The case manager assigned to a child with a serious mental illness shall not disclose to any person other than the case manager's immediate supervisor and the mental health professional providing clinical supervision of the case manager information on the child, the child's family, or services provided to the child or the child's family without informed written consent unless required to do so by statute or under the Minnesota Government Data Practices Act. Informed written consent must comply with section 13.05, subdivision 4, paragraph (d), and specify the purpose and use for which the case manager may disclose the information.

(b) The consent or authorization must be obtained from the child's parent unless: (1) the parental rights are terminated; or (2) consent is otherwise provided under sections 144.341 to 144.347; 253B.04, subdivision 1; 260C.148; 260C.151; and 260C.201, subdivision 1, the terms of appointment of a court-appointed guardian or conservator, or federal regulations governing substance use disorder services.

Subd. 6. **Information for billing.** Each provider of outpatient treatment, family community support services, day treatment services, emergency services, professional home-based family treatment services, residential treatment, or acute care hospital inpatient treatment must include the name and home address of each child for whom services are included on a bill submitted to a county, if the release of that information under subdivision 5 has been obtained and if the county requests the information. Each provider must try to obtain the consent of the child's family. Each provider must explain to the child's family that the information can only be released with the consent of the child's family and may be used only for purposes of payment and maintaining provider accountability. The provider shall document the attempt in the child's record.

Subd. 7. **Restricted access to data.** The county board shall establish procedures to ensure that the names and addresses of children receiving mental health services and their families are disclosed only to:

(1) county employees who are specifically responsible for determining county of financial responsibility or making payments to providers;

(2) staff who provide treatment services or case management and their clinical supervisors; and

(3) personnel of the welfare system or health care providers who have access to the data under section 13.46, subdivision 7.

Release of mental health data on individuals submitted under subdivisions 5 and 6, to persons other than those specified in this subdivision, or use of this data for purposes other than those stated in subdivisions 5 and 6, results in civil or criminal liability under section 13.08 or 13.09.

History: *1989 c 282 art 4 s 43; 1990 c 568 art 5 s 15-17; 1991 c 292 art 6 s 58 subd 1; 1999 c 139 art 4 s 2; 1Sp2001 c 9 art 9 s 14,15; 2002 c 379 art 1 s 113; 1Sp2003 c 14 art 11 s 11; 2007 c 147 art 8 s 38; 2012 c 216 art 6 s 13; 2015 c 71 art 2 s 13; 2016 c 158 art 2 s 49; 1Sp2017 c 6 art 8 s 6; 2021 c 30 art 17 s 41,42; 1Sp2021 c 7 art 11 s 2; 2022 c 98 art 4 s 7,8,51; 2025 c 38 art 8 s 29,30*

245.4877 EDUCATION AND PREVENTION SERVICES.

Education and prevention services must be available to all children residing in the county. Education and prevention services must be designed to:

(1) convey information regarding mental illnesses, mental health needs, and treatment resources to the general public;

(2) at least annually, distribute to individuals and agencies identified by the county board and the local children's mental health advisory council information on predictors and symptoms of mental illnesses, where mental health services are available in the county, and how to access the services;

(3) increase understanding and acceptance of problems associated with mental illnesses;

(4) improve people's skills in dealing with high-risk situations known to affect children's mental health and functioning;

(5) prevent development or deepening of mental illnesses; and

(6) refer each child with mental illness or the child's family with additional mental health needs to appropriate mental health services.

History: *1989 c 282 art 4 s 44; 2015 c 21 art 1 s 41; 2025 c 38 art 8 s 31*

245.4878 MENTAL HEALTH IDENTIFICATION AND INTERVENTION.

By January 1, 1991, mental health identification and intervention services must be available to meet the needs of all children and their families residing in the county, consistent with section 245.4873. Mental health identification and intervention services must be designed to identify children who are at risk of needing or who need mental health services. The county board must provide intervention and offer treatment services to each child who is identified as needing mental health services. The county board must offer intervention services to each child who is identified as being at risk of needing mental health services.

History: *1989 c 282 art 4 s 45; 1995 c 207 art 8 s 9*

245.4879 EMERGENCY SERVICES.

Subdivision 1. **Availability of emergency services.** County boards must provide or contract for mental health emergency services according to section 245.469.

Subd. 2. MS 2020 [Repealed, 2021 c 30 art 17 s 113]

History: *1989 c 282 art 4 s 46; 1990 c 568 art 5 s 18; 1991 c 312 s 2; 2021 c 30 art 16 s 3*

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 mental illness residing in the county and the child's family. Services may be provided directly by the county through county-operated mental health clinics meeting the standards of chapter 245I; by contract with privately operated mental health clinics meeting the standards of chapter 245I; by contract with hospital mental health outpatient programs certified by the Joint Commission on Accreditation of Hospital Organizations; or by contract with a mental health professional. 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.

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

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

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

(3) develops individual treatment plans; and

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

Subd. 3. **Mental health crisis services.** County boards must provide or contract for mental health crisis services within the county to meet the needs of children with mental illness residing in the county who are determined, through an assessment by a mental health professional, to be experiencing a mental health crisis or mental health emergency. The mental health crisis services provided must be medically necessary, as defined in section 62Q.53, subdivision 2, and necessary for the safety of the child or others regardless of the setting.

History: *1989 c 282 art 4 s 47; 1990 c 568 art 2 s 39; 1991 c 255 s 19; 1991 c 292 art 6 s 58 subd 1; 1993 c 339 s 4; 1Sp2001 c 9 art 9 s 16; 2002 c 379 art 1 s 113; 1Sp2003 c 14 art 11 s 11; 2007 c 147 art 8 s 38; 2009 c 79 art 7 s 4; 2021 c 30 art 17 s 43; 2025 c 38 art 8 s 32,33*

245.4881 CASE MANAGEMENT AND FAMILY COMMUNITY SUPPORT SERVICES.

Subdivision 1. **Availability of case management services.** (a) The county board shall provide case management services for each child with serious mental illness who is a resident of the county and the child's family who request or consent to the services. Case management services must be offered to a child with a serious mental illness who is over the age of 18 consistent with section 245.4875, subdivision 8, or the child's legal representative, provided the child's service needs can be met within the children's service system. Before discontinuing case management services under this subdivision for children between the ages of 17 and 21, a transition plan must be developed. The transition plan must be developed with the child and, with the consent of a child age 18 or over, the child's parent, guardian, or legal representative. The transition plan should include plans for health insurance, housing, education, employment, and treatment. Staffing ratios must be sufficient to serve the needs of the clients. The case manager must meet the requirements in section 245.4871, subdivision 4.

(b) Except as permitted by law and the commissioner under demonstration projects, case management services provided to children with serious mental illness eligible for medical assistance must be billed to the medical assistance program under sections 256B.02, subdivision 8, and 256B.0625.

(c) Case management services are eligible for reimbursement under the medical assistance program. Costs of mentoring, supervision, and continuing education may be included in the reimbursement rate methodology used for case management services under the medical assistance program.

Subd. 2. **Notification and determination of case management eligibility.** (a) The county board shall notify, as appropriate, the child, child's parent, or child's legal representative of the child's potential eligibility for case management services within five working days after receiving a request from an individual or a referral from a provider under section 245.4876, subdivision 4.

(b) The county board shall send a notification written in plain language of potential eligibility for case management and family community support services. The notification shall identify the designated case management providers and shall contain:

(1) a brief description of case management and family community support services;

(2) the potential benefits of these services;

(3) the identity and current phone number of the county employee designated to coordinate case management activities;

(4) an explanation of how to obtain county assistance in obtaining a diagnostic assessment, if needed; and

(5) an explanation of the appeal process.

The county board shall send the notice, as appropriate, to the child, the child's parent, or the child's legal representative, if any.

(c) The county board must promptly determine whether a child who requests or is referred for case management services meets the criteria of section 245.4871, subdivision 6. If a diagnostic assessment is needed to make the determination, the county board must offer to assist the child and the child's family in obtaining one. The county board shall notify, in writing, the child and the child's representative, if any, of the eligibility determination. If the child is determined to be eligible for case management services, and if the child and the child's family consent to the services, the county board shall refer the child to the case

management provider for case management services. If the child is determined not to be eligible or refuses case management services, the county board shall notify the child of the appeal process and shall offer to refer the child to a mental health provider or other appropriate service provider and to assist the child in making an appointment with the provider of the child's choice.

Subd. 3. **Duties of case manager.** (a) Upon a determination of eligibility for case management services, the case manager shall develop an individual family community support plan for a child as specified in subdivision 4, review the child's progress, monitor the provision of services, and, if the child and the child's parent or legal guardian consent, complete a written functional assessment as defined in section 245.4871, subdivision 18a. If services are to be provided in a host county that is not the county of financial responsibility, the case manager shall consult with the host county and obtain a letter demonstrating the concurrence of the host county regarding the provision of services.

(b) The case manager shall note in the child's record the services needed by the child and the child's family, the services requested by the family, services that are not available, and the unmet needs of the child and child's family. The case manager shall note this provision in the child's record.

Subd. 4. **Individual family community support plan.** (a) For each child, the case manager must develop an individual family community support plan that incorporates the child's individual treatment plan. The individual treatment plan may not be a substitute for the development of an individual family community support plan. The case manager is responsible for developing the individual family community support plan within 30 days of intake based on a diagnostic assessment and for implementing and monitoring the delivery of services according to the individual family community support plan. The case manager must review the plan at least every 180 calendar days after it is developed, unless the case manager has received a written request from the child's family or an advocate for the child for a review of the plan every 90 days after it is developed. To the extent appropriate, the child with serious mental illness, the child's family, advocates, service providers, and significant others must be involved in all phases of development and implementation of the individual family community support plan. Notwithstanding the lack of an individual family community support plan, the case manager shall assist the child and child's family in accessing the needed services listed in section 245.4884, subdivision 1.

(b) The child's individual family community support plan must state:

(1) the goals and expected outcomes of each service and criteria for evaluating the effectiveness and appropriateness of the service;

(2) the activities for accomplishing each goal;

(3) a schedule for each activity; and

(4) the frequency of face-to-face contacts by the case manager, as appropriate to client need and the implementation of the individual family community support plan.

Subd. 5. **Coordination between case manager and family community support services.** (a) The county board must establish procedures that ensure ongoing contact and coordination between the case manager and the family community support services as well as other mental health services for each child.

(b) The case manager must have at least one case management contact in every calendar month with the child, the child's parents, or the child's legal representative.

Subd. 6. MS 1989 Supp [Repealed, 1990 c 568 art 5 s 35]

Subd. 7. MS 1989 Supp [Repealed, 1990 c 568 art 5 s 35]

Subd. 8. MS 1989 Supp [Repealed, 1990 c 568 art 5 s 35]

Subd. 9. MS 1989 Supp [Repealed, 1990 c 568 art 5 s 35]

Subd. 10. MS 1989 Supp [Repealed, 1990 c 568 art 5 s 35]

History: *1989 c 282 art 4 s 48; 1990 c 568 art 5 s 19-22,34; 1991 c 292 art 6 s 18; 1997 c 7 art 1 s 95; 1997 c 93 s 2; 1999 c 245 art 5 s 8; 1Sp2003 c 14 art 11 s 11; 2004 c 288 art 3 s 10; 2013 c 108 art 4 s 7; 2014 c 262 art 3 s 5,6; 2022 c 98 art 17 s 26; 2023 c 50 art 1 s 10,11; 2025 c 38 art 4 s 14; art 8 s 34,35; 2026 c 121 art 3 s 5*

245.4882 RESIDENTIAL TREATMENT SERVICES.

Subdivision 1. **Availability of residential treatment services.** County boards must provide or contract for enough residential treatment services to meet the needs of each child with serious mental illness residing in the county and needing this level of care. Length of stay is based on the child's residential treatment need and shall be reviewed every 90 days. Services must be appropriate to the child's age and treatment needs and must be made available as close to the county as possible. Residential treatment must be designed to:

(1) help the child improve family living and social interaction skills;

(2) help the child gain the necessary skills to return to the community;

(3) stabilize crisis admissions; and

(4) work with families throughout the placement to improve the ability of the families to care for children with serious mental illness in the home.

Subd. 2. **Specific requirements.** A provider of residential services to children must be licensed under applicable rules adopted by the commissioner and must be clinically supervised by a mental health professional.

Subd. 2a. **Assessment requirements.** (a) A residential treatment service provider must complete a diagnostic assessment of a child within ten calendar days of the child's admission. If a diagnostic assessment has been completed by a mental health professional within the past 180 days, a new diagnostic assessment need not be completed unless in the opinion of the current treating mental health professional the child's mental health status has changed markedly since the assessment was completed.

(b) Notwithstanding the timeline requirements under Minnesota Rules, part 2960.0070, subpart 5, item C, subitems (1) and (2), the license holder must complete the screenings required by Minnesota Rules, part 2960.0070, subpart 5, item A, subitems (2), (3), (4), and (6), within ten calendar days. The license holder must complete the screenings required under Minnesota Rules, part 2960.0070, subpart 5, item A, subitems (1) and (5), according to the timelines in Minnesota Rules, part 2960.0070, subpart 5, item C, subitems (1) to (3).

Subd. 3. **Transition to community.** Residential treatment facilities and regional treatment centers serving children must plan for and assist those children and their families in making a transition to less restrictive community-based services. Discharge planning for the child to return to the community must include identification of and referrals to appropriate home and community supports that meet the needs of the child and family. Discharge planning must begin within 30 days after the child enters residential treatment and be updated every 60 days. Residential treatment facilities must also arrange for appropriate follow-up

care in the community. Before a child is discharged, the residential treatment facility or regional treatment center shall provide notification to the child's case manager, if any, so that the case manager can monitor and coordinate the transition and make timely arrangements for the child's appropriate follow-up care in the community.

Subd. 4. **Admission, continued stay, and discharge criteria.** No later than January 1, 1992, the county board shall ensure that placement decisions for residential treatment services are based on the clinical needs of the child. The county board shall ensure that each entity under contract to provide residential treatment services has admission, continued stay, discharge criteria and discharge planning criteria as part of the contract. Contracts shall specify specific responsibilities between the county and service providers to ensure comprehensive planning and continuity of care between needed services according to data privacy requirements. The county board shall ensure that, at least ten days prior to discharge, the operator of the residential treatment facility shall provide written notification of the discharge to the child's parent or caretaker, the local education agency in which the child is enrolled, and the receiving education agency to which the child will be transferred upon discharge. When the child has an individualized education program, the notice shall include a copy of the individualized education program. All contracts for the provision of residential services must include provisions guaranteeing clients the right to appeal under section 245.4887 and to be advised of their appeal rights.

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 mental illness 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.

Subd. 6. **Crisis admissions and stabilization.** (a) A child may be referred for residential treatment services under this section for the purpose of crisis stabilization by:

(1) a mental health professional as defined in section 245I.04, subdivision 2;

(2) a physician licensed under chapter 147 who is assessing a child in an emergency department; or

(3) a member of a mobile crisis team who meets the qualifications under section 245I.24, subdivision 5.

(b) A provider making a referral under paragraph (a) must conduct an assessment of the child's mental health needs and make a determination that the child is experiencing a mental health crisis and is in need of residential treatment services under this section.

(c) A child may receive services under this subdivision for up to 30 days and must be subject to the screening and admissions criteria and processes under section 245.4885 thereafter.

[See Note.]

History: *1989 c 282 art 4 s 49; 1990 c 568 art 5 s 23; 1991 c 292 art 6 s 19,20,58 subd 1; 1Sp1993 c 1 art 7 s 10; 1995 c 207 art 8 s 10; 1997 c 203 art 5 s 1; 1999 c 139 art 4 s 2; 2009 c 174 art 1 s 1; 1Sp2011 c 11 art 3 s 12; 2012 c 216 art 6 s 13; 2014 c 262 art 3 s 7; 1Sp2021 c 7 art 11 s 3,4; 2022 c 99 art 1 s 8,9; 2025 c 38 art 8 s 36,37; 2026 c 121 art 8 s 5*

NOTE: The amendment to subdivision 6 by Laws 2026, chapter 121, article 8, section 5, is effective January 1, 2028. Laws 2026, chapter 121, article 8, section 17.

245.4883 ACUTE CARE HOSPITAL INPATIENT SERVICES.

Subdivision 1. MS 2012 [Repealed, 2014 c 262 art 3 s 18]

Subd. 2. **Specific requirements.** Providers of acute care hospital inpatient services for children must meet applicable standards established by the commissioners of health and human services.

Subd. 3. **Admission, continued stay, and discharge criteria.** No later than January 1, 1992, the county board shall ensure that placement decisions for acute care hospital inpatient treatment services are based on the clinical needs of the child and, if appropriate, the child's family. The county board shall ensure that each entity under contract with the county to provide acute care hospital treatment services has admission, continued stay, discharge criteria and discharge planning criteria as part of the contract. Contracts should specify the specific responsibilities between the county and service providers to ensure comprehensive planning and continuity of care between needed services according to data privacy requirements. All contracts for the provision of acute care hospital inpatient treatment services must include provisions guaranteeing clients the right to appeal under section 245.4887 and to be advised of their appeal rights.

History: *1989 c 282 art 4 s 50; 1990 c 568 art 5 s 24; 1991 c 292 art 6 s 21,58 subd 1*

245.4884 FAMILY COMMUNITY SUPPORT SERVICES.

Subdivision 1. **Availability of family community support services.** By July 1, 1991, county boards must provide or contract for sufficient family community support services within the county to meet the needs of each child with serious mental illness who resides in the county and the child's family. Children or their parents may be required to pay a fee in accordance with section 245.481.

Family community support services must be designed to improve the ability of children with serious mental illness to:

(1) manage basic activities of daily living;

(2) function appropriately in home, school, and community settings;

(3) participate in leisure time or community youth activities;

(4) set goals and plans;

(5) reside with the family in the community;

(6) participate in after-school and summer activities;

(7) make a smooth transition among mental health and education services provided to children; and

(8) make a smooth transition into the adult mental health system as appropriate.

In addition, family community support services must be designed to improve overall family functioning if clinically appropriate to the child's needs, and to reduce the need for and use of placements more intensive, costly, or restrictive both in the number of admissions and lengths of stay than indicated by the child's diagnostic assessment.

The commissioner of human services shall work with mental health professionals to develop standards for clinical supervision of family community support services. These standards shall be incorporated in rule and in guidelines for grants for family community support services.

Subd. 2. **Day treatment services provided.** (a) Day treatment services must be part of the family community support services available to each child with serious mental illness residing in the county. A child or the child's parent may be required to pay a fee according to section 245.481. Day treatment services must be designed to:

(1) provide a structured environment for treatment;

(2) provide support for residing in the community;

(3) prevent placements that are more intensive, costly, or restrictive than necessary to meet the child's need;

(4) coordinate with or be offered in conjunction with the child's education program;

(5) provide therapy and family intervention for children that are coordinated with education services provided and funded by schools; and

(6) operate during all 12 months of the year.

(b) County boards may request a waiver from including day treatment services if they can document that:

(1) alternative services exist through the county's family community support services for each child who would otherwise need day treatment services; and

(2) county demographics and geography make the provision of day treatment services cost ineffective and unfeasible.

Subd. 3. **Professional home-based family treatment provided.** (a) By January 1, 1991, county boards must provide or contract for sufficient professional home-based family treatment within the county to meet the needs of each child with serious mental illness who is at risk of residential treatment or therapeutic foster care due to the child's mental illness or who is returning to the home from residential treatment or therapeutic foster care. The child or the child's parent may be required to pay a fee according to section 245.481. The county board shall require that all service providers of professional home-based family treatment set fee schedules approved by the county board that are based on the child's or family's ability to pay. The professional home-based family treatment must be designed to assist each child with serious mental illness who is at risk of or who is returning from residential treatment or therapeutic foster care and the child's family to:

(1) improve overall family functioning in all areas of life;

(2) treat the child's symptoms of mental illness that contribute to a risk of residential treatment or therapeutic foster care;

(3) provide a positive change in the emotional, behavioral, and mental well-being of children and their families; and

(4) reduce risk of residential treatment or therapeutic foster care for the identified child with serious mental illness and other siblings or successfully reunify and reintegrate into the family a child returning from residential treatment or therapeutic foster care due to mental illness.

(b) Professional home-based family treatment must be provided by a team consisting of a mental health professional and others who are skilled in the delivery of mental health services to children and families in conjunction with other human service providers. The professional home-based family treatment team must

maintain flexible hours of service availability and must provide or arrange for crisis services for each family, 24 hours a day, seven days a week. Case loads for each professional home-based family treatment team must be small enough to permit the delivery of intensive services and to meet the needs of the family. Professional home-based family treatment providers shall coordinate services and service needs with case managers assigned to children and their families. The treatment team must develop an individual treatment plan that identifies the specific treatment objectives for both the child and the family.

Subd. 4. **Therapeutic support of foster care.** By January 1, 1992, county boards must provide or contract for foster care with therapeutic support as defined in section 245.4871, subdivision 34. Foster families caring for children with serious mental illness must receive training and supportive services, as necessary, at no cost to the foster families within the limits of available resources.

Subd. 5. **Benefits assistance.** The county board must offer help to a child with serious mental illness and the child's family in applying for federal benefits, including Supplemental Security Income, medical assistance, and Medicare.

History: *1990 c 568 art 5 s 25; 1991 c 292 art 6 s 22; 1992 c 571 art 10 s 12; 2025 c 38 art 8 s 38*

245.4885 SCREENING FOR INPATIENT AND RESIDENTIAL TREATMENT.

Subdivision 1. **Admission criteria.** (a) Prior to admission or placement, except in the case of an emergency, all children referred for treatment of serious mental illness in a treatment foster care setting, residential treatment facility, or informally admitted to a regional treatment center shall undergo an assessment to determine the appropriate level of care if county funds are used to pay for the child's services. An emergency includes when a child is in need of and has been referred for crisis stabilization services under section 245.4882, subdivision 6. A child who has been referred to residential treatment for crisis stabilization services in a residential treatment center is not required to undergo an assessment under this section.

(b) The county board shall determine the appropriate level of care for a child when county-controlled funds are used to pay for the child's residential treatment under this chapter, including residential treatment provided in a qualified residential treatment program as defined in section 260C.007, subdivision 26d. When a county board does not have responsibility for a child's placement and the child is enrolled in a prepaid health program under section 256B.69, the enrolled child's contracted health plan must determine the appropriate level of care for the child. When Indian Health Services funds or funds of a tribally owned facility funded under the Indian Self-Determination and Education Assistance Act, Public Law 93-638, are used for the child, the Indian Health Services or 638 Tribal health facility must determine the appropriate level of care for the child. When more than one entity bears responsibility for a child's coverage, the entities shall coordinate level of care determination activities for the child to the extent possible.

(c) The child's level of care determination shall determine whether the proposed treatment:

(1) is necessary;

(2) is appropriate to the child's individual treatment needs;

(3) cannot be effectively provided in the child's home; and

(4) provides a length of stay as short as possible consistent with the individual child's needs.

(d) When a level of care determination is conducted, the county board or other entity may not determine that a screening of a child, referral, or admission to a residential treatment facility is not appropriate solely because services were not first provided to the child in a less restrictive setting and the child failed to make

progress toward or meet treatment goals in the less restrictive setting. The level of care determination must be based on a diagnostic assessment of a child that evaluates the child's family, school, and community living situations; and an assessment of the child's need for care out of the home using a validated tool which assesses a child's functional status and assigns an appropriate level of care to the child. The validated tool must be approved by the commissioner of human services and may be the validated tool approved for the child's assessment under section 260C.704 if the juvenile treatment screening team recommended placement of the child in a qualified residential treatment program. If a diagnostic assessment has been completed by a mental health professional within the past 180 days, a new diagnostic assessment need not be completed unless in the opinion of the current treating mental health professional the child's mental health status has changed markedly since the assessment was completed. The child's parent shall be notified if an assessment will not be completed and of the reasons. A copy of the notice shall be placed in the child's file. Recommendations developed as part of the level of care determination process shall include specific community services needed by the child and, if appropriate, the child's family, and shall indicate whether these services are available and accessible to the child and the child's family. The child and the child's family must be invited to any meeting where the level of care determination is discussed and decisions regarding residential treatment are made. The child and the child's family may invite other relatives, friends, or advocates to attend these meetings.

(e) During the level of care determination process, the child, child's family, or child's legal representative, as appropriate, must be informed of the child's eligibility for case management services and family community support services and that an individual family community support plan is being developed by the case manager, if assigned.

(f) The level of care determination, placement decision, and recommendations for mental health services must be documented in the child's record and made available to the child's family, as appropriate.

Subd. 1a. **Emergency admission.** Effective July 1, 2006, if a child is admitted to a treatment foster care setting, residential treatment facility, or held for emergency care by a regional treatment center under section 253B.051, subdivision 2, the level of care determination must occur within five working days of admission.

Subd. 2. **Qualifications.** Level of care determination of children for treatment foster care, residential, and inpatient services must be conducted by a mental health professional. Where appropriate and available, culturally informed mental health consultants must participate in the level of care determination. Mental health professionals providing level of care determination for treatment foster care, inpatient, and residential services must not be financially affiliated with any nongovernment entity which may be providing those services.

Subd. 3. **Individual placement agreement.** The county board shall enter into an individual placement agreement with a provider of residential treatment services to a child eligible for county-paid services under this section. The agreement must specify the payment rate and terms and conditions of county payment for the placement.

Subd. 4. MS 1992 [Repealed, 1993 c 337 s 20]

Subd. 5. **Summary data collection.** The county board shall annually collect summary information on the number of children screened, the age and racial or ethnic background of the children, the presenting problem, and the screening recommendations. The county shall include information on the degree to which these recommendations are followed and the reasons for not following recommendations. Summary data

shall be available to the public and shall be used by the county board and local children's advisory council to identify needed service development.

History: *1989 c 282 art 4 s 51; 1990 c 568 art 5 s 26,27; 1991 c 292 art 6 s 23-25; 1995 c 207 art 8 s 11; 1999 c 139 art 4 s 2; 1Sp2001 c 9 art 9 s 17; 2002 c 379 art 1 s 113; 1Sp2003 c 14 art 11 s 11; 1Sp2005 c 4 art 2 s 4-6; 2009 c 167 s 5; 2009 c 174 art 1 s 2,3; 2010 c 303 s 1,2; 1Sp2020 c 2 art 5 s 2; 2021 c 30 art 10 s 1; 1Sp2021 c 7 art 11 s 5; 2022 c 98 art 17 s 26; 2022 c 99 art 1 s 10; 2023 c 25 s 118; 2023 c 50 art 1 s 12; 2025 c 38 art 8 s 39*

245.4886 MS 1990 [Renumbered 245.4887]

245.4886 MS 2002 [Repealed, 1Sp2003 c 14 art 11 s 12]

245.4887 MS 1990 [Renumbered 245.4888]

245.4887 APPEALS.

A child or a child's family, as appropriate, who requests mental health services under sections 245.487 to 245.4889 must be advised of services available and the right to appeal as described in this section at the time of the request and each time the individual family community support plan or individual treatment plan is reviewed. A child whose request for mental health services under sections 245.487 to 245.4889 is denied, not acted upon with reasonable promptness, or whose services are suspended, reduced, or terminated by action or inaction for which the county board is responsible under sections 245.487 to 245.4889 may contest that action or inaction before the state agency according to section 256.045. The commissioner shall monitor the nature and frequency of administrative appeals under this section.

History: *1989 c 282 art 4 s 52; 1991 c 292 art 6 s 58 subd 1; 1Sp2003 c 14 art 11 s 11; 2007 c 147 art 8 s 38; 2022 c 98 art 17 s 26; 2023 c 50 art 1 s 13*

245.4888 MS 2002 [Repealed, 1Sp2003 c 14 art 11 s 12]

CHILDREN'S MENTAL HEALTH GRANTS

245.4889 CHILDREN'S MENTAL HEALTH GRANTS.

Subdivision 1. **Establishment and authority.** (a) The commissioner is authorized to make grants from available appropriations to assist:

(1) counties;

(2) Indian Tribes;

(3) children's collaboratives under section 142D.15 or 245.493; or

(4) mental health service providers.

(b) The following services are eligible for grants under this section:

(1) services to children with mental illness as defined in section 245.4871, subdivision 15, and their families;

(2) transition services under section 245.4875, subdivision 8, for young adults under age 21 and their families;

(3) respite care services for children with mental illness or serious mental illness who are at risk of residential treatment or hospitalization; who are already in residential treatment or therapeutic foster care or in family foster settings as defined in chapter 142B and at risk of change in foster care or placement in a residential facility or other higher level of care; who have utilized crisis services or emergency room services; or who have experienced a loss of in-home staffing support. Allowable activities and expenses for respite care services are defined under subdivision 4. A child is not required to have case management services to receive respite care services. Counties must work to provide access to regularly scheduled respite care;

(4) children's mental health crisis services;

(5) child-, youth-, and family-specific mobile response and stabilization services models;

(6) mental health services for people from cultural and ethnic minorities, including supervision of clinical trainees who are Black, indigenous, or people of color;

(7) children's mental health screening and follow-up diagnostic assessment and treatment;

(8) services to promote and develop the capacity of providers to use evidence-based practices in providing children's mental health services;

(9) school-linked mental health services under section 245.4901;

(10) building evidence-based mental health intervention capacity for children birth to age five;

(11) suicide prevention and counseling services that use text messaging statewide;

(12) mental health first aid training;

(13) training for parents, collaborative partners, and mental health providers on the impact of adverse childhood experiences and trauma and development of an interactive website to share information and strategies to promote resilience and prevent trauma;

(14) transition age services to develop or expand mental health treatment and supports for adolescents and young adults 26 years of age or younger;

(15) early childhood mental health consultation under section 245.4908;

(16) evidence-based interventions for youth at risk of developing or experiencing a first episode of psychosis, and a public awareness campaign on the signs and symptoms of psychosis;

(17) psychiatric consultation for primary care practitioners;

(18) providers to begin operations and meet program requirements when establishing a new children's mental health program. These may be start-up grants; and

(19) evidence-based interventions for youth and young adults at risk of developing or experiencing an early episode of bipolar disorder.

(c) Services under paragraph (b) must be designed to help each child to function and remain with the child's family in the community and delivered consistent with the child's treatment plan. Transition services to eligible young adults under this paragraph must be designed to foster independent living in the community.

(d) As a condition of receiving grant funds, a grantee shall obtain all available third-party reimbursement sources, if applicable.

(e) The commissioner may establish and design a pilot program to expand the mobile response and stabilization services model for children, youth, and families. The commissioner may use grant funding to consult with a qualified expert entity to assist in the formulation of measurable outcomes and explore and position the state to submit a Medicaid state plan amendment to scale the model statewide.

Subd. 2. **Grant application and reporting requirements.** To apply for a grant, an applicant organization shall submit an application and budget for the use of the money in the form specified by the commissioner. The commissioner shall make grants only to entities whose applications and budgets are approved by the commissioner. In awarding grants, the commissioner shall give priority to applications that indicate plans to collaborate in the development, funding, and delivery of services with other agencies in the local system of care. The commissioner shall specify requirements for reports, including quarterly fiscal reports under section 256.01, subdivision 2, paragraph (o). The commissioner shall require collection of data and periodic reports that the commissioner deems necessary to demonstrate the effectiveness of each service.

Subd. 3. **Commissioner duty to report on use of grant funds biennially.** (a) By November 1, 2016, and biennially thereafter, the commissioner of human services shall provide sufficient information to the members of the legislative committees having jurisdiction over mental health funding and policy issues to evaluate the use of funds appropriated under this section. The commissioner shall provide, at a minimum, the following information:

(1) the amount of funding for children's mental health grants, what programs and services were funded in the previous two years, and outcome data for the programs and services that were funded; and

(2) the amount of funding for other targeted services and the location of services.

(b) This subdivision expires January 1, 2032.

Subd. 4. **Respite care services.** Respite care services under subdivision 1, paragraph (b), clause (3), include hourly or overnight stays at a licensed foster home or with a qualified and approved family member or friend and may occur at a child's or provider's home. Respite care services may also include the following activities and expenses:

(1) recreational, sport, and nonsport extracurricular activities and programs for the child including camps, clubs, lessons, group outings, sports, or other activities and programs;

(2) family activities, camps, and retreats that the family does together and provide a break from the family's circumstance;

(3) cultural programs and activities for the child and family designed to address the unique needs of individuals who share a common language, racial, ethnic, or social background; and

(4) costs of transportation, food, supplies, and equipment directly associated with approved respite care services and expenses necessary for the child and family to access and participate in respite care services.

History: *2007 c 147 art 8 s 8; 2015 c 71 art 2 s 14,15; 1Sp2017 c 6 art 8 s 7; 1Sp2019 c 9 art 6 s 2; 1Sp2020 c 2 art 5 s 3; 1Sp2021 c 7 art 11 s 6; 2022 c 98 art 6 s 4,5; art 14 s 11; 2023 c 70 art 9 s 3; 2024 c 80 art 2 s 74; art 4 s 26; 2024 c 115 art 16 s 41,42; 2024 c 127 art 61 s 3; 2025 c 38 art 8 s 40; 1Sp2025 c 3 art 15 s 5; 2026 c 95 art 5 s 2*

245.490 MS 2012 [Repealed, 2014 c 262 art 3 s 18]

SCHOOL-LINKED BEHAVIORAL HEALTH GRANTS

245.4901 SCHOOL-LINKED BEHAVIORAL HEALTH GRANTS.

Subdivision 1. **Establishment.** The commissioner of human services shall establish a school-linked behavioral health grant program to provide early identification and intervention for students with mental health and substance use disorder needs and to build the capacity of schools to support students with mental health and substance use disorder needs in the classroom.

Subd. 2. **Eligible applicants.** An eligible applicant for a school-linked behavioral health grant is an entity or provider that is:

(1) a mental health clinic certified under section 245I.20;

(2) a community mental health center under section 256B.0625, subdivision 5;

(3) an Indian health service facility or a facility owned and operated by a Tribe or Tribal organization operating under United States Code, title 25, section 5321;

(4) a provider of children's therapeutic services and supports as defined in section 256B.0943;

(5) enrolled in medical assistance as a mental health or substance use disorder provider agency and employs at least two full-time equivalent mental health professionals qualified according to section 245I.04, subdivision 2, or two alcohol and drug counselors licensed or exempt from licensure under chapter 148F who are qualified to provide clinical services to children and families;

(6) licensed under chapter 245G and in compliance with the applicable requirements in chapters 245A, 245C, and 260E, section 626.557, and Minnesota Rules, chapter 9544; or

(7) a licensed professional in private practice as defined in section 245G.01, subdivision 17, who meets the requirements of section 254B.0501, subdivision 4.

Subd. 3. **Allowable grant activities and related expenses.** (a) Allowable grant activities and related expenses may include but are not limited to:

(1) identifying and diagnosing mental health conditions and substance use disorders of students;

(2) delivering mental health and substance use disorder treatment and services to students and their families, including via telehealth consistent with section 256B.0625, subdivision 3b;

(3) supporting families in meeting their child's needs, including accessing needed mental health services to support the child's parent in caregiving and navigating health care, social service, and juvenile justice systems;

(4) providing transportation for students receiving school-linked behavioral health services when school is not in session;

(5) building the capacity of schools to meet the needs of students with mental health and substance use disorder concerns, including school staff development activities for licensed and nonlicensed staff; and

(6) purchasing equipment, connection charges, on-site coordination, set-up fees, and site fees in order to deliver school-linked behavioral health services via telehealth.

(b) Grantees shall obtain all available third-party reimbursement sources as a condition of receiving a grant. For purposes of this grant program, a third-party reimbursement source excludes a public school as defined in section 120A.20, subdivision 1. Grantees shall serve students regardless of health coverage status or ability to pay.

Subd. 4. **Data collection and outcome measurement.** Grantees shall provide data to the commissioner for the purpose of evaluating the effectiveness of the school-linked behavioral health grant program, no more frequently than twice per year. Data provided by grantees must include only the number of clients served, client demographics, payor information, client-related clinical and ancillary services including hours of direct client services, and hours of ancillary support services. Qualitative data may also be collected to demonstrate outcomes. The commissioner must consult with grantees to develop ongoing outcome measures for program capacity and performance.

Subd. 5. **Consultation; grant awards.** In administering the grant program, the commissioner shall consult with school districts that have not received grants under this section but that wish to collaborate with a community mental health provider. The commissioner shall also work with culturally specific providers to allow the providers to serve students from their community in multiple schools. When awarding grants, the commissioner shall consider the need to have consistency of providers over time among schools and students.

History: *1Sp2019 c 9 art 6 s 3; 2021 c 30 art 17 s 44; 1Sp2021 c 7 art 6 s 28; art 11 s 7; 2023 c 70 art 9 s 4,5; 2025 c 38 art 4 s 15; 1Sp2025 c 9 art 4 s 55*

245.4902 MS 2024 [Repealed, 2025 c 20 s 294]

245.4903 CULTURAL AND ETHNIC MINORITY INFRASTRUCTURE GRANT PROGRAM.

Subdivision 1. **Establishment.** The commissioner of human services must establish a cultural and ethnic minority infrastructure grant program to ensure that mental health and substance use disorder treatment supports and services are culturally specific and culturally responsive to meet the cultural needs of communities served.

Subd. 2. **Eligible applicants.** An eligible applicant is a licensed entity or provider from a cultural or ethnic minority population that:

(1) provides mental health or substance use disorder treatment services and supports to individuals from cultural and ethnic minority populations, including members of those populations who identify as lesbian, gay, bisexual, transgender, or queer;

(2) provides, or is qualified and has the capacity to provide, clinical supervision and support to members of culturally diverse and ethnic minority communities so they may become qualified mental health and substance use disorder treatment providers; or

(3) has the capacity and experience to provide training for mental health and substance use disorder treatment providers on cultural competency and cultural humility.

Subd. 3. **Allowable grant activities.** (a) Grantees must engage in activities and provide supportive services to ensure and increase equitable access to culturally specific and responsive care and build organizational and professional capacity for licensure and certification for the communities served. Allowable grant activities include but are not limited to:

(1) providing workforce development activities focused on recruiting, supporting, training, and supervising mental health and substance use disorder practitioners and professionals from diverse racial, cultural, and ethnic communities;

(2) helping members of racial and ethnic minority communities become qualified mental health and substance use disorder professionals, practitioners, clinical supervisors, recovery peer specialists, mental health certified peer specialists, and mental health certified family peer specialists;

(3) providing culturally specific outreach, early intervention, trauma-informed services, and recovery support in mental health and substance use disorder services;

(4) providing trauma-informed and culturally responsive mental health and substance use disorder supports and services to children and families, youth, or adults who are from cultural and ethnic minority backgrounds and are uninsured or underinsured;

(5) expanding mental health and substance use disorder services, particularly in greater Minnesota;

(6) training mental health and substance use disorder treatment providers on cultural competency and cultural humility;

(7) providing activities that increase the availability of culturally responsive mental health and substance use disorder services for children and families, youth, or adults, or that increase the availability of substance use disorder services for individuals from cultural and ethnic minorities in the state;

(8) providing interpreter services at intensive residential treatment facilities, children's residential treatment centers, or psychiatric residential treatment facilities in order for children or adults with limited English proficiency or children or adults who are fluent in another language to be able to access treatment; and

(9) paying for case-specific consultation between a mental health professional and the appropriate diverse mental health professional in order to facilitate the provision of services that are culturally appropriate to a client's needs.

(b) The commissioner must assist grantees with meeting third-party credentialing requirements, and grantees must obtain all available third-party reimbursement sources as a condition of receiving grant money. Grantees must serve individuals from cultural and ethnic minority communities regardless of health coverage status or ability to pay.

Subd. 4. **Data collection and outcomes.** Grantees must provide regular data summaries to the commissioner for purposes of evaluating the effectiveness of the cultural and ethnic minority infrastructure grant program. The commissioner must use identified culturally appropriate outcome measures instruments to evaluate outcomes and must evaluate program activities by analyzing whether the program:

(1) increased access to culturally specific services for individuals from cultural and ethnic minority communities across the state;

(2) increased the number of individuals from cultural and ethnic minority communities served by grantees;

(3) increased cultural responsiveness and cultural competency of mental health and substance use disorder treatment providers;

(4) increased the number of mental health and substance use disorder treatment providers and clinical supervisors from cultural and ethnic minority communities;

(5) increased the number of mental health and substance use disorder treatment organizations owned, managed, or led by individuals who are Black, Indigenous, or people of color;

(6) reduced health disparities through improved clinical and functional outcomes for those accessing services; and

(7) led to an overall increase in culturally specific mental health and substance use disorder service availability.

History: *2023 c 70 art 9 s 6*

245.4904 INTERMEDIATE SCHOOL DISTRICT BEHAVIORAL HEALTH GRANT PROGRAM.

Subdivision 1. **Establishment.** The commissioner of human services must establish a grant program to improve behavioral health outcomes for youth attending a qualifying school unit and to build the capacity of schools to support student and teacher needs in the classroom. For purposes of this section, "qualifying school unit" means an intermediate school district organized under section 136D.01.

Subd. 2. **Eligible applicants.** An eligible applicant is an intermediate school district organized under section 136D.01 and a partner entity or provider that has demonstrated capacity to serve the youth identified in subdivision 1 that is:

(1) a mental health clinic certified under section 245I.20;

(2) a community mental health center under section 256B.0625, subdivision 5;

(3) an Indian health service facility or a facility owned and operated by a Tribe or Tribal organization operating under United States Code, title 25, section 5321;

(4) a provider of children's therapeutic services and supports as defined in section 256B.0943;

(5) enrolled in medical assistance as a mental health or substance use disorder provider agency and employs at least two full-time equivalent mental health professionals qualified according to section 245I.04, subdivision 2, or two alcohol and drug counselors licensed or exempt from licensure under chapter 148F who are qualified to provide clinical services to children and families;

(6) licensed under chapter 245G and in compliance with the applicable requirements in chapters 245A, 245C, and 260E; section 626.557; and Minnesota Rules, chapter 9544; or

(7) a licensed professional in private practice as defined in section 245G.01, subdivision 17, who meets the requirements of section 254B.0501, subdivision 4.

Subd. 3. **Allowable grant activities and related expenses.** (a) Allowable grant activities and related expenses include but are not limited to:

(1) identifying mental health conditions and substance use disorders of students;

(2) delivering mental health and substance use disorder treatment and supportive services to students and their families within the classroom, including via telehealth consistent with section 256B.0625, subdivision 3b;

(3) delivering therapeutic interventions and customizing an array of supplementary learning experiences for students;

(4) supporting families in meeting their child's needs, including navigating health care, social service, and juvenile justice systems;

(5) providing transportation for students receiving behavioral health services when school is not in session;

(6) building the capacity of schools to meet the needs of students with mental health and substance use disorder concerns, including school staff development activities for licensed and nonlicensed staff; and

(7) purchasing equipment, connection charges, on-site coordination, set-up fees, and site fees in order to deliver school-linked behavioral health services via telehealth.

(b) Grantees must obtain all available third-party reimbursement sources as a condition of receiving grant funds. For purposes of this grant program, a third-party reimbursement source does not include a public school as defined in section 120A.20, subdivision 1. Grantees shall serve students regardless of health coverage status or ability to pay.

Subd. 4. **Calculating the share of the appropriation.** (a) Grants must be awarded to qualifying school units proportionately.

(b) The commissioner must calculate the share of the appropriation to be used in each qualifying school unit by multiplying the total appropriation going to the grantees by the qualifying school unit's average daily membership in a setting of federal instructional level 4 or higher and then dividing by the total average daily membership in a setting of federal instructional level 4 or higher for the same year for all qualifying school units.

Subd. 5. **Data collection and outcome measurement.** Grantees must provide data to the commissioner for the purpose of evaluating the intermediate school district behavioral health innovation grant program. The commissioner must consult with grantees to develop outcome measures for program capacity and performance.

History: *2025 c 38 art 4 s 16; 1Sp2025 c 9 art 4 s 55*

245.4905 FIRST EPISODE OF PSYCHOSIS GRANT PROGRAM.

Subdivision 1. **Creation.** The first episode of psychosis grant program is established in the Department of Human Services to fund evidence-based interventions for youth at risk of developing or experiencing a first episode of psychosis and a public awareness campaign on the signs and symptoms of psychosis. First episode of psychosis services are eligible for children's mental health grants as specified in section 245.4889, subdivision 1, paragraph (b), clause (16).

Subd. 2. **Activities.** (a) All first episode of psychosis grant programs must:

(1) provide intensive treatment and support for adolescents and adults experiencing or at risk of experiencing a first psychotic episode. Intensive treatment and support includes medication management, psychoeducation for an individual and an individual's family, case management, employment support, education support, cognitive behavioral approaches, social skills training, peer support, crisis planning, and stress management;

(2) conduct outreach and provide training and guidance to mental health and health care professionals, including postsecondary health clinicians, on early psychosis symptoms, screening tools, and best practices;

(3) ensure access for individuals to first psychotic episode services under this section, including access for individuals who live in rural areas; and

(4) use all available funding streams.

(b) Grant money may also be used to pay for housing or travel expenses for individuals receiving services or to address other barriers preventing individuals and their families from participating in first psychotic episode services.

Subd. 3. **Eligibility.** Program activities must be provided to people 15 to 40 years old with early signs of psychosis.

Subd. 4. **Outcomes.** Evaluation of program activities must utilize evidence-based practices and must include the following outcome evaluation criteria:

(1) whether individuals experience a reduction in psychotic symptoms;

(2) whether individuals experience a decrease in inpatient mental health hospitalizations; and

(3) whether individuals experience an increase in educational attainment.

Subd. 5. **Federal aid or grants.** The commissioner of human services must comply with all conditions and requirements necessary to receive federal aid or grants.

History: *2022 c 99 art 1 s 11; 2025 c 20 s 197*

245.4906 MENTAL HEALTH CERTIFIED PEER SPECIALIST GRANT PROGRAM.

Subdivision 1. **Establishment.** The commissioner of human services must establish a mental health certified peer specialist grant program to provide funding for the training of mental health certified peer specialists who provide services to support individuals with lived experience of mental illness under section 256B.0615.

Subd. 2. **Eligible applicants.** An eligible applicant is a licensed entity or provider that employs a mental health certified peer specialist qualified under section 245I.04, subdivision 10, and that provides services to individuals receiving assertive community treatment under section 256B.0622, intensive residential treatment services under section 256B.0632, adult rehabilitative mental health services under section 256B.0623, or crisis response services under section 256B.0624.

Subd. 3. **Allowable grant activities.** Grantees must use grant funding to provide training for mental health certified peer specialists as specified in section 256B.0615, subdivision 5.

Subd. 4. **Outcomes.** (a) Grantees must provide an annual report to the commissioner for the purposes of evaluating the effectiveness of the grant program. The report must include:

(1) the number of mental health certified peer specialists who received training using the grant funds under this section; and

(2) the extent to which individuals receiving peer services experienced progress on achieving treatment goals and experienced a reduction in hospital admissions.

(b) The commissioner must submit the results of the evaluation to the chairs and ranking minority members of the legislative committees with jurisdiction over mental health.

History: *2023 c 70 art 17 s 5; 2025 c 38 art 7 s 3*

245.4907 MENTAL HEALTH CERTIFIED FAMILY PEER SPECIALIST GRANT PROGRAM.

Subdivision 1. **Establishment.** The commissioner of human services must establish a mental health certified peer family specialist grant program to provide funding for training for mental health certified peer family specialists who provide services to support individuals with lived experience of mental illness under section 256B.0616.

Subd. 2. **Eligible applicants.** An eligible applicant is a licensed entity or provider that employs a mental health certified peer family specialist qualified under section 245I.04, subdivision 12, and that provides services to families who have a child:

(1) with a mental illness or serious mental illness under chapter 245;

(2) receiving inpatient hospitalization under section 256B.0625, subdivision 1;

(3) admitted to a residential treatment facility under section 245.4882;

(4) receiving children's intensive behavioral health services under section 256B.0946;

(5) receiving day treatment or children's therapeutic services and supports under section 256B.0943; or

(6) receiving crisis response services under section 256B.0624.

Subd. 3. **Allowable grant activities.** Grantees must use grant funding to provide training for mental health family peer specialist candidates and continuing education to certified family peer specialists as specified in section 256B.0616, subdivision 5.

Subd. 4. **Outcomes.** (a) Grantees must provide an annual report to the commissioner for the purposes of evaluating the effectiveness of the grant program. The report must include:

(1) the number of mental health certified peer specialists who received training using the grant funds under this section; and

(2) the extent to which individuals receiving family peer services experienced progress on achieving treatment goals and experienced a reduction in hospital admissions.

(b) The commissioner must submit the results of the evaluation to the chairs and ranking minority members of the legislative committees with jurisdiction over mental health.

History: *2023 c 70 art 17 s 6; 2025 c 38 art 4 s 17; art 8 s 41*

245.4908 EARLY CHILDHOOD MENTAL HEALTH CONSULTATION GRANTS.

Subdivision 1. **Establishment.** The commissioner of human services must establish an early childhood mental health consultation grant program to support the delivery of specialized mental health care consultation to child care, social services, educational, and health programs that serve children five years of age or younger.

Subd. 2. **Eligible applicants.** An applicant is eligible for an early childhood mental health consultation grant under this section if the applicant is:

(1) a mental health clinic certified under section 245I.20;

(2) a community mental health center under section 256B.0625, subdivision 5;

(3) an Indian health service facility or a facility owned and operated by a Tribe or Tribal organization operating under United States Code, title 25, section 5321;

(4) a provider of children's therapeutic services and supports, as defined in section 256B.0943; or

(5) an agency with expertise in infant and early childhood mental health that has the competency to provide early childhood mental health consultation and training.

Subd. 3. **Allowable grant activities and related expenses.** Grant money must be used to provide early childhood mental health consultation, including but not limited to:

(1) supporting early identification of social, emotional, and behavioral concerns for children five years of age or younger through observation, screening support, and guidance to early childhood professionals;

(2) developing and delivering training to early childhood professionals that includes evidence-based or evidence-informed clinical practices related to infant and early childhood mental health, and train-the-trainer models to build capacity for grantees to train the grantee's staff; and

(3) providing direct or reflective consultation to early childhood professionals.

Subd. 4. **Data collection and outcome measurement.** (a) The commissioner must consult with grantees to develop ongoing outcome measures for program capacity and performance.

(b) Grantees must collect and report the data required under paragraph (c) quarterly to the commissioner in a form and manner specified by the commissioner, for the purpose of evaluating the effectiveness of the grant program.

(c) Grantees must provide the following data to the commissioner:

(1) the number of sites, programs, and early childhood professionals served by the grantee;

(2) demographics of participants served by the grantee; and

(3) data to demonstrate outcomes related to improving early childhood professionals' ability to support the mental, social, and emotional development of young children.

History: *2026 c 95 art 5 s 3*

CHILDREN'S MENTAL HEALTH INTEGRATED FUND

245.491 CITATION; DECLARATION OF PURPOSE.

Subdivision 1. **Citation.** Sections 245.491 to 245.495 may be cited as "the children's mental health integrated fund."

Subd. 2. **Purpose.** The legislature finds that children with mental illnesses or 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 employment and economic development. 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 245.495 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; 1994 c 483 s 1; 1Sp2003 c 14 art 11 s 11; 2009 c 86 art 1 s 89; 2025 c 38 art 8 s 42*

245.492 DEFINITIONS.

Subdivision 1. **Definitions.** The definitions in this section apply to sections 245.491 to 245.495.

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 1995 for children's mental health services, for special education services, and for other services for children with emotional or behavioral disturbances and their families.

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 mental illnesses 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. MS 2012 [Repealed, 2014 c 262 art 3 s 18]

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. MS 2012 [Repealed, 2014 c 262 art 3 s 18]

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) individualized rehabilitation services.

Services provided by the integrated service system must meet the requirements set out in sections 245.487 to 245.4889. 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 125A.30.

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 125A.22, 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 245.495. 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. MS 2012 [Repealed, 2014 c 262 art 3 s 18]

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. MS 2012 [Repealed, 2014 c 262 art 3 s 18]

Subd. 20. MS 1994 [Repealed, 1995 c 207 art 11 s 12]

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. **Individualized rehabilitation services.** "Individualized rehabilitation 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. Individualized rehabilitation 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; 1994 c 647 art 13 s 18; 1995 c 207 art 8 s 13-16; 1998 c 397 art 11 s 3; 1Sp2003 c 14 art 11 s 11; 2007 c 147 art 8 s 38; 2025 c 38 art 8 s 43*

245.493 LOCAL CHILDREN'S MENTAL HEALTH COLLABORATIVE.

Subdivision 1. **Qualification requirements.** 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 and nongovernmental entities such as parents of children in the target population; parent and consumer organizations; community, civic, and religious organizations; private and nonprofit mental and physical health care providers; culturally specific organizations; local foundations; and businesses, or at a minimum one county, one school district or special education cooperative, one mental health entity, and, by July 1, 1998, one juvenile justice or corrections entity, must agree to the following:

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

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

(3) to develop a plan to contribute funds to the children's mental health collaborative.

Subd. 1a. **Duties of certain coordinating bodies.** (a) By mutual agreement of the collaborative and a coordinating body listed in this subdivision, a children's mental health collaborative or a collaborative established by the merger of a children's mental health collaborative and a family services collaborative under section 142D.15, may assume the duties of a community transition interagency committee established

under section 125A.22; an interagency early intervention committee established under section 125A.30; or a local advisory council established under section 245.4875, subdivision 5.

(b) Two or more family services collaboratives or children's mental health collaboratives may consolidate decision making, pool resources, and collectively act on behalf of the individual collaboratives, based on a written agreement among the participating collaboratives.

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

(1) notify the commissioner of human services within ten days of formation by signing a collaborative agreement and providing the commissioner with a copy of the signed agreement;

(2) identify a service delivery area and an operational target population within that service delivery area. The operational 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 operational target population must also be economically viable for the service delivery area;

(3) seek to maximize federal revenues available to serve children in the target population by designating local expenditures for services for these children and their families that can be matched with federal dollars;

(4) 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 that meets the requirements for state and federal reimbursement and develop interagency agreements necessary to implement the system;

(5) 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 needs of children in the target population and their families;

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

(7) spend funds generated by the local children's mental health collaborative as required in sections 245.491 to 245.495;

(8) 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;

(9) submit its integrated service system design to the Children's Cabinet for approval within one year of notifying the commissioner of human services of its formation;

(10) provide an annual report and the collaborative's planned timeline to expand its operational target population to the Children's Cabinet; and

(11) expand its operational target population.

Subd. 3. **Information sharing.** (a) The members of a local children's mental health collaborative may share data on individuals being served by the collaborative or its members if the individual, as defined in section 13.02, subdivision 8, gives written informed consent and the information sharing is necessary in order for the collaborative to carry out duties under subdivision 2. Data on individuals shared under this subdivision retain the original classification as defined under section 13.02, as to each member of the collaborative with whom the data is shared.

(b) If a federal law or regulation impedes information sharing that is necessary in order for a collaborative to carry out duties under subdivision 2, the appropriate state agencies shall attempt to get a waiver or exemption from the applicable law or regulation.

History: *1Sp1993 c 1 art 7 s 13; 1994 c 618 art 1 s 27; 1995 c 207 art 8 s 17; art 11 s 11; 1997 c 203 art 5 s 2,3; 1Sp1997 c 4 art 2 s 40; 1998 c 397 art 11 s 3; 1Sp2003 c 14 art 4 s 3; art 11 s 11; 2015 c 21 art 1 s 42-44; 2017 c 40 art 1 s 49; 2024 c 80 art 4 s 26; 2024 c 115 art 16 s 42*

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 125A.08; 245.4871, subdivision 21; 245.4881, subdivision 4; 253B.03, subdivision 7; 260C.212, subdivision 1; and 260C.201, subdivision 6;

(4) meet all standards and provide all mental health services as required in sections 245.487 to 245.4889, 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 245.495;

(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; 1998 c 397 art 11 s 3; 1999 c 139 art 4 s 2; 1Sp2003 c 14 art 11 s 11; 2007 c 147 art 8 s 38*

245.4932 REVENUE ENHANCEMENT; AUTHORITY AND RESPONSIBILITIES.

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

(1) the collaborative must establish an integrated fund;

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

(3) 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;

(4) the collaborative shall use any enhanced revenue attributable to the activities of the collaborative, including administrative and service revenue, solely to provide mental health services or to expand the operational target population. The lead county or other qualified entity may not use enhanced federal revenue for any other purpose;

(5) 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 with the commissioner of human services;

(6) the collaborative or its members may elect to pay the nonfederal share of the medical assistance costs for services designated by the collaborative; and

(7) 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. MS 2012 [Repealed, 2014 c 262 art 3 s 18]

Subd. 3. MS 2012 [Repealed, 2014 c 262 art 3 s 18]

Subd. 4. MS 2012 [Repealed, 2014 c 262 art 3 s 18]

History: *1Sp1993 c 1 art 7 s 15; 1995 c 207 art 8 s 18-21; 2002 c 277 s 3; 2003 c 112 art 2 s 50; 1Sp2003 c 14 art 11 s 11; 2009 c 101 art 2 s 109; 2012 c 216 art 12 s 5*

245.4933 MS 2012 [Repealed, 2014 c 262 art 3 s 18]

245.494 MS 2012 [Repealed, 2014 c 262 art 3 s 18]

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, paragraph (o). 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 operational 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, paragraph (n). 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 245.495, 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.

History: *1Sp1993 c 1 art 7 s 17; 1995 c 207 art 8 s 25; 1Sp1995 c 3 art 16 s 13; 2003 c 130 s 12; 1Sp2003 c 14 art 11 s 11; 2015 c 78 art 4 s 61; 2025 c 20 s 198*

245.496 MS 2002 [Repealed, 1Sp2003 c 14 art 11 s 12]

245.50 INTERSTATE CONTRACTS, MENTAL HEALTH, CHEMICAL HEALTH, DETOXIFICATION SERVICES.

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

(a) "Bordering state" means Iowa, North Dakota, South Dakota, or Wisconsin.

(b) "Receiving agency" means a public or private hospital, mental health center, chemical health treatment facility, detoxification facility, or other person or organization which provides mental health, chemical health, or detoxification services under this section to individuals from a state other than the state in which the agency is located.

(c) "Receiving state" means the state in which a receiving agency is located.

(d) "Sending agency" means a state or county agency which sends an individual to a bordering state for treatment or detoxification under this section.

(e) "Sending state" means the state in which the sending agency is located.

Subd. 2. **Purpose and authority.** (a) The purpose of this section is to enable appropriate treatment or detoxification services to be provided to individuals, across state lines from the individual's state of residence, in qualified facilities that are closer to the homes of individuals than are facilities available in the individual's home state.

(b) Unless prohibited by another law and subject to the exceptions listed in subdivision 3, a county board, the commissioner of human services, or the Direct Care and Treatment executive board may contract with an agency or facility in a bordering state for mental health, chemical health, or detoxification services for residents of Minnesota, and a Minnesota mental health, chemical health, or detoxification agency or facility may contract to provide services to residents of bordering states. Except as provided in subdivision 5, a person who receives services in another state under this section is subject to the laws of the state in which services are provided. A person who will receive services in another state under this section must be informed of the consequences of receiving services in another state, including the implications of the differences in state laws, to the extent the individual will be subject to the laws of the receiving state.

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 the subject of a presentence investigation; or

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

Subd. 4. **Contracts.** Contracts entered into under this section must, at a minimum:

(1) describe the services to be provided;

(2) establish responsibility for the costs of services;

(3) establish responsibility for the costs of transporting individuals receiving services under this section;

(4) specify the duration of the contract;

(5) specify the means of terminating the contract;

(6) specify the terms and conditions for refusal to admit or retain an individual; and

(7) identify the goals to be accomplished by the placement of an individual under this section.

Subd. 5. **Special contracts; bordering states.** (a) An individual who is detained, committed, or placed on an involuntary basis under chapter 253B may be confined or treated in a bordering state pursuant to a contract under this section. An individual who is detained, committed, or placed on an involuntary basis under the civil law of a bordering state may be confined or treated in Minnesota pursuant to a contract under this section. A peace or health officer who is acting under the authority of the sending state may transport an individual to a receiving agency that provides services pursuant to a contract under this section and may transport the individual back to the sending state under the laws of the sending state. Court orders valid under the law of the sending state are granted recognition and reciprocity in the receiving state for individuals covered by a contract under this section to the extent that the court orders relate to confinement for treatment or care of mental illness, chemical dependency, or detoxification. Such treatment or care may address other conditions that may be co-occurring with the mental illness or chemical dependency. These court orders are not subject to legal challenge in the courts of the receiving state. Individuals who are detained, committed, or placed under the law of a sending state and who are transferred to a receiving state under this section continue to be in the legal custody of the authority responsible for them under the law of the sending state. Except in emergencies, those individuals may not be transferred, removed, or furloughed from a receiving agency without the specific approval of the authority responsible for them under the law of the sending state.

(b) While in the receiving state pursuant to a contract under this section, an individual shall be subject to the sending state's laws and rules relating to length of confinement, reexaminations, and extensions of confinement. No individual may be sent to another state pursuant to a contract under this section until the receiving state has enacted a law recognizing the validity and applicability of this section.

(c) If an individual receiving services pursuant to a contract under this section leaves the receiving agency without permission and the individual is subject to involuntary confinement under the law of the sending state, the receiving agency shall use all reasonable means to return the individual to the receiving agency. The receiving agency shall immediately report the absence to the sending agency. The receiving state has the primary responsibility for, and the authority to direct, the return of these individuals within its borders and is liable for the cost of the action to the extent that it would be liable for costs of its own resident.

(d) Responsibility for payment for the cost of care remains with the sending agency.

(e) This subdivision also applies to county contracts under subdivision 2 which include emergency care and treatment provided to a county resident in a bordering state.

(f) If a Minnesota resident is admitted to a facility in a bordering state under this chapter, an individual who is licensed in the bordering state may act as a court examiner under sections 253B.07, 253B.08, 253B.092, 253B.12, and 253B.17 subject to the same requirements and limitations in section 253B.02, subdivision 4d. An examiner under section 253B.02, subdivision 7, may initiate an emergency hold under section 253B.051 on a Minnesota resident who is in a hospital that is under contract with a Minnesota governmental entity under this section provided the resident, in the opinion of the examiner, meets the criteria in section 253B.051.

(g) This section shall apply to detoxification services that are unrelated to treatment whether the services are provided on a voluntary or involuntary basis.

Subd. 6. **Contract notice.** A Minnesota mental health, chemical health, or detoxification agency or facility entering into a contract with a bordering state under this section must, within 30 days of the contract's effective date, provide the commissioner of human services with a copy of the contract. If the contract is amended, the agency or facility must provide the commissioner with a copy of each amendment within 30 days of the amendment's effective date.

History: *1985 c 253 s 1; 1993 c 102 s 1,2; 1994 c 529 s 1; 2002 c 375 art 2 s 7-9; 2006 c 193 s 1-3; 2007 c 147 art 8 s 9; 2009 c 167 s 6; 2011 c 110 art 1 s 8; 2022 c 58 s 95; 2023 c 50 art 4 s 2; 2025 c 38 art 3 s 28; art 4 s 18,19*

245.51 INTERSTATE COMPACT ON MENTAL HEALTH.

The Interstate Compact on Mental Health is hereby enacted into law and entered into by this state with all other states legally joining therein in the form as follows:

INTERSTATE COMPACT ON MENTAL HEALTH

The contracting states solemnly agree that:

ARTICLE I

The party states find that the proper and expeditious treatment of the mentally ill and mentally deficient can be facilitated by cooperative action, to the benefit of the patients, their families, and society as a whole. Further, the party states find that the necessity of and desirability for furnishing such care and treatment bears no primary relation to the residence or citizenship of the patient but that, on the contrary, the controlling factors of community safety and humanitarianism require that facilities and services be made available for all who are in need of them. Consequently, it is the purpose of this compact and of the party states to provide the necessary legal basis for the institutionalization or other appropriate care and treatment of the mentally ill and mentally deficient under a system that recognizes the paramount importance of patient welfare and to establish the responsibilities of the party states in terms of such welfare.

ARTICLE II

As used in this compact:

(a) "Sending state" shall mean a party state from which a patient is transported pursuant to the provisions of the compact or from which it is contemplated that a patient may be so sent.

(b) "Receiving state" shall mean a party state to which a patient is transported pursuant to the provisions of the compact or to which it is contemplated that a patient may be so sent.

(c) "Institution" shall mean any hospital or other facility maintained by a party state or political subdivision thereof for the care and treatment of mental illness or mental deficiency.

(d) "Patient" shall mean any person subject to or eligible as determined by the laws of the sending state, for institutionalization or other care, treatment, or supervision pursuant to the provisions of this compact.

(e) "Aftercare" shall mean care, treatment and services provided a patient, as defined herein, on convalescent status or conditional release.

(f) "Mental illness" shall mean mental disease to such extent that a person so afflicted requires care and treatment for his own welfare, or the welfare of others, or of the community.

(g) "Mental deficiency" shall mean mental deficiency as defined by appropriate clinical authorities to such extent that a person so afflicted is incapable of managing himself and his affairs, but shall not include mental illness as defined herein.

(h) "State" shall mean any state, territory or possession of the United States, the District of Columbia, and the Commonwealth of Puerto Rico.

ARTICLE III

(a) Whenever a person physically present in any party state shall be in need of institutionalization by reason of mental illness or mental deficiency, he shall be eligible for care and treatment in an institution in that state irrespective of his residence, settlement or citizenship qualifications.

(b) The provisions of paragraph (a) of this article to the contrary notwithstanding, any patient may be transferred to an institution in another state whenever there are factors based upon clinical determinations indicating that the care and treatment of said patient would be facilitated or improved thereby. Any such institutionalization may be for the entire period of care and treatment or for any portion or portions thereof. The factors referred to in this paragraph shall include the patient's full record with due regard for the location of the patient's family, character of the illness and probable duration thereof, and such other factors as shall be considered appropriate.

(c) No state shall be obliged to receive any patient pursuant to the provisions of paragraph (b) of this article unless the sending state has given advance notice of its intention to send the patient; furnished all available medical and other pertinent records concerning the patient; given the qualified medical or other appropriate clinical authorities of the receiving state an opportunity to examine the patient if said authorities so wish; and unless the receiving state shall agree to accept the patient.

(d) In the event that the laws of the receiving state establish a system of priorities for the admission of patients, an interstate patient under this compact shall receive the same priority as a local patient and shall be taken in the same order and at the same time that he would be taken if he were a local patient.

(e) Pursuant to this compact, the determination as to the suitable place of institutionalization for a patient may be reviewed at any time and such further transfer of the patient may be made as seems likely to be in the best interest of the patient.

ARTICLE IV

(a) Whenever, pursuant to the laws of the state in which a patient is physically present, it shall be determined that the patient should receive aftercare or supervision, such care or supervision may be provided in a receiving state. If the medical or other appropriate clinical authorities having responsibility for the care and treatment of the patient in the sending state shall have reason to believe that aftercare in another state would be in the best interest of the patient and would not jeopardize the public safety, they shall request the appropriate authorities in the receiving state to investigate the desirability of affording the patient such aftercare in said receiving state, and such investigation shall be made with all reasonable speed. The request for investigation shall be accompanied by complete information concerning the patient's intended place of residence and the identity of the person in whose charge it is proposed to place the patient, the complete medical history of the patient, and such other documents as may be pertinent.

(b) If the medical or other appropriate clinical authorities having responsibility for the care and treatment of the patient in the sending state and the appropriate authorities in the receiving state find that the best interest of the patient would be served thereby, and if the public safety would not be jeopardized thereby, the patient may receive aftercare or supervision in the receiving state.

(c) In supervising, treating, or caring for a patient on aftercare pursuant to the terms of this article, a receiving state shall employ the same standards of visitation, examination, care, and treatment that it employs for similar local patients.

ARTICLE V

Whenever a dangerous or potentially dangerous patient escapes from an institution in any party state, that state shall promptly notify all appropriate authorities within and without the jurisdiction of the escape in a manner reasonably calculated to facilitate the speedy apprehension of the escapee. Immediately upon the apprehension and identification of any such dangerous or potentially dangerous patient, he shall be detained in the state where found pending disposition in accordance with law.

ARTICLE VI

The duly accredited officers of any state party to this compact, upon the establishment of their authority and the identity of the patient, shall be permitted to transport any patient being moved pursuant to this compact through any and all states party to this compact, without interference.

ARTICLE VII

(a) No person shall be deemed a patient of more than one institution at any given time. Completion of transfer of any patient to an institution in a receiving state shall have the effect of making the person a patient of the institution in the receiving state.

(b) The sending state shall pay all costs of and incidental to the transportation of any patient pursuant to this compact, but any two or more party states may, by making a specific agreement for that purpose, arrange for a different allocation of costs as among themselves.

(c) No provision of this compact shall be construed to alter or affect any internal relationships among the departments, agencies and officers of and in the government of a party state, or between a party state and its subdivisions, as to the payment of costs, or responsibilities therefor.

(d) Nothing in this compact shall be construed to prevent any party state or subdivision thereof from asserting any right against any person, agency or other entity in regard to costs for which such party state or subdivision thereof may be responsible pursuant to any provision of this compact.

(e) Nothing in this compact shall be construed to invalidate any reciprocal agreement between a party state and a nonparty state relating to institutionalization, care or treatment of the mentally ill or mentally deficient, or any statutory authority pursuant to which such agreements may be made.

ARTICLE VIII

(a) Nothing in this compact shall be construed to abridge, diminish, or in any way impair the rights, duties, and responsibilities of any patient's guardian on his own behalf or in respect of any patient for whom he may serve, except that where the transfer of any patient to another jurisdiction makes advisable the appointment of a supplemental or substitute guardian, any court of competent jurisdiction in the receiving state may make such supplemental or substitute appointment and the court which appointed the previous guardian shall upon being duly advised of the new appointment, and upon the satisfactory completion of

such accounting and other acts as such court may by law require, relieve the previous guardian of power and responsibility to whatever extent shall be appropriate in the circumstances; provided, however, that in the case of any patient having settlement in the sending state, the court of competent jurisdiction in the sending state shall have the sole discretion to relieve a guardian appointed by it or continue his power and responsibility, whichever it shall deem advisable. The court in the receiving state may, in its discretion, confirm or reappoint the person or persons previously serving as guardian in the sending state in lieu of making a supplemental or substitute appointment.

(b) The term "guardian" as used in paragraph (a) of this article shall include any guardian, trustee, legal committee, conservator, or other person or agency however denominated who is charged by law with power to act for or responsibility for the person or property of a patient.

ARTICLE IX

(a) No provision of this compact except Article V shall apply to any person institutionalized while under sentence in a penal or correctional institution or while subject to trial on a criminal charge, or whose institutionalization is due to the commission of an offense for which, in the absence of mental illness or mental deficiency, said person would be subject to incarceration in a penal or correctional institution.

(b) To every extent possible, it shall be the policy of states party to this compact that no patient shall be placed or detained in any prison, jail or lockup, but such patient shall, with all expedition, be taken to a suitable institutional facility for mental illness or mental deficiency.

ARTICLE X

(a) Each party state shall appoint a "compact administrator" who, on behalf of his state, shall act as general coordinator of activities under the compact in his state and who shall receive copies of all reports, correspondence, and other documents relating to any patient processed under the compact by his state either in the capacity of sending or receiving state. The compact administrator or his duly designated representative shall be the official with whom other party states shall deal in any matter relating to the compact or any patient processed thereunder.

(b) The compact administrators of the respective party states shall have power to promulgate reasonable rules and regulations to carry out more effectively the terms and provisions of this compact.

ARTICLE XI

The duly constituted administrative authorities of any two or more party states may enter into supplementary agreements for the provision of any service or facility or for the maintenance of any institution on a joint or cooperative basis whenever the states concerned shall find that such agreements will improve services, facilities, or institutional care and treatment in the fields of mental illness or mental deficiency. No such supplementary agreement shall be construed so as to relieve any party state of any obligation which it otherwise would have under other provisions of this compact.

ARTICLE XII

This compact shall enter into full force and effect as to any state when enacted by it into law and such state shall thereafter be a party thereto with any and all states legally joining therein.

ARTICLE XIII

(a) A state party to this compact may withdraw therefrom by enacting a statute repealing the same. Such withdrawal shall take effect one year after notice thereof has been communicated officially and in writing

to the governors and compact administrators of all other party states. However, the withdrawal of any state shall not change the status of any patient who has been sent to said state or sent out of said state pursuant to the provisions of the compact.

(b) Withdrawal from any agreement permitted by Article VII(b) as to costs or from any supplementary agreement made pursuant to Article XI shall be in accordance with the terms of such agreement.

ARTICLE XIV

This compact shall be liberally construed so as to effectuate the purposes thereof. The provisions of this compact shall be severable and if any phrase, clause, sentence or provision of this compact is declared to be contrary to the Constitution of any party state or of the United States or the applicability thereof to any government, agency, person or circumstance is held invalid, the validity of the remainder of this compact and the applicability thereof to any government, agency, person or circumstance shall not be affected thereby. If this compact shall be held contrary to the constitution of any state party thereto, the compact shall remain in full force and effect as to the remaining states and in full force and effect as to the state affected as to all severable matters.

History: *1957 c 326 s 1*

245.52 CHIEF EXECUTIVE OFFICER OF DIRECT CARE AND TREATMENT AS COMPACT ADMINISTRATOR.

The chief executive officer of Direct Care and Treatment is hereby designated as "compact administrator." The chief executive officer shall have the powers and duties specified in the compact, and may, in the name of the state of Minnesota, subject to the approval of the attorney general as to form and legality, enter into such agreements authorized by the compact as the chief executive officer deems appropriate to effecting the purpose of the compact. The chief executive officer shall, within the limits of the appropriations for the care of persons with mental illness or developmental disabilities, authorize such payments as are necessary to discharge any financial obligations imposed upon this state by the compact or any agreement entered into under the compact.

If the patient has no established residence in a Minnesota county, the commissioner of human services shall designate the county of financial responsibility for the purposes of carrying out the provisions of the Interstate Compact on Mental Health as it pertains to patients being transferred to Minnesota. The commissioner of human services shall designate the county which is the residence of the person in Minnesota who initiates the earliest written request for the patient's transfer.

History: *1957 c 326 s 2; 1981 c 98 s 1; 1984 c 654 art 5 s 58; 1985 c 21 s 4; 1986 c 444; 2005 c 56 s 1; 2025 c 38 art 3 s 29*

245.53 TRANSMITTAL OF COPIES OF ACT.

Duly authenticated copies of sections 245.51 to 245.53 shall, upon its approval, be transmitted by the secretary of state to the governor of each state, the Attorney General and the Secretary of State of the United States, and the Council of State Governments.

History: *1957 c 326 s 3*

245.61 COUNTY BOARDS; GRANTS FOR LOCAL MENTAL HEALTH PROGRAMS.

County boards are hereby authorized to make grants to public or private agencies to establish and operate local mental health programs to provide the following services: (a) collaborative and cooperative services

with public health and other groups for programs of prevention of mental illness, developmental disability, alcoholism, and other psychiatric disabilities; (b) informational and educational services to the general public, and lay and professional groups; (c) consultative services to schools, courts and health and welfare agencies, both public and private, including diagnostic evaluation of cases from juvenile courts; (d) outpatient diagnostic and treatment services; (e) rehabilitative services for patients suffering from mental or emotional disorders, developmental disability, alcoholism, and other psychiatric conditions particularly those who have received prior treatment in an inpatient facility; (f) detoxification in alcoholism evaluation and service facilities.

History: *1957 c 392 s 1; 1969 c 1043 s 7; 1973 c 123 art 5 s 7; 1976 c 163 s 43; 1979 c 324 s 13; 2005 c 56 s 1*

245.62 COMMUNITY MENTAL HEALTH CENTER.

Subdivision 1. **Establishment.** Any city, county, town, combination thereof, or private nonprofit corporation may establish a community mental health center.

Subd. 2. **Definition.** A community mental health center is a private nonprofit corporation or public agency approved under the standards of section 256B.0625, subdivision 5.

Subd. 3. MS 2020 [Repealed, 2021 c 30 art 17 s 113]

Subd. 4. MS 2020 [Repealed, 2021 c 30 art 17 s 113]

History: *1957 c 392 s 2; 1959 c 530 s 1; 1967 c 888 s 1; 1973 c 123 art 5 s 7; 1973 c 583 s 14; 1973 c 773 s 1; 1975 c 69 s 1; 1979 c 324 s 14; 1983 c 312 art 5 s 1; 1984 c 640 s 32; 1989 c 282 art 4 s 54; 1991 c 255 s 19; 1997 c 7 art 5 s 23,24; 2005 c 56 s 1; 2017 c 40 art 1 s 50; 2021 c 30 art 17 s 45*

245.63 MS 2012 [Repealed, 2014 c 262 art 3 s 18]

245.64 MS 1988 [Repealed, 1989 c 282 art 4 s 64]

245.65 MS 1978 [Repealed, 1979 c 324 s 50]

245.651 MS 1978 [Repealed, 1979 c 324 s 50]

245.652 MS 2012 [Repealed, 2014 c 262 art 3 s 18]

245.66 COMMUNITY MENTAL HEALTH CENTER BOARDS.

Every city, county, town, combination thereof or nonprofit corporation establishing a community mental health center shall establish a community mental health center board. The community mental health center board may include county commissioner representatives from each participating county and shall be representative of the local population, including at least health and human service professions and advocate associations, other fields of employment, and the general public. Each community mental health center board shall be responsible for the governance and performance of its center.

History: *1957 c 392 s 6; 1959 c 303 s 1; 1963 c 796 s 2; 1973 c 123 art 5 s 7; 1975 c 69 s 3; 1975 c 169 s 2; 1979 c 324 s 17; 1981 c 355 s 21; 1983 c 312 art 5 s 2*

245.67 MS 1980 [Repealed, 1981 c 355 s 34]

245.68 MS 1980 [Repealed, 1981 c 355 s 34]

245.69 Subdivision 1. MS 2012 [Repealed, 2014 c 262 art 3 s 18]

Subd. 1a. MS 1986 [Repealed, 1987 c 403 art 2 s 164]

Subd. 2. MS 2020 [Repealed, 2021 c 30 art 17 s 113]

245.691 MS 1978 [Repealed, 1979 c 324 s 50]

245.692 MS 1971 [Repealed, 1973 c 572 s 18]

245.693 MS 1971 [Repealed, 1973 c 572 s 18]

245.694 MS 1971 [Repealed, 1973 c 572 s 18]

245.695 MS 1971 [Repealed, 1973 c 572 s 18]

245.696 ADDITIONAL DUTIES OF COMMISSIONER.

Subdivision 1. **Behavioral Health Division.** A Behavioral Health Division is created in the Department of Human Services. The division shall enforce and coordinate the laws administered by the commissioner of human services, relating to mental illness, which the commissioner assigns to the division. The Behavioral Health Division shall be under the supervision of an assistant commissioner of behavioral health appointed by the commissioner. The commissioner, working with the assistant commissioner of behavioral health, shall oversee and coordinate services to people with mental illness in community programs throughout the state.

Subd. 2. **Specific duties.** In addition to the powers and duties already conferred by law, the commissioner of human services shall:

(1) review and evaluate local programs and the performance of administrative and mental health personnel and make recommendations to county boards and program administrators;

(2) provide consultative staff service to communities and advocacy groups to assist in ascertaining local needs and in planning and establishing community mental health programs;

(3) employ qualified personnel to implement this chapter;

(4) adopt rules for minimum standards in community mental health services as directed by the legislature;

(5) cooperate with the commissioners of health and employment and economic development to coordinate services and programs for people with mental illness;

(6) evaluate the needs of people with mental illness as they relate to assistance payments, medical benefits, nursing home care, and other state and federally funded services;

(7) provide data and other information, as requested, to the Advisory Council on Mental Health;

(8) develop and maintain a data collection system to provide information on the prevalence of mental illness, the need for specific mental health services and other services needed by people with mental illness, funding sources for those services, and the extent to which state and local areas are meeting the need for services;

(9) apply for grants and develop pilot programs to test and demonstrate new methods of assessing mental health needs and delivering mental health services;

(10) study alternative reimbursement systems and make waiver requests that are deemed necessary by the commissioner;

(11) provide technical assistance to county boards to improve fiscal management and accountability and quality of mental health services, and consult regularly with county boards, public and private mental health agencies, and client advocacy organizations for purposes of implementing this chapter;

(12) promote coordination between the mental health system and other human service systems in the planning, funding, and delivery of services; entering into cooperative agreements with other state and local agencies for that purpose as deemed necessary by the commissioner;

(13) conduct research regarding the relative effectiveness of mental health treatment methods as the commissioner deems appropriate, and for this purpose, enter treatment facilities, observe clients, and review records in a manner consistent with the Minnesota Government Data Practices Act, chapter 13;

(14) enter into contracts and promulgate rules the commissioner deems necessary to carry out the purposes of this chapter; and

(15) administer county mental health grants on a calendar year basis, unless that procedure hinders the achievement of the purposes of a particular grant.

History: *1987 c 342 s 1; 1988 c 689 art 2 s 94; 1989 c 282 art 4 s 55; 1990 c 568 art 5 s 28; 1994 c 483 s 1; 1994 c 529 s 2; 2004 c 206 s 52; 2024 c 79 art 8 s 11*

245.697 STATE ADVISORY COUNCIL ON MENTAL HEALTH.

Subdivision 1. **Creation.** (a) A State Advisory Council on Mental Health is created. The council must have members appointed by the governor in accordance with federal requirements. In making the appointments, the governor shall consider appropriate representation of communities of color. The council must be composed of:

(1) the assistant commissioner of the Department of Human Services who oversees behavioral health policy;

(2) a representative of the Department of Human Services responsible for the medical assistance program;

(3) a representative of Direct Care and Treatment;

(4) a representative of the Department of Health;

(5) a representative of the Department of Children, Youth, and Families;

(6) one member of each of the following professions:

(i) psychiatry;

(ii) psychology;

(iii) social work;

(iv) nursing;

(v) marriage and family therapy; and

(vi) professional clinical counseling;

(7) one representative from each of the following advocacy groups: Mental Health Association of Minnesota, NAMI-MN, Minnesota Disability Law Center, American Indian Mental Health Advisory Council, and a consumer-run mental health advocacy group;

(8) providers of mental health services;

(9) consumers of mental health services;

(10) family members of persons with mental illnesses;

(11) legislators;

(12) social service agency directors;

(13) county commissioners; and

(14) other members reflecting a broad range of community interests, including family physicians, or members as the United States Secretary of Health and Human Services may prescribe by regulation or as may be selected by the governor.

(b) The council shall select a chair. Terms, compensation, and removal of members and filling of vacancies are governed by section 15.059. Notwithstanding provisions of section 15.059, the council and its subcommittee on children's mental health do not expire. The commissioner of human services shall provide staff support and supplies to the council.

Subd. 2. **Duties.** The State Advisory Council on Mental Health shall:

(1) advise the governor and heads of state departments and agencies about policy, programs, and services affecting people with mental illness;

(2) advise the commissioner of human services on all phases of the development of mental health aspects of the biennial budget;

(3) advise the governor about the development of innovative mechanisms for providing and financing services to people with mental illness;

(4) encourage state departments and other agencies to conduct needed research in the field of mental health;

(5) review recommendations of the subcommittee on children's mental health;

(6) educate the public about mental illness and the needs and potential of people with mental illness;

(7) review and comment on all grants dealing with mental health and on the development and implementation of state and local mental health plans; and

(8) coordinate the work of local children's and adult mental health advisory councils and subcommittees.

Subd. 2a. **Subcommittee on Children's Mental Health.** The State Advisory Council on Mental Health (the "advisory council") must have a Subcommittee on Children's Mental Health. The subcommittee must make recommendations to the advisory council on policies, laws, regulations, and services relating to children's mental health. Members of the subcommittee must include:

(1) the commissioners or designees of the commissioners of the Departments of Human Services; Children, Youth, and Families; Health; Education; State Planning; and Corrections;

(2) a designee of the Direct Care and Treatment executive board;

(3) the commissioner of commerce or a designee of the commissioner who is knowledgeable about medical insurance issues;

(4) at least one representative of an advocacy group for children with mental illnesses;

(5) providers of children's mental health services, including at least one provider of services to preadolescent children, one provider of services to adolescents, and one hospital-based provider;

(6) parents of children who have mental illnesses;

(7) a present or former consumer of adolescent mental health services;

(8) educators currently working with children with mental illnesses;

(9) people knowledgeable about the needs of children with mental illnesses of minority races and cultures;

(10) people experienced in working with children with mental illnesses who have committed status offenses;

(11) members of the advisory council;

(12) one person from the local corrections department and one representative of the Minnesota District Judges Association Juvenile Committee; and

(13) county commissioners and social services agency representatives.

The chair of the advisory council shall appoint subcommittee members described in clauses (4) to (12) through the process established in section 15.0597. The chair shall appoint members to ensure a geographical balance on the subcommittee. Terms, compensation, removal, and filling of vacancies are governed by subdivision 1, except that terms of subcommittee members who are also members of the advisory council are coterminous with their terms on the advisory council. The subcommittee shall meet at the call of the subcommittee chair who is elected by the subcommittee from among its members. The subcommittee expires with the expiration of the advisory council.

Subd. 3. **Reports.** The State Advisory Council on Mental Health shall report from time to time on its activities to the governor, the chairs of the appropriate policy committees of the house of representatives and senate, and the commissioners of health, employment and economic development, and human services. It shall file a formal report with the governor not later than October 15 of each even-numbered year so that the information contained in the report, including recommendations, can be included in the governor's budget message to the legislature. It shall also report to the chairs of the appropriate policy committees of the house of representatives and senate not later than November 15 of each even-numbered year.

History: *1987 c 342 s 2; 1988 c 629 s 45; 1988 c 689 art 2 s 95,96; 1989 c 282 art 4 s 56-58; 1990 c 568 art 5 s 29; 1991 c 292 art 6 s 27; 1994 c 483 s 1; 1Sp1995 c 3 art 16 s 13; 1997 c 7 art 2 s 33,34; 1997 c 192 s 32; 1999 c 39 s 1; 2003 c 112 art 1 s 17; 2003 c 130 s 12; 2004 c 206 s 52; 2012 c 247 art 5 s 2; 2021 c 30 art 13 s 2; 2024 c 79 art 8 s 12,13; 2024 c 125 art 5 s 43; 2024 c 127 art 50 s 43; 2025 c 21 s 32,33; 2025 c 38 art 8 s 44*

245.698 MS 1988 [Repealed, 1989 c 282 art 4 s 64]

245.699 MS 2006 [Repealed, 2007 c 133 art 2 s 13]

245.70 MENTAL HEALTH; FEDERAL AID.

Subdivision 1. **Mentally ill.** The commissioner of human services is designated the state agency to establish and administer a statewide plan for the care, treatment, diagnosis, or rehabilitation, of the mentally ill which are or may be required as a condition for eligibility for benefits under any federal law and in particular under the Federal Alcohol, Drug Abuse and Mental Health Block Grant Law, United States Code, title 42, sections 300X to 300X-9. The commissioner of human services is authorized and directed to receive, administer, and expend any funds that may be available under any federal law or from any other source, public or private, for such purposes.

Subd. 2. **Mental health block grants.** The commissioner of human services is designated the state authority to establish and administer the state plan for the federal mental health funds available under the alcohol, drug abuse, and mental health services block grant, United States Code, title 42, sections 300X to 300X-9. The commissioner shall receive and administer the available federal mental health funds.

History: *1965 c 626 s 1; 1982 c 607 s 1; 1984 c 654 art 5 s 58; 1985 c 252 s 1*

245.71 CONDITIONS TO FEDERAL AID FOR MENTALLY ILL.

Subdivision 1. **Federal aid or block grants.** The commissioner of human services may comply with all conditions and requirements necessary to receive federal aid or block grants with respect to the establishment, construction, maintenance, equipment or operation, for all the people of this state, of adequate facilities and services as specified in section 245.70.

Subd. 2. MS 2006 [Repealed by amendment, 2007 c 133 art 2 s 8]

History: *1965 c 626 s 2; 1982 c 607 s 2; 1984 c 640 s 32; 1984 c 654 art 5 s 58; 1985 c 252 s 2; 2007 c 133 art 2 s 8*

245.711 MS 1992 [Repealed, 1Sp1993 c 1 art 7 s 50]

245.712 MS 1992 [Repealed, 1Sp1993 c 1 art 7 s 50]

245.713 ALLOCATION FORMULA.

Subdivision 1. MS 1986 [Repealed, 1987 c 403 art 2 s 164]

Subd. 2. **Total funds available; allocation.** Funds granted to the state by the federal government under United States Code, title 42, sections 300X to 300X-9 each federal fiscal year for mental health services must be allocated as follows:

(a) Any amount set aside by the commissioner of human services for American Indian organizations within the state, which funds shall not duplicate any direct federal funding of American Indian organizations and which funds shall be at least 25 percent of the total federal allocation to the state for mental health services. Money from this source may be used for special committees to advise the commissioner on mental health programs and services for American Indians and other minorities or underserved groups. For purposes of this subdivision, "American Indian organization" means an American Indian Tribe or Band or an organization providing mental health services that is legally incorporated as a nonprofit organization registered with the secretary of state and governed by a board of directors having at least a majority of American Indian directors.

(b) An amount not to exceed five percent of the federal block grant allocation for mental health services to be retained by the commissioner for administration.

(c) Any amount permitted under federal law which the commissioner approves for demonstration or research projects for severely disturbed children and adolescents, the underserved, special populations or multiply disabled mentally ill persons. The groups to be served, the extent and nature of services to be provided, the amount and duration of any grant awards are to be based on criteria set forth in the Alcohol, Drug Abuse and Mental Health Block Grant Law, United States Code, title 42, sections 300X to 300X-9, and on state policies and procedures determined necessary by the commissioner. Grant recipients must comply with applicable state and federal requirements and demonstrate fiscal and program management capabilities that will result in provision of quality, cost-effective services.

(d) The amount required under federal law, for federally mandated expenditures.

(e) An amount not to exceed 15 percent of the federal block grant allocation for mental health services to be retained by the commissioner for planning and evaluation.

Subd. 3. MS 1986 [Repealed, 1987 c 403 art 2 s 164]

Subd. 4. MS 2004 [Repealed, 2005 c 98 art 3 s 25]

History: *1982 c 607 s 5; 1984 c 654 art 5 s 58; 1985 c 252 s 4; 1987 c 403 art 2 s 41; 1989 c 282 art 4 s 59; 2005 c 98 art 3 s 25; 2007 c 147 art 11 s 23; 2022 c 98 art 6 s 6*

245.714 MS 2012 [Repealed, 2014 c 262 art 3 s 18]

245.715 MS 2012 [Repealed, 2014 c 262 art 3 s 18]

245.716 MS 2004 [Repealed, 2005 c 98 art 3 s 25]

245.717 MS 2012 [Repealed, 2014 c 262 art 3 s 18]

245.718 MS 2012 [Repealed, 2014 c 262 art 3 s 18]

245.72 MS 1980 [Repealed, 1981 c 355 s 34]

245.721 MS 2012 [Repealed, 2014 c 262 art 3 s 18]

245.73 SERVICES FOR ADULTS WITH MENTAL ILLNESS; GRANTS.

Subdivision 1. **Commissioner's duty.** The commissioner shall establish a statewide program to assist counties in ensuring provision of services to adult mentally ill persons. The commissioner shall make grants to county boards to provide community-based services to mentally ill persons through programs licensed under sections 245A.01 to 245A.16.

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.

Subd. 2a. **Special programs.** Grants received pursuant to this section may be used to fund innovative programs in residential facilities, related to structured physical fitness programs designed as part of a mental health treatment plan.

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.

Subd. 4. **Rules; reports.** The commissioner shall promulgate an emergency and permanent rule to govern grant applications, approval of applications, allocation of grants, and maintenance of service and financial records by grant recipients. The commissioner shall specify requirements for reports, including quarterly fiscal reports, according to section 256.01, subdivision 2, paragraph (o). The commissioner shall require collection of data for compliance, monitoring and evaluation purposes and shall require periodic reports to demonstrate the effectiveness of the services in helping adult mentally ill persons remain and function in their own communities. As a part of the report required by section 245.461, the commissioner shall report to the legislature as to the effectiveness of this program and recommendations regarding continued funding.

Subd. 5. **Transfer of funds.** The commissioner may transfer money from adult mental health residential program grants to community support program grants under section 256K.10 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: *1981 c 360 art 2 s 14; 1983 c 164 s 1; 1984 c 640 s 32; 1986 c 349 s 1; 1987 c 384 art 2 s 1; 1989 c 89 s 3; 1989 c 282 art 2 s 55,56; art 4 s 60; 1990 c 568 art 5 s 30; 1Sp1993 c 1 art 7 s 21-23; 2015 c 78 art 4 s 61; 2024 c 80 art 8 s 68*

245.735 CERTIFIED COMMUNITY BEHAVIORAL HEALTH CLINIC SERVICES.

Subdivision 1. MS 2020 [Repealed, 2021 c 30 art 11 s 8]

Subd. 1a. **Definitions.** (a) For the purposes of this section, the terms in this subdivision have the meanings given.

(b) "Alcohol and drug counselor" has the meaning given in section 245G.11, subdivision 5.

(c) "Care coordination" means the activities required to coordinate care across settings and providers for a person served to ensure seamless transitions across the full spectrum of health services. Care coordination includes outreach and engagement; documenting a plan of care for medical, behavioral health, and social services and supports in the integrated treatment plan; assisting with obtaining appointments; confirming appointments are kept; developing a crisis plan; tracking medication; and implementing care coordination agreements with external providers. Care coordination may include psychiatric consultation with primary care practitioners and with mental health clinical care practitioners.

(d) "Community needs assessment" means an assessment to identify community needs and determine the community behavioral health clinic's capacity to address the needs of the population being served.

(e) "Comprehensive evaluation" means a person-centered, family-centered, and trauma-informed evaluation meeting the requirements of subdivision 4b completed for the purposes of diagnosis and treatment planning.

(f) "Designated collaborating organization" means an entity meeting the requirements of subdivision 3a with a formal agreement with a CCBHC to furnish CCBHC services.

(g) "Functional assessment" means an assessment of a client's current level of functioning relative to functioning that is appropriate for someone the client's age and that meets the requirements of subdivision 4a.

(h) "Initial evaluation" means an evaluation completed by a mental health professional that gathers and documents information necessary to formulate a preliminary diagnosis and begin client services.

(i) "Integrated treatment plan" means a documented plan of care that is person- and family-centered and formulated to respond to a client's needs and goals.

(j) "Mental health professional" has the meaning given in section 245I.04, subdivision 2.

(k) "Mobile crisis services" has the meaning given in section 256B.0624, subdivision 2.

(l) "Preliminary screening and risk assessment" means a mandatory screening and risk assessment that is completed at the first contact with the prospective CCBHC service recipient and determines the acuity of client need.

[See Note.]

Subd. 2. MS 2020 [Repealed, 2021 c 30 art 11 s 8]

Subd. 2a. **Establishment.** The certified community behavioral health clinic model is an integrated payment and service delivery model that uses evidence-based behavioral health practices to achieve better outcomes for individuals experiencing behavioral health concerns while achieving sustainable rates for providers and economic efficiencies for payors.

[See Note.]

Subd. 3. **Certified community behavioral health clinics.** (a) The commissioner shall establish state certification and recertification processes for certified community behavioral health clinics (CCBHCs) that satisfy all federal requirements necessary for CCBHCs certified under this section to be eligible for reimbursement under medical assistance, without service area limits based on geographic area or region. The commissioner shall consult with CCBHC stakeholders before establishing and implementing changes in the certification or recertification process and requirements. Any changes to the certification or recertification process or requirements must be consistent with the most recently issued Certified Community Behavioral Health Clinic Certification Criteria published by the Substance Abuse and Mental Health Services Administration. The commissioner must allow a transition period for CCBHCs to meet the revised criteria on or before January 1, 2025. The commissioner is authorized to amend the state's Medicaid state plan or the terms of the demonstration to comply with federal requirements.

(b) As part of the state CCBHC certification and recertification processes, the commissioner shall provide to entities applying for certification or requesting recertification the standard requirements of the community needs assessment and the staffing plan that are consistent with the most recently issued Certified Community Behavioral Health Clinic Certification Criteria published by the Substance Abuse and Mental Health Services Administration.

(c) The commissioner shall schedule a certification review that includes a site visit within 90 calendar days of receipt of an application for certification or recertification.

(d) Entities that choose to be CCBHCs must:

(1) complete a community needs assessment and complete a staffing plan that is responsive to the needs identified in the community needs assessment and update both the community needs assessment and the staffing plan no less frequently than every 36 months;

(2) comply with state licensing requirements and other requirements issued by the commissioner;

(3) employ or contract with a medical director. A medical director must be a physician licensed under chapter 147 and either certified by the American Board of Psychiatry and Neurology, certified by the American Osteopathic Board of Neurology and Psychiatry, or eligible for board certification in psychiatry. A registered nurse who is licensed under sections 148.171 to 148.285 and is certified as a nurse practitioner in adult or family psychiatric and mental health nursing by a national nurse certification organization may serve as the medical director when a CCBHC is unable to employ or contract a qualified physician;

(4) employ or contract for clinic staff who have backgrounds in diverse disciplines, including licensed mental health professionals and licensed alcohol and drug counselors, and staff who are culturally and linguistically trained to meet the needs of the population the clinic serves;

(5) ensure that clinic services are available and accessible to individuals and families of all ages and genders with access on evenings and weekends and that crisis management services are available 24 hours per day;

(6) establish fees for clinic services for individuals who are not enrolled in medical assistance using a sliding fee scale that ensures that services to patients are not denied or limited due to an individual's inability to pay for services;

(7) comply with quality assurance reporting requirements and other reporting requirements included in the most recently issued Certified Community Behavioral Health Clinic Certification Criteria published by the Substance Abuse and Mental Health Services Administration;

(8) provide crisis mental health and substance use services, withdrawal management services, emergency crisis intervention services, and stabilization services through existing mobile crisis services; screening, assessment, and diagnosis services, including risk assessments and level of care determinations; person- and family-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. CCBHCs must directly provide the majority of these services to enrollees, but may coordinate some services with another entity through a collaboration or agreement, pursuant to subdivision 3a;

(9) provide coordination of care across settings and providers to ensure seamless transitions for individuals being served across the full spectrum of health services, including acute, chronic, and behavioral needs;

(10) be certified as a mental health clinic under section 245I.20;

(11) comply with standards established by the commissioner relating to CCBHC screenings, assessments, and evaluations that are consistent with this section;

(12) be licensed to provide substance use disorder treatment under chapter 245G;

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

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

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

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

(17) provide services that comply with the evidence-based practices described in subdivision 3d;

(18) provide peer services as defined in sections 256B.0615, 256B.0616, and 245G.07, subdivision 2a, paragraph (b), clause (2), as applicable when peer services are provided; and

(19) inform all clients upon initiation of care of the full array of services available under the CCBHC model.

[See Note.]

Subd. 3a. **Designated collaborating organizations.** If a certified CCBHC is unable to provide one or more of the services listed in subdivision 3, paragraph (d), clauses (8) to (19), the CCBHC may contract with another entity that has the required authority to provide that service and that meets the requirements of the most recently issued Certified Community Behavioral Health Clinic Certification Criteria published by the Substance Abuse and Mental Health Services Administration.

[See Note.]

Subd. 3b. **Exemptions to host county approval.** Notwithstanding any other law that requires a county contract or other form of county approval for a service listed in subdivision 3, paragraph (d), clause (8), a CCBHC that meets the requirements of this section may receive the prospective payment under section 256B.0625, subdivision 5m, for that service without a county contract or county approval.

[See Note.]

Subd. 3c. **Variances.** When the standards listed in this section or other applicable standards conflict or address similar issues in duplicative or incompatible ways, the commissioner may grant variances to state requirements if the variances do not conflict with federal requirements for services reimbursed under medical assistance. If standards overlap, the commissioner may substitute all or a part of a licensure or certification that is substantially the same as another licensure or certification. The commissioner shall consult with stakeholders before granting variances under this provision. For a CCBHC that is certified but not approved for prospective payment under section 256B.0625, subdivision 5m, the commissioner may grant a variance under this paragraph if the variance does not increase the state share of costs.

[See Note.]

Subd. 3d. **Evidence-based practices.** The commissioner shall issue a list of required evidence-based practices to be delivered by CCBHCs and may also provide a list of recommended evidence-based practices. The commissioner may update the list to reflect advances in outcomes research and medical services for persons living with mental illnesses or substance use disorders. The commissioner shall take into consideration the adequacy of evidence to support the efficacy of the practice across cultures and ages, the workforce available, and the current availability of the practice in the state. At least 30 days before issuing the initial list or issuing any revisions, the commissioner shall provide stakeholders with an opportunity to comment.

[See Note.]

Subd. 3e. **Recertification.** A CCBHC must apply for recertification every 36 months.

[See Note.]

Subd. 3f. **Notice and opportunity for correction.** (a) The commissioner shall provide a formal written notice to an applicant for CCBHC certification outlining the determination of the application and process for applicable and necessary corrective action required of the applicant signed by the commissioner or appropriate division director to applicant entities within 45 calendar days of the site visit.

(b) The commissioner may reject an application if the applicant entity does not take all corrective actions specified in the notice and notify the commissioner that the applicant entity has done so within 60 calendar days.

(c) The commissioner must send the applicant entity a final decision on the corrected application within 45 calendar days of the applicant entity's notice to the commissioner that the applicant has taken the required corrective actions.

[See Note.]

Subd. 3g. **Decertification process.** The commissioner must establish a process for decertification. The commissioner must 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, certification, or recertification process.

[See Note.]

Subd. 3h. **Minimum staffing standards.** A CCBHC must meet minimum staffing requirements required by the most recently issued Certified Community Behavioral Health Clinic Certification Criteria published by the Substance Abuse and Mental Health Services Administration.

[See Note.]

Subd. 4. MS 2020 [Repealed, 2021 c 30 art 11 s 8]

Subd. 4a. **Functional assessment requirements.** (a) For adults, a functional assessment may be completed using a Daily Living Activities-20 tool.

(b) Notwithstanding any law to the contrary, a functional assessment performed by a CCBHC that meets the requirements of this subdivision satisfies the requirements in:

(1) section 256B.0623, subdivision 9;

(2) section 245.4711, subdivision 3; and

(3) Minnesota Rules, part 9520.0914, subpart 2.

[See Note.]

Subd. 4b. **Requirements for comprehensive evaluations.** (a) A comprehensive evaluation must be completed for all new clients within 60 calendar days following the preliminary screening and risk assessment.

(b) Only a mental health professional may complete a comprehensive evaluation. The mental health professional must consult with an alcohol and drug counselor when substance use disorder services are deemed clinically appropriate.

(c) The comprehensive evaluation must consist of the synthesis of existing information including but not limited to an external diagnostic assessment, crisis assessment, preliminary screening and risk assessment, initial evaluation, and primary care screenings.

(d) A comprehensive evaluation must be completed in the cultural context of the client and updated to reflect changes in the client's conditions and at the client's request or when the client's condition no longer meets the existing diagnosis.

(e) The psychiatric evaluation and management service fulfills requirements for the comprehensive evaluation when a client of a CCBHC is receiving exclusively psychiatric evaluation and management services. The CCBHC shall complete the comprehensive evaluation within 60 calendar days of a client's referral for additional CCBHC services.

(f) For clients engaging exclusively in substance use disorder services at the CCBHC, a substance use disorder comprehensive assessment as defined in section 245G.05, subdivision 2, that is completed within 60 calendar days of service initiation shall fulfill requirements of the comprehensive evaluation.

(g) Notwithstanding any law to the contrary, a comprehensive evaluation performed by a CCBHC that meets the requirements of this subdivision satisfies the requirements in:

(1) section 245.462, subdivision 20, paragraph (c);

(2) section 245.4711, subdivision 2, paragraph (b);

(3) section 245.4871, subdivision 6;

(4) section 245.4881, subdivision 2, paragraph (c);

(5) section 245G.04, subdivision 1;

(6) section 245G.05, subdivision 1;

(7) section 245I.10, subdivisions 4 to 6;

(8) section 256B.0623, subdivisions 3, clause (4), 8, and 10;

(9) section 256B.0943, subdivisions 3 and 6, paragraph (b), clause (1);

(10) Minnesota Rules, part 9520.0909, subpart 1;

(11) Minnesota Rules, part 9520.0910, subparts 1 and 2; and

(12) Minnesota Rules, part 9520.0914, subpart 2.

[See Note.]

Subd. 4c. **Requirements for initial evaluations.** (a) A CCBHC must complete either an initial evaluation or a comprehensive evaluation as required by the most recently issued Certified Community Behavioral Health Clinic Certification Criteria published by the Substance Abuse and Mental Health Services Administration.

(b) Notwithstanding any law to the contrary, an initial evaluation performed by a CCBHC that meets the requirements of this subdivision satisfies the requirements in:

(1) section 245.4711, subdivision 4;

(2) section 245.4881, subdivisions 3 and 4;

(3) section 245I.10, subdivision 5;

(4) section 256B.0623, subdivisions 3, clause (4), 8, and 10;

(5) section 256B.0943, subdivisions 3 and 6, paragraph (b), clauses (1) and (2);

(6) Minnesota Rules, part 9520.0909, subpart 1;

(7) Minnesota Rules, part 9520.0910, subpart 1;

(8) Minnesota Rules, part 9520.0914, subpart 2;

(9) Minnesota Rules, part 9520.0918, subparts 1 and 2; and

(10) Minnesota Rules, part 9520.0919, subpart 2.

[See Note.]

Subd. 4d. **Requirements for integrated treatment plans.** (a) An integrated treatment plan must be completed within 60 calendar days following the preliminary screening and risk assessment and updated no less frequently than every six months or when the client's circumstances change.

(b) Only a mental health professional may complete an integrated treatment plan. The mental health professional must consult with an alcohol and drug counselor when substance use disorder services are deemed clinically appropriate. An alcohol and drug counselor may approve the integrated treatment plan. The integrated treatment plan must be developed through a shared decision-making process with the client, the client's support system if the client chooses, or, for children, with the family or caregivers.

(c) The integrated treatment plan must:

(1) use the ASAM 6 dimensional framework; and

(2) incorporate prevention, medical and behavioral health needs, and service delivery.

(d) The psychiatric evaluation and management service fulfills requirements for the integrated treatment plan when a client of a CCBHC is receiving exclusively psychiatric evaluation and management services. The CCBHC must complete an integrated treatment plan within 60 calendar days of a client's referral for additional CCBHC services.

(e) Notwithstanding any law to the contrary, an integrated treatment plan developed by a CCBHC that meets the requirements of this subdivision satisfies the requirements in:

(1) section 245G.06, subdivision 1;

(2) section 245G.09, subdivision 3, paragraph (a), clause (6); and

(3) section 245I.10, subdivisions 7 and 8.

[See Note.]

Subd. 4e. **Additional licensing and certification requirements.** (a) This subdivision applies to programs and clinics that are a part of a CCBHC.

(b) The requirements for initial evaluations under subdivision 4c, comprehensive evaluations under subdivision 4b, and integrated treatment plans under subdivision 4d are incorporated into the licensing requirements for substance use disorder treatment programs under chapter 245G.

(c) The requirements for initial evaluations under subdivision 4c, comprehensive evaluations under subdivision 4b, and integrated treatment plans under subdivision 4d are incorporated into the certification requirements for mental health clinics under section 245I.20.

(d) The Department of Human Services licensing division will review, inspect, and investigate for compliance with the requirements in subdivisions 4b to 4d for programs or clinics subject to this subdivision.

[See Note.]

Subd. 5. **Information systems support.** The commissioner and the state chief information officer shall provide information systems support to the projects as necessary to comply with state and federal requirements, including data reporting requirements.

Subd. 6. **Section 223 of the Protecting Access to Medicare Act entities.** Payment for services rendered by CCBHCs to individuals who have commercial insurance as the primary payer and medical assistance as secondary payer is subject to the requirements under section 256B.37.

[See Note.]

Subd. 7. **Addition of CCBHCs to section 223 state demonstration programs.** (a) If the commissioner's request under subdivision 6 to reenter the demonstration program established by section 223 of the Protecting Access to Medicare Act is approved, upon reentry the commissioner must follow all federal guidance on the addition of CCBHCs to section 223 state demonstration programs.

(b) Prior to participating in the demonstration, a CCBHC must meet the demonstration certification criteria and prospective payment system guidance in effect at that time and be certified as a CCBHC by the state. The Substance Abuse and Mental Health Services Administration attestation process for CCBHC expansion grants is not sufficient to constitute state certification. CCBHCs newly added to the demonstration must participate in all aspects of the state demonstration program, including but not limited to quality measurement and reporting, evaluation activities, and state CCBHC demonstration program requirements, such as use of state-specified evidence-based practices. A newly added CCBHC must report on quality measures before its first full demonstration year if it joined the demonstration program in calendar year 2023 out of alignment with the state's demonstration year cycle. A CCBHC may provide services in multiple locations and in community-based settings subject to federal rules of the 223 demonstration authority or Medicaid state plan authority.

(c) If a CCBHC meets the definition of a satellite facility, as defined by the Substance Abuse and Mental Health Services Administration, and was established after April 1, 2014, the CCBHC cannot receive payment as a part of the demonstration program.

[See Note.]

Subd. 8. **Grievance procedures required.** CCBHCs and designated collaborating organizations must allow all service recipients access to grievance procedures, which must satisfy the minimum requirements

of medical assistance and other grievance requirements such as those that may be mandated by relevant accrediting entities.

[See Note.]

History: *2015 c 71 art 2 s 16; 2016 c 189 art 16 s 1,2; 2018 c 182 art 2 s 6; 1Sp2019 c 9 art 6 s 4; 1Sp2020 c 2 art 2 s 1; 2021 c 30 art 11 s 1-3,7; 2022 c 98 art 4 s 9; 2023 c 70 art 18 s 1-20; 2024 c 127 art 61 s 4; 2025 c 20 s 199; 1Sp2025 c 9 art 4 s 1; 2026 c 121 art 7 s 1,55; art 8 s 6*

NOTE: Subdivisions 1a, 2a, 3, 3a, 3b, 3c, 3d, 3e, 3f, 3g, 3h, 4a, 4b, 4c, 4d, 4e, 7, and 8 are repealed by Laws 2026, chapter 121, article 7, section 55, effective January 1, 2028. Laws 2026, chapter 121, article 7, section 56.

NOTE: The amendment to subdivision 3 by Laws 2024, chapter 127, article 61, section 4, is effective upon federal approval. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained. Laws 2024, chapter 127, article 61, section 4, the effective date.

NOTE: The amendment to subdivision 3 by Laws 2025, First Special Session chapter 9, article 4, section 1, is effective upon federal approval. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained. Laws 2025, First Special Session chapter 9, article 4, section 1, the effective date.

NOTE: The amendment to subdivision 4d by Laws 2026, chapter 121, article 8, section 6, is effective January 1, 2028. Laws 2026, chapter 121, article 8, section 17.

NOTE: The amendment to subdivision 6 by Laws 2026, chapter 121, article 7, section 1, is effective January 1, 2028. Laws 2026, chapter 121, article 7, section 56.

NOTE: Subdivision 7 is effective upon federal approval. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained. Laws 2023, chapter 70, article 18, section 19, the effective date.

245.74 MS 1986 [Repealed, 1987 c 403 art 2 s 164]

245.75 FEDERAL GRANTS FOR MINNESOTA INDIANS.

The commissioner of human services is authorized to enter into contracts with the Department of Health, Education, Welfare and the Department of Interior, Bureau of Indian Affairs, for the purpose of receiving federal grants for the welfare and relief of Minnesota Indians.

History: *1965 c 886 s 23; 1984 c 654 art 5 s 58; 2005 c 10 art 1 s 44*

245.76 MS 1986 [Repealed, 1987 c 403 art 2 s 164]

245.765 REIMBURSEMENT OF COUNTY FOR CERTAIN INDIAN WELFARE COSTS.

Subdivision 1. **Reimbursement.** The commissioner of human services, to the extent that state and federal money is available therefor, shall reimburse any county for all welfare costs expended by the county to any Indian who is an enrolled member of the Red Lake Band of Chippewa Indians and resides upon the Red Lake Indian Reservation. The commissioner may advance payments to a county on an estimated basis subject to audit and adjustment at the end of each state fiscal year. Reimbursements shall be prorated if the state appropriation for this purpose is insufficient to provide full reimbursement.

Subd. 2. **Rules.** The commissioner may promulgate rules for the carrying out of the provisions of subdivision 1, and may negotiate for and accept grants from the United States for the purposes of this section.

History: *1971 c 935 s 1; 1981 c 360 art 1 s 20; 1984 c 654 art 5 s 58; 1986 c 444*

245.77 MS 2012 [Repealed, 2014 c 262 art 3 s 18]

245.771 [Renumbered 142F.05]

245.775 MS 1988 [Repealed, 1Sp1989 c 1 art 16 s 21]

245.78 MS 1974 [Repealed, 1976 c 243 s 15]

245.781 MS 1986 [Repealed, 1987 c 333 s 20]

245.782 MS 1986 [Repealed, 1987 c 333 s 20]

245.783 MS 1986 [Repealed, 1987 c 333 s 20]

245.79 MS 1974 [Repealed, 1976 c 243 s 15]

245.791 MS 1986 [Repealed, 1987 c 333 s 20]

245.792 MS 1986 [Repealed, 1987 c 333 s 20]

245.80 MS 1974 [Repealed, 1976 c 243 s 15]

245.801 MS 1986 [Repealed, 1987 c 333 s 20]

245.802 FACILITIES FOR PEOPLE WITH MENTAL ILLNESS; RULES.

Subdivision 1. MS 1986 [Repealed, 1987 c 333 s 20]

Subd. 1a. MS 1986 [Repealed, 1987 c 333 s 20]

Subd. 1b. **Monitoring of facilities.** After June 30, 1989, no residential facility licensed by the commissioner of human services or the commissioner of health, other than facilities specifically licensed for people with mental illness, may have more than four residents with a diagnosis of mental illness. The commissioner of health, with the cooperation of the commissioner of human services, shall monitor licensed boarding care, board and lodging, and supervised living facilities to assure that this requirement is met. By January 1, 1989, the commissioner of health shall recommend to the legislature an appropriate mechanism for enforcing this requirement.

Subd. 2. MS 1986 [Repealed, 1987 c 333 s 20]

Subd. 2a. **Specific review of rules.** The commissioner shall:

(1) provide in rule for various levels of care to address the residential treatment needs of persons with mental illness;

(2) review Category I and II programs established in Minnesota Rules, parts 9520.0500 to 9520.0670 to ensure that the categories of programs provide a continuum of residential service programs for persons with mental illness;

(3) provide in rule for a definition of the term "treatment" as used in relation to persons with mental illness;

(4) adjust funding mechanisms by rule as needed to reflect the requirements established by rule for services being provided;

(5) review and recommend staff educational requirements and staff training as needed; and

(6) review and make changes in rules relating to residential care and service programs for persons with mental illness as the commissioner may determine necessary.

Subd. 3. MS 1986 [Repealed, 1987 c 333 s 20]

Subd. 4. MS 1986 [Repealed, 1987 c 333 s 20]

Subd. 5. **Housing services for persons with mental illness.** The commissioner of human services shall study the housing needs of people with mental illness and shall articulate a continuum of services from residential treatment as the most intensive service through housing programs as the least intensive. The commissioner shall develop recommendations for implementing the continuum of services and shall present the recommendations to the legislature by January 31, 1988.

History: *1976 c 243 s 7; 1977 c 305 s 45; 1980 c 618 s 18; 1981 c 360 art 2 s 15; 1Sp1981 c 4 art 1 s 115; 1982 c 424 s 130; 1984 c 542 s 6; 1984 c 654 art 5 s 58; 1984 c 658 s 2; 1985 c 248 s 70; 1986 c 444; 1987 c 197 s 1-4; 1994 465 art 3 s 8; 2016 c 158 art 1 s 214*

245.803 MS 1986 [Repealed, 1987 c 333 s 20]

245.804 MS 1986 [Repealed, 1987 c 333 s 20]

245.805 MS 1986 [Repealed, 1987 c 333 s 20]

245.81 MS 1974 [Repealed, 1976 c 243 s 15]

245.811 MS 1986 [Repealed, 1987 c 333 s 20]

245.812 MS 1986 [Repealed, 1987 c 333 s 20]

245.813 MS 1978 [Repealed, 1980 c 542 s 2]

245.814 LIABILITY INSURANCE FOR LICENSED PROVIDERS.

Subdivision 1. **Insurance for foster home providers.** (a) The commissioner of human services or the commissioner of children, youth, and families shall within the appropriation provided purchase and provide insurance to individuals licensed as foster home providers to cover their liability for:

(1) injuries or property damage caused or sustained by persons in foster care in their home; and

(2) actions arising out of alienation of affections sustained by the birth parents of a foster child or birth parents or children of a foster adult.

(b) Each commissioner shall provide insurance for the providers the commissioner licenses.

(c) For purposes of this subdivision, insurance for homes licensed to provide adult foster care shall be limited to family adult foster care homes as defined in section 245A.02, subdivision 6f, and family adult day services licensed under section 245A.143.

Subd. 2. **Application of coverage.** Coverage shall apply to all foster homes licensed by the Department of Human Services or the Department of Children, Youth, and Families, licensed by a federally recognized

Tribal government, or established by the juvenile court and certified by the commissioner of corrections pursuant to section 260B.198, subdivision 1, paragraph (a), clause (3), item (v), to the extent that the liability is not covered by the provisions of the standard homeowner's or automobile insurance policy. The insurance shall not cover property owned by the individual foster home provider, damage caused intentionally by a person over 12 years of age, or property damage arising out of business pursuits or the operation of any vehicle, machinery, or equipment.

Subd. 3. **Compensation provisions.** (a) If the commissioner of human services or the commissioner of children, youth, and families is unable to obtain insurance through ordinary methods for coverage of foster home providers, the appropriation shall be returned to the general fund and the state shall pay claims subject to the following limitations.

(b) Compensation shall be provided only for injuries, damage, or actions set forth in subdivision 1.

(c) Compensation shall be subject to the conditions and exclusions set forth in subdivision 2.

(d) The state shall provide compensation for bodily injury, property damage, or personal injury resulting from the foster home providers activities as a foster home provider while the foster child or adult is in the care, custody, and control of the foster home provider in an amount not to exceed $250,000 for each occurrence.

(e) The state shall provide compensation for damage or destruction of property caused or sustained by a foster child or adult in an amount not to exceed $250 for each occurrence.

(f) The compensation in paragraphs (d) and (e) is the total obligation for all damages because of each occurrence regardless of the number of claims made in connection with the same occurrence, but compensation applies separately to each foster home. The state shall have no other responsibility to provide compensation for any injury or loss caused or sustained by any foster home provider or foster child or foster adult.

(g) This coverage is extended as a benefit to foster home providers to encourage care of persons who need the providers' care. Nothing in this section shall be construed to mean that foster home providers are agents or employees of the state nor does the state accept any responsibility for the selection, monitoring, supervision, or control of foster home providers which is exclusively the responsibility of the counties which shall regulate foster home providers in the manner set forth in the rules of the commissioners of human services and children, youth, and families.

Subd. 4. **Liability insurance; risk pool.** If the commissioner that licenses a program determines that appropriate commercial liability insurance coverage is not available for a licensed foster home, group home, developmental achievement center, or day care provider, and that coverage available through the joint underwriting authority of the commissioner of commerce or other public entity is not appropriate for the provider or a class of providers, the commissioner of human services; the commissioner of children, youth, and families; and the commissioner of commerce may jointly establish a risk pool to provide coverage for licensed providers out of premiums or fees paid by providers. The commissioners may set limits on coverage, establish premiums or fees, determine the proportionate share of each provider to be collected in a premium or fee based on the provider's claim experience and other factors the commissioners consider appropriate, establish eligibility and application requirements for coverage, and take other action necessary to accomplish the purposes of this subdivision. A human services risk pool fund is created for the purposes of this subdivision. Fees and premiums collected from providers for risk pool coverage are appropriated to the risk pool fund. Interest earned from the investment of money in the fund must be credited to the fund and money in the fund is appropriated to the commissioners of human services and children, youth, and families in proportion to the amounts insured by each commissioner to pay administrative costs and covered claims for

participating providers. In the event that money in the fund is insufficient to pay outstanding claims and associated administrative costs, the commissioners of human services and children, youth, and families may assess providers participating in the risk pool amounts sufficient to pay the costs. The commissioners of human services and children, youth, and families may not assess a provider an amount exceeding one year's premiums collected from that provider.

Subd. 5. **Foster care parent liability insurance.** The commissioner of children, youth, and families may use federal reimbursement money earned on an expenditure for foster care parent liability insurance premiums to offset the costs of the premiums. The commissioners of children, youth, and families and human services will work with the insurance provider to transition coverage and responsibility as appropriate while avoiding a lapse in coverage.

History: *1977 c 360 s 1; 1980 c 614 s 125; 1984 c 654 art 5 s 58; 1986 c 313 s 10; 1986 c 455 s 61; 1988 c 689 art 2 s 99-101; 1994 c 465 art 1 s 62; 1994 c 631 s 31; 1999 c 139 art 4 s 2; 1Sp2001 c 9 art 11 s 2; 2002 c 379 art 1 s 113; 2004 c 288 art 1 s 1; 1Sp2017 c 6 art 7 s 23; 2020 c 83 art 1 s 67; 2023 c 25 s 119; 2024 c 80 art 1 s 45; 2025 c 21 s 34-37; 2025 c 38 art 8 s 45*

245.82 MS 1974 [Repealed, 1976 c 243 s 15]

245.821 TREATMENT FACILITIES FOR PERSONS WITH DISABILITIES.

Subdivision 1. **Notice required.** Notwithstanding any law to the contrary, no private or public facility for the treatment, housing, or counseling of more than five persons with mental illness, physical disability, developmental disability, substance use disorder, or another form of dependency, nor any correctional facility for more than five persons, shall be established without 30 days' written notice to the affected municipality or other political subdivision.

Subd. 2. **State funds available.** No state funds shall be made available to or be expended by any state or local agency for facilities or programs enumerated in this section unless and until the provisions of this section have been complied with in full.

History: *1974 c 274 s 3; 1985 c 21 s 5; 1992 c 464 art 1 s 55; 2005 c 56 s 1; 2022 c 98 art 4 s 51; 2024 c 125 art 1 s 2; 2024 c 127 art 46 s 2*

245.825 AVERSIVE AND DEPRIVATION PROCEDURES; LICENSED FACILITIES AND SERVICES.

Subdivision 1. **Rules governing aversive and deprivation procedures.** The commissioner of human services shall by October, 1983, promulgate rules governing the use of aversive and deprivation procedures in all licensed facilities and licensed services serving persons with developmental disabilities. No provision of these rules shall encourage or require the use of aversive and deprivation procedures. The rules shall prohibit: (1) the application of certain aversive and deprivation procedures in facilities except as authorized and monitored by the commissioner; (2) the use of aversive and deprivation procedures that restrict the consumers' normal access to nutritious diet, drinking water, adequate ventilation, necessary medical care, ordinary hygiene facilities, normal sleeping conditions, and necessary clothing; and (3) the use of faradic shock without a court order. The rule shall further specify that consumers may not be denied ordinary access to legal counsel and next of kin. In addition, the rule may specify other prohibited practices and the specific conditions under which permitted practices are to be carried out. For any persons receiving faradic shock, a plan to reduce and eliminate the use of faradic shock shall be in effect upon implementation of the procedure.

Subd. 1a. MS 1998 [Repealed, 1999 c 86 art 2 s 6]

Subd. 1b. **Review and approval.** Notwithstanding the provisions of Minnesota Rules, parts 9525.2700 to 9525.2810, the commissioner may designate the county case manager to authorize the use of controlled procedures as defined in Minnesota Rules, parts 9525.2710, subpart 9, and 9525.2740, subparts 1 and 2, after review and approval by the interdisciplinary team and the internal review committee as required in Minnesota Rules, part 9525.2750, subparts 1a and 2. Use of controlled procedures must be reported to the commissioner in accordance with the requirements of Minnesota Rules, part 9525.2750, subpart 2a.

Subd. 2. MS 1994 [Repealed, 1995 c 207 art 11 s 12]

History: *1982 c 637 s 1,2; 1984 c 654 art 5 s 58; 1985 c 21 s 6; 1987 c 110 s 1; 1992 c 464 art 1 s 55; 1995 c 207 art 11 s 4; 1999 c 86 art 2 s 3; 2005 c 56 s 1; 2024 c 125 art 1 s 3; 2024 c 127 art 46 s 3*

245.8251 RULES FOR POSITIVE SUPPORT STRATEGIES AND PROHIBITIONS AND LIMITS ON RESTRICTIVE INTERVENTIONS; LICENSED FACILITIES AND PROGRAMS.

Subdivision 1. **Rules governing the use of positive support strategies and restrictive interventions.** The commissioner of human services shall, by August 31, 2015, adopt rules to govern the use of positive support strategies, and ensure the applicability of chapter 245D prohibitions and limits on the emergency use of manual restraint and on the use of restrictive interventions to facilities and services governed by the rules. The rules apply to all facilities and services licensed under chapter 245D, and all licensed facilities and licensed services serving persons with a developmental disability or related condition, except child care is governed by section 142B.63. For the purposes of this section, "developmental disability or related condition" has the meaning given in Minnesota Rules, part 9525.0016, subpart 2, items A to E.

Subd. 2. **Data collection.** (a) The commissioner shall, with stakeholder input, identify data elements specific to incidents of emergency use of manual restraint and positive support transition plans for persons receiving services from licensed facilities and licensed services under chapter 245D and in licensed facilities and licensed services serving persons with a developmental disability or related condition as defined in Minnesota Rules, part 9525.0016, subpart 2, effective January 1, 2014. Licensed facilities and licensed services shall report the data in a format and at a frequency determined by the commissioner of human services to the commissioner and the Office of the Ombudsman for Mental Health and Developmental Disabilities.

(b) Beginning July 1, 2013, licensed facilities and licensed services regulated under Minnesota Rules, parts 9525.2700 to 9525.2810, shall submit data regarding the use of all controlled procedures identified in Minnesota Rules, part 9525.2740, in a format and at a frequency determined by the commissioner to the commissioner and the Office of the Ombudsman for Mental Health and Developmental Disabilities.

Subd. 3. **External program review committee.** Rules adopted according to this section shall establish requirements for an external program review committee appointed by the commissioner to monitor the implementation of the rules and make recommendations to the commissioner about any needed policy changes after adoption of the rules.

Subd. 4. **Interim review panel.** (a) The commissioner shall establish an interim review panel by August 15, 2014, for the purpose of reviewing requests for emergency use of procedures that have been part of an approved positive support transition plan when necessary to protect a person from imminent risk of serious injury as defined in section 245.91, subdivision 6, due to self-injurious behavior. The panel must make recommendations to the commissioner to approve or deny these requests based on criteria to be established by the interim review panel. The interim review panel shall operate until the external program review committee is established as required under subdivision 3.

(b) Members of the interim review panel shall be selected based on their expertise and knowledge related to the use of positive support strategies as alternatives to the use of restrictive interventions. The commissioner shall seek input and recommendations in establishing the interim review panel. Members of the interim review panel shall include the following representatives:

(1) an expert in positive supports;

(2) a mental health professional, as defined in section 245.462;

(3) a licensed health professional as defined in section 245D.02, subdivision 14; and

(4) a representative of the Department of Health.

History: *2013 c 108 art 8 s 4; 2014 c 312 art 27 s 5; 2018 c 163 s 1; 2024 c 80 art 2 s 74; 2024 c 115 art 16 s 41*

245.826 USE OF RESTRICTIVE TECHNIQUES AND PROCEDURES IN FACILITIES SERVING CHILDREN WITH MENTAL ILLNESSES.

When amending rules governing facilities serving children with mental illnesses that are licensed under section 245A.09 and Minnesota Rules, parts 2960.0510 to 2960.0530 and 2960.0580 to 2960.0700, the commissioner of human services shall include provisions governing the use of restrictive techniques and procedures. No provision of these rules may encourage or require the use of restrictive techniques and procedures. The rules must prohibit: (1) the application of certain restrictive techniques or procedures in facilities, except as authorized in the child's case plan and monitored by the county caseworker responsible for the child; (2) the use of restrictive techniques or procedures that restrict the clients' normal access to nutritious diet, drinking water, adequate ventilation, necessary medical care, ordinary hygiene facilities, normal sleeping conditions, and necessary clothing; and (3) the use of corporal punishment. The rule may specify other restrictive techniques and procedures and the specific conditions under which permitted techniques and procedures are to be carried out.

History: *1990 c 542 s 6; 2016 c 158 art 1 s 86; 2025 c 38 art 8 s 46*

245.8261 RESTRICTIVE PROCEDURES PLANNING AND REPORTING.

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

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

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

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

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

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

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

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

Subd. 2. **Restrictive procedures plan.** (a) A services provider under subdivision 1, paragraph (a), shall have on file and available for viewing a restrictive procedures plan for children in its program that must include at least the following:

(1) the list of restrictive procedures the provider intends to use;

(2) how the provider will monitor and control the use of restrictive procedures;

(3) a description of the training that staff who use restrictive procedures must complete prior to staff implementation of restrictive procedures;

(4) how the provider will document information needed to prepare the annual report required in subdivision 15; and

(5) how the provider will ensure that the child receives treatment for any injury caused by the use of a restrictive procedure.

(b) For purposes of this section, allowable restrictive procedures include those procedures allowed under subdivision 4, paragraph (a).

Subd. 3. **Definitions.** (a) For the purposes of this section, the terms in this subdivision have the meanings given them.

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

(c) "Child" means a person under 18 years of age.

(d) "Individual treatment plan" has the meaning given in section 245.4871, subdivision 21, as required for children's mental health services providers in section 245.4876, subdivision 3. The individual treatment plan must be based on a diagnostic assessment, which includes assessments and review of medical conditions and risks of psychological trauma that might be incurred by use of seclusion or restraint.

(e) "Mechanical restraints" means the use of devices to limit a child's movement or hold a child immobile. The term does not mean mechanical restraints used to:

(1) treat a child's medical needs;

(2) protect a child known to be at risk of injury resulting from lack of coordination or frequent loss of consciousness; or

(3) position a child with physical disabilities in a manner specified in the child's plan of care.

(f) "Physical escort" means physical intervention or contact used as a behavior management technique to guide or carry a child to safety or away from an unsafe or potentially harmful and escalating situation.

(g) "Physical holding" means physical intervention intended to hold a child immobile or limit a child's movement by using body contact as the only source of physical restraint. The term does not mean physical contact:

(1) used to facilitate a child's response or completion of a task when the child does not resist or the child's resistance is minimal in intensity and duration; and

(2) necessary to conduct a medical examination or treatment.

(h) "Restrictive procedures" means application of an action, force, or condition that controls, constrains, or suppresses the action, behavior, intention, bodily placement, or bodily location of a child in a manner that is involuntary, unintended by that child, depriving, or aversive to that child.

(i) "Time out" means removing a child from an activity to a location where the child cannot participate or observe the activity and includes moving or ordering a child to an unlocked room.

(j) "Seclusion" involves the confining of a child alone in a room from which egress is beyond the child's control or prohibited by a mechanism such as a lock or by a device or object positioned to hold the door closed or otherwise prevent the child from leaving the room. The room used for seclusion must be well-lighted, well-ventilated, clean, have an observation window that allows staff to directly monitor the child in seclusion, fixtures that are tamperproof, electrical switches located immediately outside the door, and doors that open out and are unlocked or locked with keyless locks that have immediate release mechanisms.

Subd. 4. **Allowable procedures.** (a) A provider may use one or more of the following restrictive procedures:

(1) physical escort;

(2) physical holding;

(3) seclusion; and

(4) the limited use of mechanical restraints only in emergency situations.

(b) A provider shall permit use of restrictive procedures only by program staff who have completed the required training and who are acting under the clinical supervision of a mental health professional.

Subd. 5. **Parental consent and notification.** Parental consent for use of seclusion and restraint procedures must be obtained when a child begins receiving services; the agreement must be reviewed at least quarterly. A provider shall notify the child's parent or guardian of the use of a restrictive procedure on the same day the procedure is used, unless the parent or guardian notifies the provider that the parent or guardian does not want to receive notification or the parent or guardian requests a different notification schedule.

Subd. 6. **Physical escort requirements.** The physical escort of a child may be used to control a child who is being guided to a place where the child will be safe and to help de-escalate interactions between the child and others. A provider who uses physical escorting with a child shall meet the following requirements:

(1) staff shall be trained according to subdivision 11;

(2) staff shall document the use of physical escort and note the technique used, the time of day, and the names of the staff and child involved; and

(3) the use of physical escort shall be consistent with the child's treatment plan.

Subd. 7. **Physical holding or seclusion.** Physical holding or seclusion may be used in emergency situations as a response to imminent serious risk of physical harm to the child or others and when less restrictive interventions are ineffective. A provider who uses physical holding or seclusion shall meet the following requirements:

(1) an immediate intervention must be necessary to protect the child or others from physical harm;

(2) the physical holding or seclusion used must be the least intrusive intervention that will effectively react to an emergency;

(3) the use of physical holding or seclusion must end when the threat of harm ends;

(4) the child must be constantly and directly observed by staff during the use of physical holding or seclusion;

(5) the use of physical holding or seclusion must be used under the supervision of a mental health professional;

(6) staff shall contact the mental health professional to inform the mental health professional about the use of physical holding or seclusion and to ask for permission to use physical holding or seclusion as soon as it may safely be done, but no later than 30 minutes after initiating the use of physical holding or seclusion;

(7) before staff uses physical holding or seclusion with a child, staff shall complete the training required in subdivision 11 regarding the use of physical holding or seclusion at the program;

(8) when the need for the use of physical holding or seclusion ends, the child must be assessed to determine if the child can safely be returned to the ongoing activities at the program;

(9) staff shall treat the child respectfully throughout the procedure;

(10) the staff person who implemented the use of physical holding or seclusion shall document its use immediately after the incident concludes and the documentation must include at least the following information:

(i) a detailed description of the incident which led to the use of physical holding or seclusion;

(ii) an explanation of why the procedure chosen needed to be used;

(iii) why less restrictive measures failed or were found to be inappropriate;

(iv) the time the physical hold or seclusion began and the time the child was released;

(v) documentation of the child's behavioral change and change in physical status for each 15-minute interval the procedure is used; and

(vi) the names of all staff involved in the use of the procedure and the names of all witnesses to the use of the procedure; and

(11) if seclusion is used, the room used for the seclusion must:

(i) be well-lighted, well-ventilated, and clean;

(ii) have an observation window which allows staff to directly monitor a child in seclusion;

(iii) have fixtures that are tamperproof, with electrical switches located immediately outside the door;

(iv) have doors that open out and are unlocked or are locked with keyless locks that have immediate release mechanisms; and

(v) have objects that may be used by a child to injure the child's self or others removed from the child and the seclusion room before the child is placed in seclusion.

Subd. 8. **Exempt techniques and procedures.** (a) Use of the instructional techniques and intervention procedures listed in this subdivision is not subject to the restrictions established by this section. The child's individual treatment plan, as defined in section 245.4871, subdivision 21, and as required in section 245.4876,

subdivision 3, must address the use of these exempt techniques and procedures. Exempt techniques and procedures include:

(1) corrective feedback or prompt to assist a child in performing a task or exhibiting a response;

(2) physical contact to facilitate a child's completion of a task or response that is directed at increasing adaptive behavior when the child does not resist or the child's resistance is minimal in intensity and duration;

(3) physical contact or a physical prompt to redirect a child's behavior when:

(i) the behavior does not pose a serious threat to the child or others;

(ii) the behavior is effectively redirected with less than 60 seconds of physical contact by staff; or

(iii) the physical contact is used to conduct a necessary medical examination or treatment; and

(4) manual or mechanical restraint to treat a child's medical needs or to protect a child known to be at risk of injury from an ongoing medical or psychological condition.

(b) The exemptions under this subdivision must not be used to circumvent the requirements for controlling the use of manual restraint. The exemptions under this subdivision are intended to allow providers the opportunity to deal effectively and naturally with instruction and treatment interventions.

Subd. 9. **Conditions on use of restrictive procedures.** Restrictive procedures must not:

(1) be implemented with a child in a manner that constitutes sexual abuse, neglect, or physical abuse under chapter 260E, the reporting of maltreatment of minors;

(2) restrict a child's normal access to a nutritious diet, drinking water, adequate ventilation, necessary medical care, ordinary hygiene facilities, or necessary clothing or to any protection required by state licensing standards and federal regulations governing the program;

(3) be used as punishment or for the convenience of staff; or

(4) deny the child visitation or contact with legal counsel and next of kin.

Subd. 10. **Prohibitions.** (a) The following actions or procedures are prohibited:

(1) using corporal punishment such as hitting, pinching, slapping, or pushing;

(2) speaking to a child in a manner that ridicules, demeans, threatens, or is abusive;

(3) requiring a child to assume and maintain a specified physical position or posture, for example, requiring a child to stand with the hands over the child's head for long periods of time or to remain in a fixed position;

(4) use of restrictive procedures as a disciplinary consequence;

(5) totally or partially restricting a child's senses, except at a level of intrusiveness that does not exceed:

(i) placing a hand in front of a child's eyes as a visual screen; or

(ii) playing music through earphones worn by the child at a level of sound that does not cause discomfort;

(6) presenting an intense sound, light, noxious smell, taste, substance, or spray, including water mist;

(7) denying or restricting a child's access to equipment and devices such as walkers, wheelchairs, hearing aids, and communication boards that facilitate the child's functioning, except as provided under paragraph (b).

(b) When the temporary removal of the equipment or device is necessary to prevent injury to the child or others or serious damage to the equipment or device, the equipment or device shall be returned to the child as soon as possible.

Subd. 11. **Training for staff.** (a) Staff who use restrictive procedures shall successfully complete training in the following skills and knowledge areas before using restrictive procedures with a child:

(1) the needs and behaviors of children;

(2) relationship-building;

(3) alternatives to restrictive procedures, including techniques to identify events and environmental factors that may trigger behavioral escalation;

(4) de-escalation methods;

(5) avoiding power struggles;

(6) documentation standards for the use of restrictive procedures;

(7) how to obtain emergency medical assistance;

(8) time limits for restrictive procedures;

(9) obtaining approval for use of restrictive procedures;

(10) the proper use of the restrictive procedures approved for the program, including simulated experiences of administering and receiving physical restraint;

(11) thresholds for employing and ceasing restrictive procedures;

(12) the physiological and psychological impact of physical holding and seclusion;

(13) how to monitor and respond to the child's physical signs of distress; and

(14) recognizing symptoms of and interventions with potential to cause positional asphyxia.

(b) Training under this subdivision must be repeated every two years.

Subd. 12. **Administrative review.** The provider shall complete an administrative review of the use of each restrictive procedure within three working days after the use of the restrictive procedure. The administrative review shall be conducted by someone other than the person who decided to impose the restrictive procedure, or that person's immediate supervisor. The child or the child's representative shall have an opportunity to present evidence and argument to the reviewer about why the procedure was unwarranted. The record of the administrative review of the use of a restrictive procedure must state whether:

(1) the required documentation was recorded;

(2) the restrictive procedure was used in accordance with the treatment plan;

(3) the standards governing the use of restrictive procedures were met; and

(4) the staff who implemented the restrictive procedures were properly trained.

Subd. 13. **Review of patterns of use of restrictive procedures.** At least quarterly, the treatment provider shall review the provider's patterns of the use of restrictive procedures. The review must be completed by the treatment provider or the program's advisory committee. The review shall consider:

(1) any patterns or problems indicated by similarities in the time of day, day of the week, duration of the use of a procedure, individuals involved, or other factors associated with the use of restrictive procedures;

(2) any injuries resulting from the use of restrictive procedures;

(3) actions needed to correct deficiencies in the program's implementation of restrictive procedures;

(4) an assessment of opportunities missed to avoid the use of restrictive procedures; and

(5) proposed actions to be taken to minimize the use of physical holding or seclusion.

Subd. 14. **Annual report.** A provider using restrictive procedures shall annually submit a report to the commissioner stating the number and types of restrictive procedures performed. The report shall be submitted in a form and manner prescribed by the commissioner. Agencies with high use of restrictive procedures will be reviewed by the commissioner to determine needed changes in policies and procedures, including staff training.

History: *2008 c 234 s 1; 2009 c 86 art 1 s 40-42; 2017 c 79 s 3; 1Sp2020 c 2 art 8 s 40*

245.827 MS 2012 [Repealed, 2014 c 262 art 3 s 18]

245.83 MS 1988 [Repealed, 1989 c 282 art 2 s 219]

245.84 MS 1988 [Repealed, 1989 c 282 art 2 s 219]

245.85 MS 1988 [Repealed, 1989 c 282 art 2 s 219]

245.86 MS 1986 [Repealed, 1988 c 689 art 2 s 269]

245.87 MS 1986 [Repealed, 1988 c 689 art 2 s 269]

245.871 MS 1988 [Repealed, 1989 c 282 art 2 s 219]

245.872 MS 1988 [Repealed, 1989 c 282 art 2 s 219]

245.873 MS 1988 [Repealed, 1989 c 282 art 2 s 219]

245.88 MS 1986 [Repealed, 1987 c 333 s 20]

245.881 MS 1986 [Repealed, 1987 c 333 s 20]

245.882 MS 1986 [Repealed, 1987 c 333 s 20]

245.883 MS 1986 [Repealed, 1987 c 333 s 20]

245.884 MS 1986 [Repealed, 1987 c 333 s 20]

245.885 MS 1986 [Repealed, 1987 c 333 s 20]

245.891 OPIOID OVERDOSE SURGE ALERT SYSTEM.

The commissioner must establish a voluntary, statewide opioid overdose surge text message alert system to prevent opioid overdose by cautioning people to refrain from substance use or to use harm reduction strategies when there is an overdose surge in their surrounding area. The alert system may include other forms of electronic alerts. The commissioner may collaborate with local agencies, other state agencies, and harm reduction organizations to promote and improve the surge alert system.

History: *2023 c 61 art 5 s 5*

245.90 COURT AWARDED FUNDS, DISPOSITION.

The commissioner of human services shall notify the house of representatives Ways and Means and senate Finance Committees of the terms of any contractual arrangement entered into by the commissioner and the attorney general, pursuant to an order of any court of law, which provides for the receipt of funds by the commissioner.

Any funds recovered or received by the commissioner pursuant to an order of any court of law shall be placed in the general fund.

History: *1975 c 434 s 24; 1984 c 654 art 5 s 58; 2004 c 284 art 2 s 16*

OMBUDSMAN FOR MENTAL HEALTH AND DEVELOPMENTAL DISABILITIES

245.91 DEFINITIONS.

Subdivision 1. **Applicability.** For the purposes of sections 245.91 to 245.97, the following terms have the meanings given them.

Subd. 2. **Agency.** "Agency" means the divisions, officials, or employees of the state Departments of Human Services, Health, and Education; of Direct Care and Treatment; and of local school districts and designated county social service agencies as defined in section 256G.02, subdivision 7, that are engaged in monitoring, providing, or regulating services or treatment for mental illness, developmental disability, or substance use disorder.

Subd. 3. **Client.** "Client" means a person served by an agency, facility, or program, who is receiving services or treatment for mental illness, developmental disability, and substance use disorder. Client also includes a now deceased person who had been served by an agency, facility, or program.

Subd. 3a. **Emergency use of manual restraint.** "Emergency use of manual restraint" has the meaning given in section 245D.02, subdivision 8a, and applies to services licensed under chapter 245D.

Subd. 4. **Facility or program.** "Facility" or "program" means a nonresidential or residential program as defined in section 245A.02, subdivisions 10 and 14, and any agency, facility, or program that provides services or treatment for mental illness, developmental disability, or substance use disorder that is required to be licensed, certified, or registered by the commissioner of human services, health, or education; a recovery residence as defined in section 254B.01, subdivision 11; peer recovery support services provided by a recovery community organization as defined in section 254B.01, subdivision 8; and an acute care inpatient facility that provides services or treatment for mental illness, developmental disability, or substance use disorder.

Subd. 4a. **Gather.** "Gather" means access to information or data for purposes of inspection and to receive copies of information or data.

Subd. 5. **Regional center.** "Regional center" means a state-operated treatment program as defined in section 253B.02, subdivision 18d.

Subd. 6. **Serious injury.** "Serious injury" means:

(1) fractures;

(2) dislocations;

(3) evidence of internal injuries;

(4) head injuries with loss of consciousness or potential for a closed head injury or concussion without loss of consciousness requiring a medical assessment by a health care professional, whether or not further medical attention was sought;

(5) lacerations involving injuries to tendons or organs, and those for which complications are present;

(6) extensive second-degree or third-degree burns, and other burns for which complications are present;

(7) extensive second-degree or third-degree frostbite, and others for which complications are present;

(8) irreversible mobility or avulsion of teeth;

(9) injuries to the eyeball;

(10) ingestion of foreign substances and objects that are harmful;

(11) near drowning;

(12) heat exhaustion or sunstroke;

(13) attempted suicide; and

(14) all other injuries and incidents considered serious after an assessment by a health care professional, including but not limited to self-injurious behavior, a medication error requiring medical treatment, a suspected delay of medical treatment, a complication of a previous injury, or a complication of medical treatment for an injury.

History: *1987 c 352 s 2; 1988 c 543 s 1-3; 1989 c 282 art 2 s 57; 1Sp1997 c 4 art 7 s 42; 2003 c 130 s 12; 2005 c 56 s 1; 2008 c 219 s 1,2; 2013 c 108 art 8 s 5; 1Sp2017 c 6 art 8 s 8,9; 1Sp2020 c 2 art 6 s 123; 2022 c 98 art 4 s 51; 2023 c 25 s 120; 2023 c 61 art 4 s 3; 2024 c 79 art 8 s 14; 2024 c 125 art 3 s 2; 2024 c 127 art 48 s 2; 2025 c 38 art 3 s 30; art 8 s 47,48; 1Sp2025 c 9 art 4 s 2; art 9 s 6*

245.92 OFFICE OF OMBUDSMAN; CREATION; QUALIFICATIONS; FUNCTION.

The ombudsman for persons receiving services or treatment for mental illness, developmental disability, or substance use disorder shall promote the highest attainable standards of treatment, competence, efficiency, and justice. The ombudsman may gather information and data about decisions, acts, and other matters of an agency, facility, or program, and shall monitor the treatment of individuals participating in a University of Minnesota Department of Psychiatry clinical drug trial. The ombudsman is appointed by the governor, serves in the unclassified service, and may be removed only for just cause. The ombudsman must be selected without regard to political affiliation and must be a person who has knowledge and experience concerning

the treatment, needs, and rights of clients, and who is highly competent and qualified. No person may serve as ombudsman while holding another public office.

History: *1987 c 352 s 3; 1988 c 543 s 4; 2005 c 56 s 1; 2008 c 219 s 3; 2016 c 189 art 1 s 22; 2022 c 98 art 4 s 51; 2025 c 38 art 8 s 49*

245.93 ORGANIZATION OF OFFICE OF OMBUDSMAN.

Subdivision 1. **Staff.** The ombudsman may appoint a deputy and a confidential secretary in the unclassified service and may appoint other employees as authorized by the legislature. The ombudsman and the full-time staff are members of the Minnesota State Retirement Association.

Subd. 2. **Advocacy.** The function of mental health and developmental disability client advocacy in the Department of Human Services is transferred to the Office of Ombudsman according to section 15.039. The ombudsman shall maintain at least one client advocate in each regional center.

Subd. 3. **Delegation.** The ombudsman may delegate to members of the staff any authority or duties of the office except the duty of formally making recommendations to an agency or facility or reports to the governor or the legislature.

History: *1987 c 352 s 4; 2005 c 56 s 1*

245.94 POWERS OF OMBUDSMAN; REVIEWS AND EVALUATIONS; RECOMMENDATIONS.

Subdivision 1. **Powers.** (a) The ombudsman may prescribe the methods by which complaints to the office are to be made, reviewed, and acted upon. The ombudsman may not levy a complaint fee.

(b) The ombudsman is a health oversight agency as defined in Code of Federal Regulations, title 45, section 164.501. The ombudsman may access patient records according to Code of Federal Regulations, title 42, section 2.53. For purposes of this paragraph, "records" has the meaning given in Code of Federal Regulations, title 42, section 2.53(a)(1)(i).

(c) The ombudsman may mediate or advocate on behalf of a client.

(d) The ombudsman may investigate the quality of services provided to clients and determine the extent to which quality assurance mechanisms within state and county government work to promote the health, safety, and welfare of clients.

(e) At the request of a client, or upon receiving a complaint or other information affording reasonable grounds to believe that the rights of one or more clients who may not be capable of requesting assistance have been adversely affected, the ombudsman may gather information and data about and analyze, on behalf of the client, the actions of an agency, facility, or program.

(f) The ombudsman may gather, on behalf of one or more clients, records of an agency, facility, or program, or records related to clinical drug trials from the University of Minnesota Department of Psychiatry, if the records relate to a matter that is within the scope of the ombudsman's authority. If the records are private and the client is capable of providing consent, the ombudsman shall first obtain the client's consent. The ombudsman is not required to obtain consent for access to private data on clients with developmental disabilities and individuals served by the Minnesota Sex Offender Program. The ombudsman may also take photographic or videographic evidence while reviewing the actions of an agency, facility, or program, with the consent of the client. The ombudsman is not required to obtain consent for access to private data on decedents who were receiving services for mental illness, developmental disability, or substance use disorder.

All data collected, created, received, or maintained by the ombudsman are governed by chapter 13 and other applicable law.

(g) Notwithstanding any law to the contrary, the ombudsman may subpoena a person to appear, give testimony, or produce documents or other evidence that the ombudsman considers relevant to a matter under inquiry. The ombudsman may petition the appropriate court in Ramsey County to enforce the subpoena. A witness who is at a hearing or is part of an investigation possesses the same privileges that a witness possesses in the courts or under the law of this state. Data obtained from a person under this paragraph are private data as defined in section 13.02, subdivision 12.

(h) The ombudsman may, at reasonable times in the course of conducting a review, enter and view premises within the control of an agency, facility, or program.

(i) The ombudsman may attend Direct Care and Treatment Review Board and Special Review Board proceedings; proceedings regarding the transfer of clients, as defined in section 246.50, subdivision 4, between institutions operated by the Direct Care and Treatment executive board; and, subject to the consent of the affected client, other proceedings affecting the rights of clients. The ombudsman is not required to obtain consent to attend meetings or proceedings and have access to private data on clients with developmental disabilities and individuals served by the Minnesota Sex Offender Program.

(j) The ombudsman shall gather data of agencies, facilities, or programs classified as private or confidential as defined in section 13.02, subdivisions 3 and 12, regarding services provided to clients with developmental disabilities and individuals served by the Minnesota Sex Offender Program.

(k) To avoid duplication and preserve evidence, the ombudsman shall inform relevant licensing or regulatory officials before undertaking a review of an action of the facility or program.

(l) The Office of Ombudsman shall provide the services of the Civil Commitment Training and Resource Center.

(m) The ombudsman shall monitor the treatment of individuals participating in a University of Minnesota Department of Psychiatry clinical drug trial and ensure that all protections for human subjects required by federal law and the Institutional Review Board are provided.

(n) Sections 245.91 to 245.97 are in addition to other provisions of law under which any other remedy or right is provided.

Subd. 2. **Matters appropriate for review.** (a) In selecting matters for review by the office, the ombudsman shall give particular attention to unusual deaths or injuries of a client or reports of emergency use of manual restraint as identified in section 245D.061, served by an agency, facility, or program, or actions of an agency, facility, or program that:

(1) may be contrary to law or rule;

(2) may be unreasonable, unfair, oppressive, or inconsistent with a policy or order of an agency, facility, or program;

(3) may be mistaken in law or arbitrary in the ascertainment of facts;

(4) may be unclear or inadequately explained, when reasons should have been revealed;

(5) may result in abuse or neglect of a person receiving treatment;

(6) may disregard the rights of a client or other individual served by an agency or facility;

(7) may impede or promote independence, community integration, and productivity for clients; or

(8) may impede or improve the monitoring or evaluation of services provided to clients.

(b) The ombudsman shall, in selecting matters for review and in the course of the review, avoid duplicating other investigations or regulatory efforts.

(c) The ombudsman shall give particular attention to the death or unusual injury of any individual who is participating in a University of Minnesota Department of Psychiatry clinical drug trial.

Subd. 2a. **Mandatory reporting.** Within 24 hours after a client suffers death or serious injury, the agency, facility, program director, or lead investigator of a clinical drug trial at the University of Minnesota Department of Psychiatry shall notify the ombudsman of the death or serious injury. The emergency use of manual restraint must be reported to the ombudsman as required under section 245D.061, subdivision 8. The ombudsman is authorized to receive identifying information about a deceased client according to Code of Federal Regulations, title 42, section 2.15, paragraph (b).

Subd. 3. **Complaints.** (a) The ombudsman may receive a complaint from any source concerning an action of an agency, facility, or program. After completing a review, the ombudsman shall inform the complainant and the agency, facility, or program. No client may be punished nor may the general condition of the client's treatment be unfavorably altered as a result of an investigation, a complaint by the client, or by another person on the client's behalf. An agency, facility, or program shall not retaliate or take adverse action against a client or other person, who in good faith makes a complaint or assists in an investigation. The ombudsman may classify as confidential, the identity of a complainant, upon request of the complainant.

(b) The ombudsman shall receive a complaint from any source concerning an action or inaction of the University of Minnesota Department of Psychiatry related to an individual who is enrolled in a department-approved clinical drug trial. No individual participating in the trial may be punished, nor may the general condition of the individual's treatment be unfavorably altered, as a result of an investigation or a complaint by the individual or the individual's advocate. The university shall not retaliate or take adverse action against any person who in good faith makes a complaint or assists in an investigation. The ombudsman may classify the identity of the complainant as confidential, upon request of the complainant.

Subd. 4. **Recommendations to agency.** (a) If, after reviewing a complaint or conducting an investigation and considering the response of an agency, facility, or program and any other pertinent material, the ombudsman determines that the complaint has merit or the investigation reveals a problem, the ombudsman may recommend that the agency, facility, or program:

(1) consider the matter further;

(2) modify or cancel its actions;

(3) alter a rule, order, or internal policy;

(4) explain more fully the action in question; or

(5) take other action.

(b) At the ombudsman's request, the agency, facility, or program shall, within a reasonable time, inform the ombudsman about the action taken on the recommendation or the reasons for not complying with it.

Subd. 5. **Recommendations to University of Minnesota.** If, after reviewing a complaint or conducting an investigation and considering the response of the clinical drug trial's primary investigator or the Department of Psychiatry, the ombudsman determines that the complaint has merit or the investigation reveals noncompliance with the federal protection of human subjects requirements or the requirements of the Institutional Review Board, the ombudsman shall recommend that the Board of Regents of the University of Minnesota take corrective action to remedy the violations.

History: *1987 c 352 s 5; 1988 c 543 s 5-8; 1989 c 282 art 2 s 58,59; 1989 c 351 s 16; 1990 c 398 s 1; 1996 c 451 art 6 s 2,3; 2005 c 56 s 1; 2008 c 219 s 4,5; 2013 c 108 art 8 s 6,7; 2014 c 275 art 1 s 37; 2016 c 158 art 1 s 87; 2016 c 189 art 1 s 23; 1Sp2017 c 6 art 8 s 10; 2022 c 98 art 4 s 51; 2024 c 79 art 8 s 15; 2024 c 125 art 5 s 43; 2024 c 127 art 50 s 43; 2025 c 38 art 8 s 50*

245.945 REIMBURSEMENT TO OMBUDSMAN FOR MENTAL HEALTH AND DEVELOPMENTAL DISABILITIES.

The commissioner shall obtain federal financial participation for eligible activity by the ombudsman for mental health and developmental disabilities. The ombudsman shall maintain and transmit to the Department of Human Services documentation that is necessary in order to obtain federal funds.

History: *1Sp2003 c 14 art 6 s 3; 2005 c 56 s 1*

245.95 RECOMMENDATIONS AND REPORTS TO GOVERNOR.

Subdivision 1. **Specific reports.** The ombudsman may send conclusions and suggestions concerning any matter reviewed to the governor. Before making public a conclusion or recommendation that expressly or implicitly criticizes an agency, facility, program, or any person, the ombudsman shall consult with the governor and the agency, facility, program, or person concerning the conclusion or recommendation. When sending a conclusion or recommendation to the governor that is adverse to an agency, facility, program, or any person, the ombudsman shall include any statement of reasonable length made by that agency, facility, program, or person in defense or mitigation of the office's conclusion or recommendation. For purposes of this subdivision, "agency, facility, program, or any person" includes the University of Minnesota Department of Psychiatry and its employees working in clinical drug trials.

Subd. 2. **General reports.** In addition to whatever conclusions or recommendations the ombudsman may make to the governor on an ad hoc basis, the ombudsman shall, at the end of each biennium, report to the governor concerning the exercise of the ombudsman's functions during the preceding biennium.

History: *1987 c 352 s 6; 1988 c 543 s 9; 1996 c 451 art 6 s 4; 2016 c 189 art 1 s 24*

245.96 CIVIL ACTIONS.

The ombudsman and designees of the ombudsman are not civilly liable for any action taken under sections 245.91 to 245.97 if the action was taken in good faith, was within the scope of the ombudsman's authority, and did not constitute willful or reckless misconduct.

History: *1986 c 444; 1987 c 352 s 7*

245.97 OMBUDSMAN COMMITTEE.

Subdivision 1. **Membership.** The Ombudsman Committee consists of 15 members appointed by the governor to three-year terms. Members shall be appointed on the basis of their knowledge of and interest in the health and human services system subject to the ombudsman's authority. In making the appointments, the governor shall try to ensure that the overall membership of the committee adequately reflects the agencies,

facilities, and programs within the ombudsman's authority and that members include consumer representatives, including clients, former clients, and relatives of present or former clients; representatives of advocacy organizations for clients and other individuals served by an agency, facility, or program; human services and health care professionals, including specialists in psychiatry, psychology, internal medicine, and forensic pathology; and other providers of services or treatment to clients.

Subd. 2. **Compensation; chair.** Members do not receive compensation, but are entitled to receive reimbursement for reasonable and necessary expenses incurred. The governor shall designate one member of the committee to serve as its chair at the pleasure of the governor.

Subd. 3. **Meetings.** The committee shall meet at least four times a year at the request of its chair or the ombudsman.

Subd. 4. **Duties.** The committee shall advise and assist the ombudsman in selecting matters for attention; developing policies, plans, and programs to carry out the ombudsman's functions and powers; and making reports and recommendations for changes designed to improve standards of competence, efficiency, justice, and protection of rights. The committee shall function as an advisory body.

Subd. 5. **Medical Review Subcommittee.** At least five members of the committee, including at least three physicians, one of whom is a psychiatrist, must be designated by the governor to serve as a Medical Review Subcommittee. Terms of service, vacancies, and compensation are governed by subdivision 2. The governor shall designate one of the members to serve as chair of the subcommittee. The Medical Review Subcommittee may have access to private and confidential data collected or created by the ombudsman that are necessary to fulfill the duties of the Medical Review Subcommittee under this section and may:

(1) make a preliminary determination of whether the death of a client that has been brought to its attention is unusual or reasonably appears to have resulted from causes other than natural causes and warrants investigation;

(2) review the causes of and circumstances surrounding the death;

(3) request the county coroner or medical examiner to conduct an autopsy;

(4) assist an agency in its investigations of unusual deaths and deaths from causes other than natural causes;

(5) make a preliminary determination of whether the death of a participant in a clinical drug trial conducted by the University of Minnesota Department of Psychiatry appears to have resulted from causes other than natural causes and warrants investigation and reporting as required by federal laws on the protection of human subjects; and

(6) submit a report regarding the death of a client to the committee, the ombudsman, the client's next-of-kin, and the facility where the death occurred and, where appropriate, make recommendations to prevent recurrence of similar deaths to the head of each affected agency or facility, or the Board of Regents of the University of Minnesota.

Subd. 6. **Terms, compensation, and removal.** The membership terms, compensation, and removal of members of the committee and the filling of membership vacancies are governed by section 15.0597.

Subd. 7. MS 2012 [Repealed, 2014 c 286 art 8 s 40]

History: *1987 c 352 s 8; 1988 c 543 s 10; 1988 c 629 s 46; 1993 c 286 s 26; 1996 c 451 art 6 s 5; 2007 c 133 art 2 s 9; 2008 c 219 s 6; 2016 c 189 art 1 s 25; 1Sp2017 c 6 art 8 s 11*

OMBUDSPERSON FOR FAMILY CHILD CARE PROVIDERS

245.975 OMBUDSPERSON FOR FAMILY CHILD CARE PROVIDERS.

Subdivision 1. **Creation and appointment.** The Office of the Ombudsperson for Family Child Care Providers is hereby created. The governor shall appoint an ombudsperson in the unclassified service to assist family child care providers with licensing, compliance, and other issues facing family child care providers. The ombudsperson must be selected without regard to the person's political affiliation and must have been a licensed family child care provider for at least three years. The ombudsperson shall serve a term of four years, which may be renewed, and may be removed prior to the end of the term for just cause.

Subd. 2. **Duties.** (a) The ombudsperson's duties shall include:

(1) advocating on behalf of a family child care provider to address all areas of concern related to the provision of child care services, including licensing monitoring activities, licensing actions, and other interactions with state and county licensing staff;

(2) providing recommendations for family child care improvement or family child care provider education;

(3) operating a telephone line to answer questions, receive complaints, and discuss agency actions when a family child care provider believes that the provider's rights or program may have been adversely affected; and

(4) assisting a family child care license applicant with navigating the application process.

(b) The ombudsperson must report annually by December 31 to the commissioner of children, youth, and families and the chairs and ranking minority members of the legislative committees with jurisdiction over child care on the services provided by the ombudsperson to child care providers, including the number and locations of child care providers served and the activities of the ombudsperson in carrying out the duties under this section. The commissioner shall determine the form of the report and may specify additional reporting requirements.

Subd. 3. **Staff.** The ombudsperson may appoint and compensate out of available funds a deputy, confidential secretary, and other employees in the unclassified service as authorized by law. The ombudsperson and the full-time staff are members of the Minnesota State Retirement Association. The ombudsperson may delegate to staff members any authority or duties of the office, except the duty to provide reports to the governor, commissioner, or the legislature.

Subd. 4. **Access to records.** (a) The ombudsperson or designee, excluding volunteers, has access to any data of a state agency necessary for the discharge of the ombudsperson's duties, including records classified as confidential data on individuals or private data on individuals under chapter 13 or any other law. The ombudsperson's data request must relate to a specific case and is subject to section 13.03, subdivision 4. If the data concerns an individual, the ombudsperson or designee shall first obtain the individual's consent. If the individual is unable to consent and has no parent or legal guardian, then the ombudsperson's or designee's access to the data is authorized by this section.

(b) The ombudsperson and designees must adhere to the Minnesota Government Data Practices Act and must not disseminate any private or confidential data on individuals unless specifically authorized by state, local, or federal law or pursuant to a court order.

(c) The commissioner of human services; the commissioner of children, youth, and families; and any county agency must provide the ombudsperson copies of all fix-it tickets, correction orders, and licensing actions issued to family child care providers.

Subd. 5. **Independence of action.** In carrying out the duties under this section, the ombudsperson may, independently of the department, provide testimony to the legislature, make periodic reports to the legislature, and address areas of concern to family child care providers.

Subd. 6. **Civil actions.** The ombudsperson or designee is not civilly liable for any action taken under this section if the action was taken in good faith, was within the scope of the ombudsperson's authority, and did not constitute willful or reckless misconduct.

Subd. 7. **Qualifications.** The ombudsperson must be a person who has knowledge and experience concerning the provision of family child care. The ombudsperson must be experienced in dealing with governmental entities, interpretation of laws and regulations, investigations, record keeping, report writing, public speaking, and management. A person is not eligible to serve as the ombudsperson while running for or holding public office or while holding a family child care license.

Subd. 8. MS 2022 [Repealed, 2024 c 115 art 16 s 47]

Subd. 9. **Posting.** (a) The commissioner of children, youth, and families shall post on the department's website the mailing address, email address, and telephone number for the office of the ombudsperson. The commissioner shall provide family child care providers with the mailing address, email address, and telephone number of the ombudsperson's office on the family child care licensing website and upon request of a family child care applicant or provider. Counties must provide family child care applicants and providers with the name, mailing address, email address, and telephone number of the ombudsperson's office upon request.

(b) The ombudsperson must approve all postings and notices required by the department and counties under this subdivision.

History: *1Sp2021 c 7 art 2 s 3; 2024 c 115 art 16 s 5-7; 1Sp2025 c 3 art 13 s 14*

COMPULSIVE GAMBLING

245.98 COMPULSIVE GAMBLING TREATMENT PROGRAM.

Subdivision 1. **Definition.** For the purposes of this section, "compulsive gambler" means a person who is chronically and progressively preoccupied with gambling and with the urge to gamble to the extent that the gambling behavior compromises, disrupts, or damages personal, family, or vocational pursuits.

Subd. 2. **Program.** The commissioner of human services shall establish a program for the treatment of compulsive gamblers. The commissioner may contract with an entity with expertise regarding the treatment of compulsive gambling to operate the program. The program may include the establishment of a statewide toll-free number, resource library, public education programs; regional in-service training programs and conferences for health care professionals, educators, treatment providers, employee assistance programs, and criminal justice representatives; and the establishment of certification standards for programs and service providers. The commissioner may enter into agreements with other entities and may employ or contract with consultants to facilitate the provision of these services or the training of individuals to qualify them to provide these services. The program may also include inpatient and outpatient treatment and rehabilitation services for residents in different settings, including a temporary or permanent residential setting for mental health or substance use disorder, and individuals in jails or correctional facilities. The program may also

include research studies. The research studies must include baseline and prevalence studies for adolescents and adults to identify those at the highest risk. The program must be approved by the commissioner before it is established.

Subd. 2a. **Assessment of certain offenders.** The commissioner shall adopt by rule criteria to be used in conducting compulsive gambling assessments of offenders under section 609.115, subdivision 9. The commissioner shall also adopt by rule standards to qualify a person to: (1) assess offenders for compulsive gambling treatment; and (2) provide treatment indicated in a compulsive gambling assessment. The rules must specify the circumstances in which, in the absence of an independent assessor, the assessment may be performed by a person with a direct or shared financial interest or referral relationship resulting in shared financial gain with a treatment provider.

Subd. 3. MS 1994 [Repealed, 1995 c 207 art 11 s 12]

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 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.

Subd. 5. **Standards.** The commissioner shall create standards for treatment and provider qualifications for the treatment component of the compulsive gambling program.

History: *1989 c 334 art 7 s 1; 1991 c 336 art 2 s 7; 1993 c 146 art 3 s 7; 1995 c 86 s 1; 1997 c 203 art 9 s 3; 2007 c 147 art 8 s 10; 2022 c 98 art 4 s 51*

245.981 MS 2020 [Repealed, 2022 c 98 art 14 s 33]

245.982 PROGRAM SUPPORT.

In order to address the problem of gambling in this state, the compulsive gambling fund should attempt to assess the beneficiaries of gambling, on a percentage basis according to the revenue they receive from gambling, for the costs of programs to help problem gamblers and their families. In that light, the governor is requested to contact the chairs of the 11 Tribal governments in this state and request a contribution of funds for the compulsive gambling program. The governor should seek a total supplemental contribution of $643,000. Funds received from the Tribal governments in this state shall be deposited in the Indian gaming revolving account.

History: *1998 c 407 art 8 s 5*

MENTAL ILLNESS CRISIS HOUSING

245.99 ADULT MENTAL ILLNESS CRISIS HOUSING ASSISTANCE PROGRAM.

Subdivision 1. **Creation.** The adult mental illness crisis housing assistance program is established in the Department of Human Services.

Subd. 2. **Rental assistance.** The program shall pay up to 90 days of housing assistance for persons with a serious mental illness who require inpatient or residential care for stabilization. The commissioner of human services may extend the length of assistance on a case-by-case basis.

Subd. 3. **Eligibility.** Housing assistance under this section is available only to persons of low or moderate income as determined by the commissioner.

Subd. 4. **Administration of crisis housing assistance.** The commissioner may contract with organizations or government units experienced in housing assistance to operate the program under this section. This program is not an entitlement. The commissioner may take any of the following steps whenever the commissioner projects that funds will be inadequate to meet demand in a given fiscal year:

(1) transfer funds from mental health grants in the same appropriation; and

(2) impose statewide restrictions as to the type and amount of assistance available to each recipient under this program, including reducing the income eligibility level, limiting reimbursement to a percentage of each recipient's costs, limiting housing assistance to 60 days per recipient, or closing the program for the remainder of the fiscal year.

History: *1999 c 245 art 4 s 8; 1Sp2001 c 9 art 9 s 19; 2002 c 379 art 1 s 113; 2016 c 189 art 16 s 3*

245.991 PROJECTS FOR ASSISTANCE IN TRANSITION FROM HOMELESSNESS PROGRAM.

Subdivision 1. **Establishment.** The commissioner of human services must establish the projects for assistance in transition from homelessness program to prevent or end homelessness for people with serious mental illness, substance use disorder, or co-occurring substance use disorder and ensure the commissioner achieves the goals of the housing mission statement in section 245.461, subdivision 4.

Subd. 2. **Eligible applicants.** An applicant for a grant under this section must be a nonprofit organization, county, or other entity that provides services to help individuals transition from homelessness.

Subd. 3. **Allowable grant activities.** Grantees must provide homeless outreach and case management services. Projects may provide clinical assessment, habilitation and rehabilitation services, community mental health services, substance use disorder treatment, housing transition and sustaining services, or direct assistance funding. Services must be provided to individuals with a serious mental illness, substance use disorder, or co-occurring substance use disorder and who are homeless or at imminent risk of homelessness. Individuals receiving homeless outreach services may be presumed eligible until a serious mental illness can be verified.

Subd. 4. **Outcomes.** (a) Grantees must submit an annual report to the commissioner for the purposes of evaluating the effectiveness of the grant program. The report must include:

(1) the number of individuals to whom the grantee provided homeless outreach services;

(2) the number of individuals the grantee enrolled in case management services;

(3) the number of individuals that were able to access mental health and substance use disorder treatment services; and

(4) the number of individuals that were able to transition from homelessness to housing.

(b) The commissioner must submit the results of the evaluation to the chairs and ranking minority members of the legislative committees with jurisdiction over mental health and homelessness.

Subd. 5. **Federal aid or grants.** The commissioner of human services must comply with all conditions and requirements necessary to receive federal aid or grants with respect to homeless services or programs as specified in section 245.70.

History: *2023 c 70 art 17 s 7; 2024 c 127 art 66 s 12; 2026 c 95 art 6 s 1*

245.992 HOUSING WITH SUPPORT FOR ADULTS WITH SERIOUS MENTAL ILLNESS PROGRAM.

Subdivision 1. **Establishment.** The commissioner of human services must establish a housing with support for adults with serious mental illness program to prevent or end homelessness for people with serious mental illness, substance use disorder, or co-occurring substance use disorder; to increase the availability of housing with support; and to ensure the commissioner may achieve the goals of the housing mission statement in section 245.461, subdivision 4.

Subd. 2. **Eligible beneficiaries.** Program activities must be provided to people with a serious mental illness, substance use disorder, or co-occurring substance use disorder, who meet homeless criteria determined by the commissioner.

Subd. 3. **Allowable grant activities.** Grantees must provide a range of activities and supportive services that ensure individuals obtain and retain permanent supportive housing. Program activities may include case management, site-based housing services, housing transition and sustaining services, outreach services, community support services, or direct assistance funding.

Subd. 4. **Outcomes.** (a) Grantees must submit an annual report to the commissioner for the purposes of evaluating the effectiveness of the grant program. The report must include:

(1) whether the grantee's housing and activities utilized evidence-based practices;

(2) the number of individuals that were able to transition from homelessness to housing;

(3) the number of individuals that were able to retain housing; and

(4) whether the individuals were satisfied with their housing.

(b) The commissioner must submit the results of the evaluation to the chairs and ranking minority members of the legislative committees with jurisdiction over mental health and homelessness.

History: *2023 c 70 art 17 s 8; 2026 c 95 art 6 s 2,3*